
Evaluation of UNICEF's District Health Systems Strengthening Initiative in Kenya, Malawi, Tanzania, and Uganda (2019–2022)

Baseline/Year 1 Report

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Preface

This is the baseline/Year 1 report for the evaluation of the District Health Systems Strengthening Initiative (DHSSi). DHSSi is a multi-year initiative being implemented in Kenya, Tanzania, Malawi, and Uganda, that is led by the UNICEF Eastern and Southern Africa Regional Office under a grant agreement with the Bill and Melinda Gates Foundation. An evaluation of this initiative is being carried out by Oxford Policy Management.

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Executive summary

Introduction

The District Health Systems Strengthening Initiative (DHSSi) supports sub-national health systems strengthening across 24 pilot districts in Kenya, Malawi, Tanzania and Uganda. The overall aim of DHSSi is to improve management and governance practices at the sub-national level, as well as to promote scale-up of effective approaches in each country. These changes are in turn expected to contribute toward a reduction in health system bottlenecks, and ultimately an improvement in the coverage of high-impact health interventions. DHSSi is funded under a grant agreement between the United Nations Children's Fund (UNICEF) and the Bill and Melinda Gates Foundation (BMGF). Phase I of the initiative runs from January 2019 until June 2022 and a second Phase is expected to take place after this. DHSSi's approach consists of support to use of evidence for planning; execution of evidence-informed operational plans (through improved health management and governance capacity); performance management; stakeholder engagement and consensus building; accountability; and a reduction of barriers related to practising good management. To support effective district planning, DHSSi has a specific focus on evidence-based planning (EBP) through the bottleneck analysis (BNA) approach. This report provides baseline and year 1 findings of DHSSi.

Evaluation purpose and approach

The purpose of the evaluation is to identify lessons that can inform ongoing DHSSi implementation and refine future programming. The evaluation is also designed to inform decisions about future investment and scale-up. Evaluation questions relate to the OECD DAC criteria, assessing DHSSi's relevance, coherence, efficiency, effectiveness and sustainability. The evaluation uses a mixed methods, theory-based design as a way to both assess and explain DHSSi's contribution and its effectiveness in generating outcomes. There are three rounds of evaluation, with data collection in 2020, 2021 and 2022. This report is for the first evaluation round.

The timing of the Year 1 assessment was affected by COVID-19, which resulted in UNICEF and BMGF temporarily suspending DHSSi implementation, and the evaluation team pausing activity. Evaluation activities resumed on a staggered basis, with fieldwork over October to December 2020 (with some further interviews in Malawi in January to February 2021). The evaluation focused on implementation until around July 2020, in line with the 2019–20 planning cycle, though with some information on more recent activities up to the time of fieldwork. Variation in DHSSi implementation status and timing between countries affects the baseline period, but in general, baseline is considered as covering the development, review and implementation of 2019–20 district plans (as 2019–20 plans were developed in late 2018–early 2019, before DHSSi began). Development of 2020–21 plans is considered part of Year 1 activities (except in Kenya, where DHSSi support for EBP was postponed until 2021, and this evaluation round is restricted to baseline findings rather than DHSSi contribution).

The Year 1 assessment focused on evaluation questions that can be best answered at this early stage of DHSSi implementation, particularly relating to relevance, coherence, and efficiency, with more preliminary indications of effectiveness and factors that may affect sustainability. At this stage, assessment of DHSSi's contribution involves initial indications rather than rigorous assessment of causality; more detailed analysis of contribution (including associated mechanisms, and positive or negative unintended consequences) will be conducted in later evaluation rounds, when DHSSi's effects have had more time to

develop. This round also focused on effectiveness of EBP activities, given the earlier stage of work on management and accountability. It is too early in DHSSi implementation to assess impact on bottlenecks or coverage, but baseline coverage information was collected to allow analysis in future years (see Annex M).

The evaluation used a combination of methods:

- An implementation log completed in collaboration with UNICEF COs to track DHSSi activities, including their reach, timing, content, and implementation strength.
- The Planning and Management Assessment Tool (PAMAT), used to guide discussion with district health management team (DHMT) members and to assess district practice in areas such as use of BNA and stakeholder involvement. The DHMT discussion was supported by a review of documents such as district plans and meeting minutes.
- Interviews at district, national and cross-country level, with. Participants included DHMT and district executive members, national government, non-government organisations (NGOs), national government development agencies, UNICEF COs, DHSSi implementing partners and the international technical partner.
- Review of district, national and DHSSi programme documents, including district annual plans.
- Analysis of routine data on health intervention coverage indicators, including identification of quarterly trends and comparison against non-DHSSi districts.

As with all evaluations and research, this evaluation faced several constraints, which have been considered in the analysis and reporting. First, availability and reliability of data on coverage of key health interventions, and construction of health management information systems (HMIS) indicators, varied between countries. Second, identifying baseline status of district practice has relied, to some extent, on retrospective analysis, which is not ideal due to issues with recall. Third, access to documentation and detail provided in documents varies, affecting assessment of planning practice. Fourth, observation of district planning and management and national policy processes would have added depth and triangulation, but due to COVID-19, it was decided with ESARO that observation should not be conducted. Fifth, fieldwork was affected by the ongoing COVID-19 pandemic, which necessitated some remote interviews and PAMAT discussions. Sixth, the interview sample was affected by resources and in some cases, limited availability among key stakeholders; further interviews with additional government departments, sub-district level managers and UNICEF managers would have brought additional perspectives.

Key findings and conclusions

In the first year of the programme, despite some delays and disruptions due to COVID-19, there was notable progress in most DHSSi contexts. In particular, this was seen in relation to EBP and BNA, which were used to develop 2020/21 annual workplans (the exception being Kenya). In general, delays and disruptions have resulted in staggered implementation across contexts, which may reinforce the advantage of regional coordination to share lessons across countries and adapt approaches.

In all contexts, support for EBP and management aligns closely with national government priorities. The four countries have invested in national planning systems and health management capacity (supported through development agencies) to facilitate the production of standardised district plans and budgets. This is in recognition of devolved health service delivery and the role of sub-national health teams in decentralised planning and management. Health information systems have enabled greater access to data, with potential to drive performance and monitoring. Within this broader context, EBP and BNA are recognised as aiding analysis and prioritisation to varying degrees.

At district level, support for EBP and management was more mixed. Some DHMTs were uncertain about the value of EBP, and the value of annual plans and budgets more generally. There were concerns with data quality, fit with the planning cycle and budget system, and limited decision and fiscal space. System hardware, such as infrastructure, human resources, essential medicines, and supplies, is the primary concern in most contexts. While DHSSi activities and EBP were seen as helpful for more accurately identifying specific problems, they were sometimes viewed as limited in actually addressing hardware constraints or other district bottlenecks due to insufficient funding and implementation of the identified solutions.

Findings suggest that DHSSi activities have resulted in stronger district health planning and management practice. In Uganda, Tanzania, and Malawi, support through DHSSi has had a clear impact on development of the 2020–21 plans, while in Kenya this support was delayed due to COVID-19. The contribution was both direct through EBP training, ongoing support for DHMTs, and funding for workshops, and indirect through the development of national guidelines and planning tools. The impact on consideration of equity in planning is less evident. The effectiveness of other activities related to management and accountability will be assessed further in later rounds of the evaluation.

Preliminary indications of factors that may enable or hinder sustainability also emerged. In Tanzania, Malawi, and Uganda, inclusion of BNA within planning guidelines is an important step in national institutionalisation of the approach. However, while national and district respondents in all countries are generally positive about EBP, there are reservations about complexity and time requirements, and the degree of government ownership varies between countries. Wider government engagement may also be needed to sustain support, as DHSSi often works with particular individuals or teams, making it reliant on individual championing and vulnerable to staff turnover. In all countries, funding from development agencies was also seen as necessary to expand EBP and (in Malawi) management training, with some stakeholders mentioning that a strong signal from national government would be needed to encourage agencies' support. All UNICEF COs have taken steps to promote sustainability and address some of these factors.

Recommendations

Draft recommendations were discussed with UNICEF COs and ESARO. This first evaluation round was necessarily broad and several areas require further investigation. In addition, the early stage of DHSSi means the consequences of different strategies are not yet fully evident. The recommendations below should, therefore, be considered as areas to explore at this stage in DHSSi.

Rationale: greater alignment between EBP and district budgeting systems is needed to reinforce the underlying rationale (and motivation) for implementing these approaches.

- UNICEF COs: Engage with all relevant government ministries and departments (e.g. Ministry of Finance) to ensure support for EBP is aligned to other district planning and budgeting systems.
- UNICEF COs/implementing partners: Involve local government departments engaged in planning and budgeting systems in discussions on EBP (e.g. District finance officers), to understand other relevant district processes and support alignment; ensure timing of support for EBP is aligned with budget cycles
- ESARO: Support learning on approaches to alignment between countries

Rationale: Earlier and wider engagement of district non-governmental organisations and other development agencies in EBP and BNA may serve to strengthen prioritisation (and the underlying causal analysis) and to identify resources to address bottlenecks.

- UNICEF COs and implementing partners: Discuss and experiment with different models of stakeholder engagement in earlier stages of planning, focusing on agencies that show the most interest and greatest complementarities.
- ESARO: Support learning on approaches to stakeholder engagement between countries.

Rationale: A number of other development agencies support district planning and management capacity, with potential synergy with DHSSi investment.

- UNICEF COs: Continue and increase engagement with other development agencies working in planning and management, to ensure mutual understanding of activities and identify opportunities for alignment.
- UNICEF COs and implementing partners: Map district-level support to local government planning and management, to avoid duplication and identify complementarities.
- ESARO: Alert COs to information on any relevant regional initiatives, and share information on complementarities identified by UNICEF COs that may be applied in other DHSSi countries.

Rationale: district governance and leadership affect district planning and management.

- UNICEF COs and implementing partners: Carefully consider the implications of the PEA findings (in Kenya, Malawi, and Uganda), and implement relevant recommendations. Given the complexity of addressing governance, leadership and accountability, closely monitor DHSSi activities in these areas to adjust support as needed. Engage with other initiatives that aim to promote effective governance, leadership and accountability, to identify complementarities.

Rationale: Lack of funding is widely seen as a constraint to applying BNA and implementing annual plans. Uncertain funding and unexpected events require changes to planned activities during the year.

- UNICEF COs and implementing partners: Clarify rationales for EBP and ensure different rationales (e.g. efficiency and resource mobilisation) are consistent with each other, and with formal and informal planning processes (e.g. prioritisation). In support to DHMT planning capacity, increase the emphasis on identifying efficiencies and strategies to address bottlenecks within existing fiscal space, and share learning about effective approaches between DHMTs. Consider ways to support DHMTs' adaptive capacity to enable continued implementation in the event of unexpected costs or changes in funding, for example contingency funding and ability to reprioritise during the year (perhaps as part of quarterly reviews and regular DHMT meetings).
- ESARO Consider and document experience from within UNICEF on supporting DHMT adaptive capacity in the face of unanticipated costs and uncertain funding.

Rationale: There are emerging findings regarding the relative merits and drawbacks of implementation models, including the type of implementing partner, approach to workshops and other capacity development activities, and planning tools.

- UNICEF COs and implementing partners: Consider the costs/benefits of expensive workshop models, whether these can be optimised through joint sessions that combine training on EBP and BNA with practical application and development of plans and options for smaller programme-based group work. Ensure workshops or other forms of support to planning provide sufficient time for solution identification and prioritisation. Support systematic consideration of equity and gender in problem analysis and identification of solutions. Ensure BNA Excel worksheets and the Action Tracker are aligned with the planning and review process and used consistently, to enable effective monitoring of bottleneck reductions. Consider how the model for management activities will address issues such as turnover and avoiding taking DHMTs from other activities.

- ESARO: Share learning on different models between COs Support COs and IPs in ensuring that BNA Excel workshops and Action Trackers are used consistently. Review EBP guidance to ensure sufficient support for consideration of equity and gender.

Table of contents

Preface	i
Executive summary	ii
List of tables and figures	viii
List of abbreviations	ix
1 Background	1
1.1 Programme overview	1
1.2 Contextual overview	5
1.3 Structure of report	7
2 Evaluation approach	8
2.1 Purpose, objectives and audiences	8
2.2 Evaluation criteria and evaluation questions	9
2.3 Methods	10
2.4 Organisation, management, and quality assurance of the evaluation work	13
2.5 Limitations	13
2.6 Ethical issues and considerations	14
3 Findings	15
3.1 Relevance: Is the intervention doing the right things?	15
3.2 Coherence: How well does the intervention fit?	20
3.3 Efficiency: How well are resources being used?	23
3.4 Effectiveness: Is the intervention achieving its objectives?	27
3.5 Sustainability: will the benefits last?	35
4 Conclusions	38
5 Lessons learned	40
6 Recommendations	42
7 References	47

List of tables and figures

Table 1:	DHSSi funding by location	1
Table 2:	DHSSi target districts	4
Table 3	National health outcomes and health financing	6
Table 4:	Evaluation questions	9
Table 5:	DHMT management performance	30
Table 6	Recommendations	42
Figure 1:	DHSSi ToC	3

List of abbreviations

ANC	Antenatal care
BMGF	Bill and Melinda Gates Foundation
BNA	Bottleneck analysis
CCHP	Comprehensive Council Health Plan
CHAI	Clinton Health Access Initiative
CHMT	County health management team (Kenya) or Council health management team (Tanzania)
CODES	Community and District Empowerment for Scale-up
CO	Country Office
CPR	Contraceptive prevalence rate
DFID	UK Department for International Development
DHFF	Direct Health Facility Financing
DHIS2	District Health Information Software
DHMT	District health management team
DHO	District Health Office/Officer
DHSSi	District Health Systems Strengthening initiative
DIP	District Implementation Plan
EBP	Evidence-based planning
ENTAF	Enhance Tanzania Foundation
ERG	Evaluation Reference Group
ESA	Eastern and Southern Africa
FPD	Foundation for Professional Development
GBV	Gender-based Violence
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
HISP	Health Information Systems Program
HMIS	Health management information system
HR	Human Resources

HUMC	Health Unit Management Committee
KCO	Kenya Country office
MCO	Malawi Country office
MoH	Ministry of Health
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
NHIF	National Hospital Insurance Fund
NTD	Neglected tropical diseases
OECD	Organisation for Economic Co-operation and Development
OPM	Oxford Policy Management
PAMAT	Planning and Management Assessment Tool
PEA	Political economy analysis
PNC	Postnatal care
PO-RALG	The President's Office for Regional Administration and Local Government
RMNCH	Reproductive, maternal, neonatal, and child health
SDG	Sustainable Development Goal
SDI	Staff Development Institute
SWOC	Strengths, weaknesses, opportunities and challenges
TCO	Tanzania Country office
ToC	Theory of change
ToR	Terms of reference
ToT	Training of trainers
UCO	Uganda Country office
UHC	Universal Health Coverage
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

1 Background

1.1 Programme overview

DHSSi supports sub-national health systems strengthening across 24 pilot districts in Kenya, Malawi, Tanzania, and Uganda, under a grant agreement between the health section of UNICEF ESARO and BMGF.¹ The overall aim of DHSSi is to improve governance and management practices at the sub-national level, as well as to promote the scale-up of effective approaches in each country. These changes are in turn expected to contribute towards a reduction in health system bottlenecks, and ultimately an improvement in coverage of high-impact health interventions. DHSSi Phase I runs from January 2019 until June 2022 and a second phase is expected. DHSSi supports the following functions:

- use of evidence for planning;
- execution of evidence-informed operational plans (through improved health management and governance capacity);
- performance management;
- stakeholder engagement and consensus building;
- accountability; and
- reduction of barriers related to practising good management.

The total budget is US\$ 9,536,604,² and breakdown by location is provided in Table 1.

Table 1: DHSSi funding by location

Location	Funding
UNICEF ESARO	US\$ 1,859,240
UNICEF HQ	US\$ 268,431
UNICEF Malawi	US\$ 1,493,099
UNICEF Uganda	US\$ 1,469,159
UNICEF Tanzania	US\$ 1,279,200
UNICEF Kenya	US\$ 1,164,764
Foundation for Professional Development (FPD, all countries)	US\$ 1,400,000

Source: DHSSi Annual Report 2020

DHSSi emerged from an established health system strengthening agenda within UNICEF. Starting in Uganda in around 2011, UNICEF has supported several initiatives in sub-national health systems strengthening and EBP in the ESARO region (Waiswa, et al., 2016).³ DHSSi

¹ The terms of reference (ToR) provide a more detailed description (see Annex A).

² DHSSi Annual Report 2020.

³ DHSSi builds on a previous BMGF-funded initiative called Community and District Empowerment for Scale-up (CODES), implemented as a randomised controlled trial in Uganda from 2014 (see Waiswa et al, 2016). CODES introduced a systematic approach to EBP and BNA in target districts, supporting DHMTs to prioritise bottlenecks and use district-specific data for planning and monitoring. The CODES approach was subsequently introduced and scaled to 16 districts in Malawi. Following CODES, UNICEF also supported the Programme Monitoring and Response initiative in Kenya, Uganda, Zimbabwe, and Swaziland, from 2014, which also focused on promoting an evidence-based culture in sub-national health management and planning.

now seeks to build on this foundation. The initiative seeks to contribute to national and global strategies, including national strategies to achieve UHC in line with Sustainable Development Goal (SDG) 3; the progressive realisation of the right of the child to the enjoyment of the highest attainable standard of health; and the BMGF Integrated Delivery Team's strategy to accelerate the launch, delivery, use, and impact of life-saving and life-changing health products and services by strengthening primary healthcare management through investment in health system middle managers.⁴

1.1.1 The DHSSi theory of change and approach

The DHSSi theory of change (ToC), shown in Figure 1, describes how improvements across the functions listed above are expected to translate into key intended outcomes. The initiative has two primary outcomes, supported by five intermediate outcomes. Capacity building for districts in data use for decision making and management is expected to support intermediate outcomes of (1) improved data use for planning, monitoring and course correction, and (2) improved execution of health operational plans. Work to address barriers to good management practice and strengthen governance and accountability supports the intermediate outcome of (3) an enhanced enabling environment for good district management practices (including institutionalisation). These steps are supported by efforts to leverage investment in health information systems and support new apps for data analysis, which are expected to result in (4) improved use of data investments to support sub-national planning. The final intermediate outcome (5) is evidence generation to inform programme design, adaptation, scale-up and sustainability.

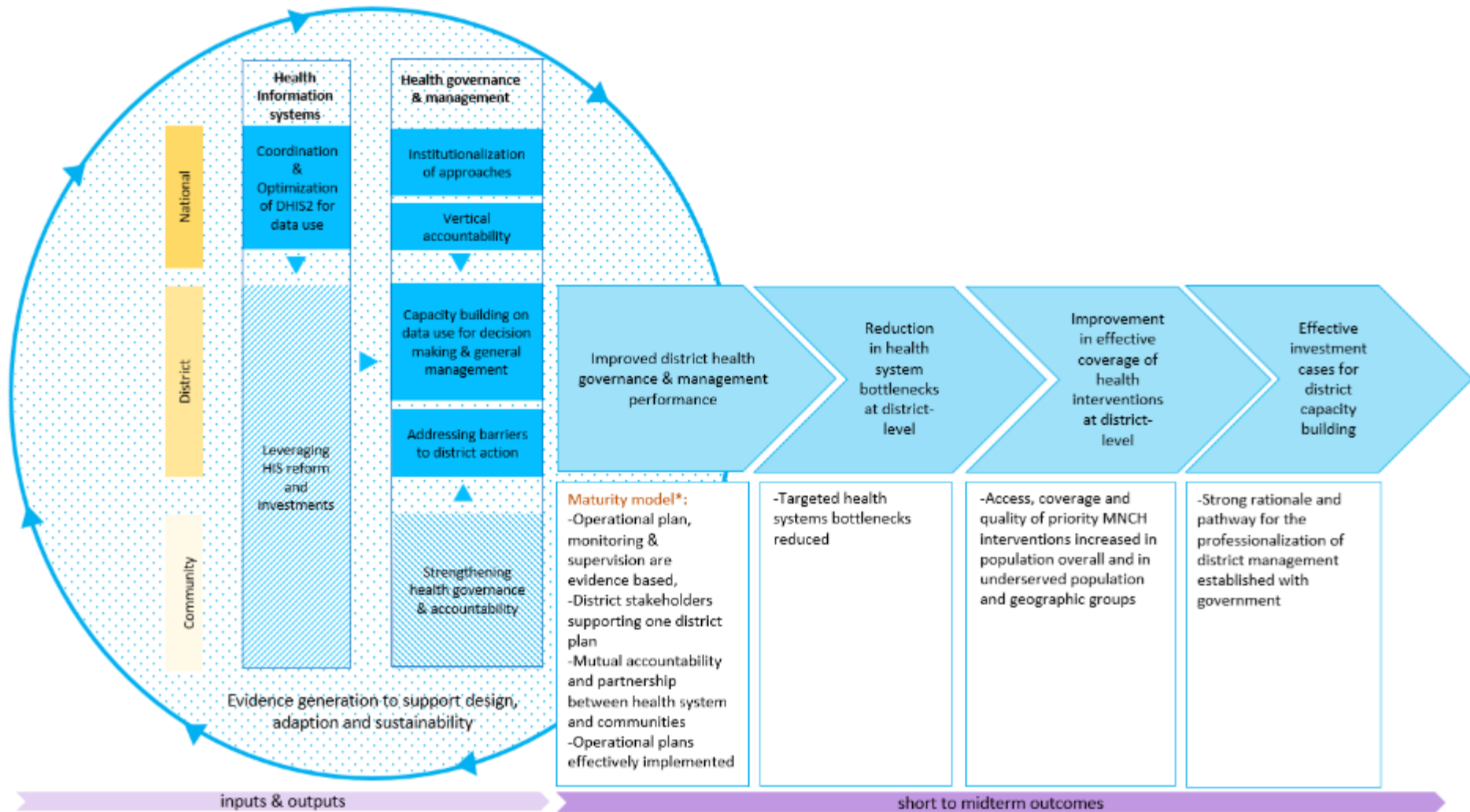
Achievement of these intermediate outcomes is expected to result in achievement of the two primary outcomes: (1) improved district health governance and management performance, which is assessed by looking at reduction in bottlenecks and improvements in population-based coverage of focal health interventions; and (2) scaling up the DHSS approach through institutionalisation, partner leveraging, and developing investment cases for the professionalisation of sub-national health management. Support for equitable outcomes is integrated in the approach through promoting consideration of underserved groups as part of sub-district planning, to improve equitable coverage.

The DHSSi results framework provides indicators to assess achievement of intermediate and primary outcomes as well as intermediate outputs.

To support effective district planning, DHSSi has a specific focus on evidence-based planning (EBP) through the bottleneck analysis (BNA) approach. This is a step-wise approach involving situation analysis, identifying bottlenecks and underlying causes, identifying and prioritising solutions, developing an implementation plan, and monitoring performance. Bottlenecks are identified by considering six determinants of effective coverage related to supply, demand and quality. Indicators for each determinant are assessed for 'tracer interventions' that represent a package of interventions or interventions delivered through the same platform (for example, through clinical, outreach or community-based services). Once bottlenecks are identified, root causes are identified using the 'five whys' technique. Equity is incorporated through considering 'equity stratifiers' (such as age, gender and location) as part of situation analysis, identification of bottlenecks, causal analysis, and during prioritisation. The BNA approach is based on a framework developed by Tanahashi (Tanahashi, 1978). It is a core part of UNICEF's health system strengthening approach, and has been used by UNICEF throughout the world (UNICEF, 2016).

⁴ From the ToR.

Figure 1: DHSSI ToC



1.1.2 Key stakeholders and implementing partners

DHSSi has 24 target districts across the four countries, shown in Table 2. Districts were selected together with the ministry of health (MoH) in each country, using a different process and set of criteria for each country (see Inception Report)⁵. At district level, targets of DHSSi activities include district health management teams and the district executive (for example, the council) in all countries, and additional stakeholders relevant for the specific country focus (for example, District Implementation Plan (DIP) coordination teams in Malawi, District service commissions in Uganda, and health facilities in Tanzania).

Table 2: DHSSi target districts

Country	Number of districts	District names
Kenya	5	Isiolo, Garissa, Kisumu, Siaya, Turkana
Malawi	5	Nkhata Bay, Zomba, Chiradzulu, Thyolo, Mangochi
Tanzania	4	Busokelo DC, Kyela DC, Chunya DC, Mbeya CC
Uganda	10	Lamwo, Kiryandongo, Oyam, Iganga, Bugweri, Kamuli, Kikuube, Kasese, Isingiro, Ntungamo

While the core focus of DHSSi activities is the district level (and facilities in Tanzania), all country strategies includes work at national level to strengthen the enabling environment for health management and governance, and to promote national ownership, scale-up, and sustainability. Through this work, DHSSi has sought to engage closely with the MoH and other relevant government ministries, such as the President's Office of Regional Administration and Local Government (PO-RALG) in Tanzania.

UNICEF's main technical partner for DHSSi is FPD, an accredited service provider for professional development that provides technical assistance for development of training curricula and strategies for improving the professional skills of health managers. At country level, DHSSi implementation is managed by UNICEF COs, together with local partners and in close partnership with government and the regional UNICEF ESARO office. Implementing partners include the Health Information Systems Program (HISP) (all countries); the Clinton Health Access Initiative (CHAI) and Staff Development Institute (SDI) in Malawi; Enhance for Tanzania Foundation (ENTAF) in Tanzania; and Baylor, AVSI, and Makerere University in Uganda. Implementing partner and stakeholder roles are described in Annex B.

1.1.3 Implementation status

Phase 1 of DHSSi is currently underway following a pause in implementation between April and September 2020⁶ to enable UNICEF COs and implementation partners to focus on the COVID-19 response. This pause led to delays in programme implementation. At the time of fieldwork, the main activities had included:

- **Working with national government and other stakeholders to support revisions to planning guidelines, plans for management capacity development, and in Uganda, guidelines on recruitment.**
- In Kenya, UNICEF established a BNA taskforce to guide EBP activities, and worked with the MoH HR Department to establish a technical working group on health management capacity development, including terms of reference and membership

⁵ OPM. June 2020. Evaluation of UNICEF's District Health Systems Strengthening Initiative in Kenya, Malawi, Tanzania and Uganda (2019 – 2022): Final Inception Report.

⁶ The extent to which activities were paused, and the dates of the pause, differ by country.

- In Malawi, UNICEF established a health leadership and management task force, comprising MoH departments and health partners, and worked with the MoH and SDI to develop a new district leadership and management capacity-building programme for DHMTs.
- In Tanzania, UNICEF worked with government to integrate BNA in the Comprehensive Council Health Plan (CCHP) guidelines as they were being revised in 2019, and to develop a 'how to' manual for health facility planning. Management activities focused on the 'Makole model' initiative, and included supporting ENTAF to conduct design meetings with government and to develop a concept note for the initiative.
- In Uganda, DHSSi supported revision of the 2016 District Planning Guidelines (Health Supplement) and development of a BNA manual during 2019, and revision of the District Service Guidelines for health worker recruitment (finalised in June 2020).
- **Training of trainers** in EBP and support to **district teams in EBP** (all countries except Kenya):
 - In Malawi, CHAI supported DHSSi districts to complete the DIP tools for 2020–21, through district workshops to provide training and complete the tools, followed by DIP write-up and partner coordination workshops. CHAI also provided ongoing support outside workshops, and worked with MoH to develop videos for virtual DIP training.
 - In Tanzania, ENTAF facilitated a national training of trainers (ToT) workshop on the CCHP and facility planning guidelines, BNA, and facilitation skills (with support from UNICEF, FPD, and PO-RALG); and training workshops for CHMTs in each DHSSi focus district (facilitated by ENTAF and ToT participants, with support from government and the Mbeya College of Health and Allied Sciences).
 - In Uganda, UNICEF and FPD facilitated a national EBP ToT workshop (October 2019) to build capacity to deliver EBP training and support district planning among DHSSi implementing partners. The MoH and UNICEF zonal offices also attended. Cascade training and support for district local governments was then provided by Baylor and AVSI. DHSSi also provided funding for performance review meetings in AVSI districts and Oyam. An online refresher training for implementing partners was held in September 2020, by UNICEF and FPD.
- **Management training** for three DHSSi districts in Malawi (a two-week course in September-October 2020).
- Work to contextualise, configure, build capacity on and use the **BNA App**, including work to agree interventions and indicators and to develop the App

More detailed information on activities conducted so far in each country is provided in the Country Reports Annex, including consideration of the extent to which activities were implemented as planned, as part of evaluating efficiency.

1.2 Contextual overview

Detailed information on the context for DHSSi is provided in the evaluation ToR (see Annex A) and the evaluation Inception Report, including information on health coverage, planning and management practice. As set out in the ToR, Eastern and Southern Africa (ESA) is the UNICEF sub-region with the second highest under-five mortality and maternal mortality in the world. Investment in health system strengthening is key to improving health outcomes. Health policies and plans are operationalised at the sub-national level, and strengthening sub-district planning and management is increasingly recognised as critical for health systems performance. So far, investment in sub-district management capacity has been relatively limited in ESA, and strengthening capacities has proved complex.

The four DHSSi countries differ with respect to the strength of the health system and population health outcomes, funding structures, decentralisation, and the current status of planning and management practice. Comparative information on national health outcomes and health financing is provided in Table 3, and in the Country Reports Annex.

Table 3 National health outcomes and health financing

Country	National health outcomes ⁷			Funding for health ⁸		
	Under-five mortality	Maternal mortality	Overall life expectancy	Donor funding as a proportion of total health budget	Health as a proportion of the national budget	Health expenditure per capita
Kenya	43 per 1,000 live births	342 per 100,000	66 years	25% in 2017/18	7% in 2017/18	US\$ 73 in 2016
Malawi	50 per 1,000 live births	349 per 100,000	64 years	85% in 2019/20	9.4% in 2019/20	US\$ 32 in 2017
Tanzania	53 per 1,000 live births	524 per 100,000	65 years	57% in 2017/18	6.7% in 2019/20	US\$ 35 in 2016
Uganda	46 per 1,000 live births	375 per 100,000	63 years	76% in 2018/19	5.1% in 2020/21	US\$ 39 in 2016

Design of DHSSi was informed by an initial 'landscaping exercise' undertaken jointly by FPD and UNICEF. This work revealed significant differences across the four country contexts with regards to the nature of health system decentralisation (with implications for decision-making and accountability relations), professionalisation of health management, and exposure to EBP and BNA.

DHSSi countries have all seen decentralisation of health service delivery over the last 25 years, albeit to different degrees and over different time periods (see the Country Reports Annex for more information about decentralisation in each country). The landscaping analysis highlighted a number of challenges in each country related to decentralisation. Devolution of health functions to the health facility level in **Tanzania** occurred rapidly, creating some challenges in transition. In **Uganda** there was a steady increase in the number of districts during the 2000s, which resulted in newly created district management teams that lack experience in managing health services and allied functions. This is exacerbated by the lack of a regional structure to provide further support and oversight to districts. In **Malawi** there are gaps in the articulation of relevant accountability structures, and in **Kenya** gaps persist in the management practices of CHMTs and sub-health

⁷ Under-five mortality and maternal mortality data is sourced from UN Inter-Agency Group for Child Mortality Estimation. 2020. *Levels and Trends in Child Mortality: Report 2020*. 2020.; WHO, et al. 2019. *Trends in Maternal Mortality: 2000 to 2017*. Geneva: WHO, 2019; life expectancy data is sourced from United Nations and Department of Economic and Social Affairs. 2019. *World Population Prospects 2019: Volume I: Comprehensive Tables*. New York: UN, 2019.

⁸ Funding data is sourced from Kenya National Treasury. (2017). *Public Expenditure Review: Health, Water and Sanitation*. 2017; WHO. 2021. Global Health Expenditure Database. [Online] 2021. <https://apps.who.int/nha/database/Select/Indicators/en>; Government of Tanzania and UNICEF (2018) 'Tanzania Health Budget Brief 2018'. Dar es Salaam; UNICEF (2020) Health sector Budget Brief. UNICEF, Tanzania; Economic Policy Research Center (2020) 'Investing In Health', Uganda Budget Brief No. 2020/3. Kampala: Economic Policy Research Center

management teams, despite efforts to strengthen their capacity.

Exposure to EBP and BNA varies between countries and districts (see Annex E). Most EBP efforts to date have come through specific grants and programmes (including previous UNICEF engagement), but EBP is starting to be incorporated into national priorities and guidelines (see Section 3.5 on sustainability and national institutionalisation). However, the DHSSi landscape analysis and information from evaluation inception discussions indicated only piecemeal uptake of EBP prior to DHSSi.

1.3 Structure of report

The remainder of the report is structured as follows: in Section 2, we present the evaluation approach and methods; in Section 3, we present findings by the OECD/DAC criteria and evaluation questions; in Section 4 we present the evaluation conclusions; in Section 5 we present lessons learned; and in Section 6 we provide recommendations. Findings specific to each DHSSi country are presented in a separate Country Reports Annex. A further annex document (Annexes A – N) contains information on the ToR, evaluation methods, baseline coverage indicators, and the results framework.

Subnational health management teams are referred to as *County* Health Management Teams in Kenya, *Council* Health Management Teams in Tanzania, and *District* Health Management Teams in Uganda and Malawi. Throughout the main report, we use the acronym DHMTs to refer generically to these sub-national health management teams across countries.

2 Evaluation approach

Details of the evaluation objectives, scope, approach and methods are provided in the Evaluation Inception Report, and summarised here.

2.1 Purpose, objectives and audiences

The purpose of the evaluation is to inform ongoing DHSSi design and implementation, and to inform future investment and scale up by examining results and identifying opportunities and challenges for sustainability and wider scaling. The objectives are to assess DHSSi results against set objectives at the end of Phase I, to support design of Phase 2, and to establish baseline information that can be used to assess impact in Phase 2. The ToR provide more detail on the specific objectives (see Annex A)

The primary expected users of the evaluation findings will be UNICEF ESARO, UNICEF COs, and BMGF, to inform their ongoing health systems strengthening agenda and policy advocacy. Other key audiences include the MoH and implementing partners in each DHSSi country, as well as other institutions and development agencies working on health systems strengthening in DHSSi countries, the ESA region and more broadly (see Annex B for an initial mapping of key stakeholders). There is currently relatively limited evidence on approaches to strengthening district health system management, so the evaluation can contribute to this gap in the health systems strengthening literature (Witter, et al., 2021).

2.1.1 Evaluation scope

Key aspects of the evaluation scope include timing in relation to DHSSi implementation, geographic locations and levels, results framework indicators covered by the evaluation, and fit with other research. The scope in the ToR was modified during inception to improve evaluability (see Annex C).

In relation to timing, the evaluation covers Phase I of DHSSi implementation, from January 2019 to June 2022. Timing of the Year 1 assessment was affected by COVID-19. Initially, the overarching timeline was anticipated to be three annual rounds of assessment taking place between June and August each year, aligning with completion of the annual government planning cycle in each country (with the Year 1 assessment additionally collecting information on the baseline period for DHSSi, before implementation began). However, as COVID-19 became more serious and DHSSi activity was paused, the evaluation team also paused. In consultation with UNICEF ESARO and UNICEF COs, planning for evaluation fieldwork resumed from August 2020, and fieldwork then began on a staggered basis and took place over October–December 2020 (with some further interviews in Malawi in January–February 2021). The evaluation focused on implementation until around July 2020, in line with the original plan of focusing on the 2019–20 planning cycle, though with some information on more recent activities up to the time of fieldwork.

The timing of data collection in Years 2 and 3 currently remains aligned with annual planning and fiscal cycles in each country, with the Year 3 assessment including summative work to bring together the evidence collected throughout the evaluation.

In relation to geographic scope, the evaluation covered all four DHSSi countries, and DHSSi activities at both district and national levels. It covered a sample of DHSSi intervention districts but did not cover non-intervention districts (see Section 2.3.3 for the sampling approach). The scope included measurement of population-level health coverage outcomes,

but excluded primary research at the community and facility level.

The evaluation scope includes providing evidence for some DHSSi results framework indicators (see ToR in Annex A). The results framework is presented in Annex N. For the purpose of assessing improved planning practice for the results framework, baseline is considered as development, review and implementation of 2019–20 district plans (as these plans were developed over late 2018–early 2019, before DHSSi implementation began), while Year 1 is considered in terms of developing the 2020–21 district plans.

The evaluation scope has been designed to align with other research commissioned by UNICEF in relation to DHSSi, to ensure complementarity of efforts. This includes implementation research commissioned by UNICEF COs on topics that relate to DHSSi (in some cases drawing on other sources of funding) and a Political Economy Analysis of sub-national health management (PEA) that is being conducted in Kenya, Uganda, and Malawi.⁹ Findings from this complementary research will contribute to future evaluation analysis, when they are made available to the evaluation team.

2.2 Evaluation criteria and evaluation questions

The evaluation questions are structured using the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) criteria (see Table 4). Initial evaluation questions in the ToR were revised during the inception period in consultation with UNICEF. Specific evaluation sub-questions are presented in Annex C. The evaluation questions correspond to the DHSSi ToC. Specifically, questions on efficiency relate to DHSSi outputs, including delivery of EBP and management capacity building activities; questions on effectiveness assess progress on the intermediate outcomes of improved data use for planning, monitoring and course correction, and improved execution of health operational plans; questions on sustainability relate to the ToC outcome of an enhanced enabling environment for good district management practices, particularly institutionalisation; and questions on impact relate to the primary outcomes of reduction in bottlenecks and improved coverage. The conceptual framework (see Annex D) shows these areas of focus, and how they are examined through different evaluation methods and analysis activities.

Table 4: Evaluation questions

OECD-DAC criteria	Evaluation questions
Relevance (Is the intervention doing the right things?)	To what extent is DHSSi's design aligned with the priorities and needs of national and district governments? To what extent does the DHSSi ToC hold under implementation?
Coherence (How well does the intervention fit?)	To what extent is DHSSi coherent with other interventions targeting district health teams? To what extent is there internal coherence between DHSSi and other UNICEF interventions?
Efficiency (How well are resources being used?)¹⁰	To what extent were DHSSi interventions implemented as planned? What are the relative strengths and disadvantages of different DHSSi

⁹ The PEA work began in 2020 and is being carried out by Johns Hopkins University. This work is exploring aspects of the enabling environment in Kenya, Uganda, and Malawi (not Tanzania). The PEA was delayed by COVID-19, so the findings have not been incorporated in the Year 1 assessment but future rounds of the evaluation will build on these findings and respond to any changes in the DHSSi approaches that result from this work.

¹⁰ Note that discussions during the inception period indicated that efficiency is a lesser priority for the evaluation stakeholders. We therefore did not undertake a dedicated cost-effectiveness or value for money study. Under the area of efficiency, we instead focused on understanding whether implementation activities were conducted as planned, and the factors that enabled or inhibited implementation progress.

OECD-DAC criteria	Evaluation questions
	implementation models?
Effectiveness (Is the intervention achieving its objectives?)	To what extent is DHSSi on course to achieve its objectives? What changes have occurred due to DHSSi at district level?
Sustainability (Will the benefits last?)	To what extent can expected results be sustained independently of UNICEF support?
Impact (What difference does the intervention make)?¹¹	To what extent is DHSSi on course to achieve its intended outcomes?

Assessing the contribution of DHSSi to equitable coverage of health services is an important component of the evaluation, including consideration of gender and human rights. In particular, data collection and analysis has considered the level of attention to gender, equity, and marginalised groups within sub-national planning, and factors affecting this. These issues have been incorporated in topic guides and other data collection tools. For example, consideration of equity in planning, including availability and use of disaggregated data to support consideration of equity in BNA, is an explicit criteria for assessment of district planning practice as part of the PAMAT used to assess results framework indicators; and community involvement in planning, an important part of accountability, is also a criteria in the PAMAT, and is included in the results framework. In future rounds, we also plan to examine equity in coverage of priority health interventions where disaggregated data are available in DHIS2 (such as by gender and location).

While all evaluation questions will be covered over the course of the three-year evaluation, the Year 1 assessment focuses more heavily on questions that can be best answered at this stage of DHSSi implementation, particularly those related to relevance, coherence, and efficiency, with more preliminary indications of effectiveness and factors that may affect sustainability. In relation to effectiveness, this round focuses on initial indications of DHSSi's contribution to stronger district health planning practice. More detailed analysis of DHSSi's contribution, rigorous assessment of causality, and examination of evaluation sub-questions related to the relative significance of different DHSSi components in contributing to outcomes, associated mechanisms, and positive or negative unintended consequences, will be part of later evaluation rounds, when the effects of DHSSi activities have had more time to develop. Assessment of effectiveness focused on planning as activities related to management and accountability were in the early stages of implementation; management and accountability activities will be assessed further in later rounds. At this stage in DHSSi, it is too early to report impact in terms of reduction in bottlenecks or improvement in coverage. Baseline coverage information was collected to allow analysis in future years (see Annex M).

2.3 Methods

2.3.1 Evaluation approach

Details on the evaluation approach are provided in the Inception Report. In brief, the

¹¹ While this evaluation includes an assessment of DHSSi's contribution towards achieving impact on population coverage indicators, we do not necessarily expect changes at this level to occur during the evaluation time horizon. Assessment of ultimate impact on downstream indicators is expected to be a greater focus for the Phase 2 evaluation. For this evaluation, and in line with the ToR, we define 'impact' primarily in relation to population-level coverage of key services. We also intend to include progress on some health system bottlenecks as part of the definition of impact when these data become available. Bottleneck indicators cover a range of dimensions, some of which represent earlier steps towards coverage (such as bottlenecks related to commodities and human resources), but some are themselves indicators of coverage that can be treated as impact indicators.

evaluation uses a theory-based approach designed to explain how DHSSi contributes to changes in district performance and other outcomes, and the conditions that affect progress. The approach involves examining evidence for the presence of outputs and outcomes along the ToC chain; examining associations between steps in the ToC chain to test expected links; identifying the mechanisms that link steps in the chain (i.e. inputs to outputs to outcomes); identifying conditions that affect progress towards outcomes; and identifying the perceived significance of, and role played by, DHSSi. As indicated earlier, rigorous assessment of causality and contribution through these approaches will be a stronger feature of later evaluation rounds, when DHSSi activities are more mature and have had more time to generate outcomes.

2.3.2 Data collection methods

The evaluation brings together and triangulates data from different qualitative and quantitative methods. Details are provided in the Inception report. Each method is summarised below.

Tracking implementation of DHSSi activities. To assess whether interventions were implemented according to the workplan, we examined implementation logs completed by COs,¹² programme documents, and other documents with information on DHSSi activities. We also discussed the implementation of activities, including challenges around implementation and changes to the original plans, during interviews with UNICEF CO staff, implementing partners, and other national- and district- level stakeholders.

The Planning and Management Assessment Tool (PAMAT). We examined changes in district planning and management practice using the PAMAT, a tool which provides a rubric to score district planning and management practice over seven domains, with indicators focused on the key practices targeted by DHSSi (see Annex F). Scores were agreed by the evaluation team based on information from a facilitated discussion with DHMT members (involving 4-10 participants in each district, see Annex G), document review (especially district plans), and interviews. PAMAT scoring also contributed to assessment of results framework indicators. The evaluation team provided training to UNICEF Uganda and implementing partners to conduct the PAMAT assessment in the seven Ugandan DHSSi districts not covered by the evaluation, and light quality assurance of their completed PAMATs.

District, national and cross-country interviews. At district level, we interviewed DHMT members, district executive members,¹³ NGOs or other district development agencies, and depending on the country context and implementation approach, district planning teams, DHSSi implementing partners, and a small number of sub-district managers. Between four and eight interviews were conducted in each district, depending on government and DHSSi structures and availability (see Annex G for a summary of interview participants). At national level, we interviewed UNICEF COs (a group interview with around 2-3 staff in each country office), representatives of relevant MoH departments, other national government departments, implementing partners, and other organisations with projects aimed at district management and planning capacity. Between four and nine interviews were conducted in each country (some were joint interviews with 2-3 participants, so the number of interview participants is higher). The sample varied depending on the country focus for DHSSi activities and government structures (see Annex G). We also interviewed the international technical partner (FPD). Interviews used semi-structured topic guides adapted to country contexts (see Annex H for the topic guides). District-level fieldwork mainly took place in-person in Year 1, with observance of key measures relating to COVID-19. National

¹² Implementation logs were completed by two COs.

¹³ For example, assembly/council at a higher administrative level than the DHMT.

interviews were convened remotely or in-person in accordance with local guidelines and participant preferences.

Document review. Document review included district-level documents, particularly annual workplans for 2019/20 and 2020/21, but also planning and review meeting minutes and other relevant documentation; national documents, such as policy guidelines, training curricula, and working group meeting minutes; and DHSSi programme documents, such as quarterly and annual reports, proposals and the implementation plan. Annex I lists the types of documentary evidence.

Quantitative data sources. We measured baseline status for population-level coverage outcomes related to maternal and child health for DHSSi and non-DHSSi districts using routine District Health Information Software 2 (DHIS2) data in each country. A list of these coverage indicators is provided in Annex L. In future years, we will measure reduction of priority bottlenecks selected by districts through their planning processes based on routine and secondary sources, using the standard UNICEF template in Excel.

2.3.3 Sampling of districts for qualitative data collection

The evaluation covers 17 of the 24 DHSSi districts, including all DHSSi districts in Malawi (five), Kenya (five) and Tanzania (four), and three in Uganda (out of 10). This includes three 'core' evaluation districts in each country with full fieldwork to address the evaluation questions. In the remaining DHSSi districts in Kenya, Malawi, and Tanzania, data collection was limited to the PAMAT assessment, for the purposes of results framework reporting. In Uganda, the evaluation team did not conduct fieldwork beyond the three core districts, but supported use of the PAMAT by implementing partners and UNICEF (as above). This approach of supporting implementing partners to conduct the PAMAT was taken due to the higher number of DHSSi districts in Uganda compared to other countries, which made conducting PAMAT in all 7 'non-core' districts beyond the evaluation scope.

The three core districts in each country were selected in discussion with UNICEF COs. Selection criteria varied between countries depending on the DHSSi programme structure and CO priorities, but included different geographical zones, particular health system needs (e.g. refugee hosting districts in Kenya and Uganda) different starting points in terms of EBP experience (particularly in Uganda, Kenya and Malawi), and different models of DHSSi support (e.g. different implementing partners in Uganda, and remote or in-person training in Malawi). The sample districts and rationale for core district selection and a summary of key district characteristics are presented in Annex E. The evaluation report focuses on findings from the three core districts in each country.

2.3.4 Analysis

Qualitative data was analysed using framework analysis, using matrices to summarise and combine data from the implementation logs, document reviews, interviews, and PAMAT discussions (see inception report for further detail).

Reliability of qualitative data was ensured through audio recording when permitted so that all information was captured (in adherence to the ethical principles described in Annex J); detailed transcription to enable accurate interpretation; facilitating openness during discussions and considering the position of participants, including potential influences on what was said, to allow careful interpretation; comparison of audio recordings against transcripts to spot-check quality; and ongoing discussion with country team leaders and research assistants to support future transcription and interviews, and to build on emerging findings.

Analysis of quantitative data on coverage indicators involved conducting a light-touch data quality assessment; assessing the extent to which indicators are comparable across countries; downloading the data from DHIS2; carrying out data quality checks and data cleaning; and identifying baseline coverage status. At this stage in DHSSi, it is too early to assess trends in bottlenecks and coverage, but baseline information is included in Annex M and will support later analysis. Analysis processes are described in Annex L.

2.4 Organisation, management, and quality assurance of the evaluation work

The evaluation team consisted of an overall team leader and qualitative and quantitative methods leads, who were responsible for leading the evaluation design, together with four country team leaders based in each of the DHSSi countries, who led primary qualitative research. Each method lead and country team leaders were supported by a research assistant. The evaluation team was supported by a project manager, who is responsible for the day-to-day management of the evaluation, with high-level strategic oversight provided by a senior project director. Finally, a senior peer reviewer and a pool of quality assurance experts have provided high-level quality assurance support throughout the project. Oversight of this evaluation is provided by the Evaluation Reference Group (ERG), chaired by the ESARO Evaluation Section, who review all evaluation deliverables (including this report). Preliminary findings were discussed with UNICEF COs and ESARO, to ensure accuracy and obtain any missing information. Feedback from these discussions has been incorporated in the report.

2.5 Limitations

As with all evaluations and research, this evaluation has faced several constraints that have been considered in the analysis and reporting.

- As anticipated at inception, availability and reliability of the data on the coverage of key health interventions varies between countries. We also found differences between countries in how HMIS indicators are constructed. These issues, and steps to clean data, are discussed in Annex L.
- Identification of the baseline status of district practice has relied, to some extent, on retrospective analysis, which is not ideal due to issues with recall.
- Document review helps to triangulate findings from other data collection methods to overcome issues of recall. However, access to documents, for baseline and Year 1, and the level of detail provided in documents, has varied, particularly for district plans. For example, in Tanzania, complete district plans were unavailable. Separate Excel files were available showing BNA, but the official plans do not include space for BNA, and use of information on the Excel files for developing plans was difficult to verify. In addition, bottlenecks indicated in the trackers (received after fieldwork) sometimes differ from those in the BNA Excel files seen during fieldwork, because of further work on BNA (our analysis focuses on the BNA charts and plans received during fieldwork, as these earlier documents were developed at the time of planning). Plans in Uganda include BNA charts and a table showing bottlenecks and causes, but the format varies between districts, and it is unclear whether BNA charts were used to identify bottlenecks for all interventions in the table. The separate Excel tracker files also in some cases contain slight differences compared to the BNA in the plans. These issues limit accurate assessment of district use of BNA and other planning steps. Observation of district planning and management and national policy processes would have added depth and triangulation, but it was decided with ESARO that observation should not be conducted

due to COVID-19 restricting meetings.

- Additional interviews would have brought further perspectives. In particular, interviews with health facility governance staff in Tanzania (who have responsibility for a number of health functions) and stakeholders in non-DHSSi districts (to assess the extent to which DHSSi interventions have been taken up in non-intervention districts) would be likely to provide useful insights but could not be conducted due to resource constraints. The interview sample was also affected by availability of key informants in some countries, particularly for some government departments. In addition, UNICEF staff at regional level were not interviewed as part of the evaluation, but did participate in initial debrief meetings and their feedback on preliminary findings has been incorporated.
- Fieldwork was affected by the ongoing COVID-19 pandemic. In several cases, face-to-face interviews had to be reorganised and conducted remotely due to, for example, upsurges in the number of COVID-19 cases among DHMT members or due to national ministry directives. PAMAT discussions were conducted remotely in three districts. We found that interview participants were often willing to spend significant time on remote discussion, so this did not affect length of interviews, but network issues sometimes affected the quality of interaction. It is also possible that conducting interviews remotely made it more difficult to establish a rapport with the respondent and to respond to non-verbal cues, adversely affecting the degree of nuance and openness achieved through these interviews. The evaluation team addressed network issues through careful facilitation of PAMAT discussions, checking understanding during interviews, and, in some cases, by providing participants with a small stipend to cover the costs of data bundles required to dial into PAMAT discussions. Despite these challenges, we found that conducting interviews remotely still allowed valuable insights to be collected and generally worked well. There were also some other benefits to remote interviews (beyond COVID-19-related safety considerations), including greater flexibility for respondents in regard to finding a schedule that suited them, and greater convenience as respondents did not have to travel to meet with the evaluation team.
- Some evaluation methods may have influenced district practice. In particular, the PAMAT discussions with DHMTs and individual interviews may have prompted reflection and identification of areas of improvement. However, this is not necessarily problematic, given the evaluation's focus on learning and supporting improvement.

2.6 Ethical issues and considerations

Ethical considerations have influenced the entire DHSSi evaluation, from recruitment and management of team members to data collection, consultations, data storage and use, and results reporting. The evaluation has been guided by United Nations Evaluations Group (UNEG) ethical standards for evaluation. A description of ethical considerations is provided in Annex J. The evaluation was approved by national ethics review committees in all countries.

3 Findings

3.1 Relevance: Is the intervention doing the right things?

Summary

- Support for EBP aligns with national and district government interests. However, the degree of ownership and extent to which governments clearly take responsibility for EBP and management activities varies.
- DHMT motivation to invest time in EBP is reduced by limited use of annual plans for budgeting and limited implementation of plans.
- BNA is seen as useful to accurately understand problems, but there are concerns about fit with data availability and DHMT time and skills; scope for BNA to affect plans as many planned activities are 'routine' or required by national guidelines; and lack of resources to implement plans.
- Management skills are of interest for national government, but were less explicitly acknowledged as a gap by DHMTs.
- There are examples in all countries of DHSSi activities being adapted to context, for example adjusting for COVID-19 and DHIS2 data availability.
- In relation to the ToC, there are emerging issues with several assumptions required for DHSSi effectiveness, such as staff turnover and data availability. These are areas of active UNICEF engagement.
- There is potential value in clarifying the processes through which DHSSi support enables more effective planning, and through which more effective planning leads to a reduction in bottlenecks, to ensure DHSSi activities are designed in ways that support these processes.

3.1.1 Does DHSSi align with national health sector priorities?

Support for EBP aligns with national government interests in all countries, including interest in strengthening data use and review processes, and supporting sub-national planning capacity. Malawi, Uganda, and Tanzania have new or updated planning guidelines or tools, and in Malawi and Tanzania particularly, DHSSi supports implementation of these revised approaches. Development agencies are seen as playing an important role in supporting district planning capacity. Development agency coordination and alignment with government priorities are also concerns for government; DHSSi contributes to coordination through support for stakeholder mapping and involvement in planning.

Support for management and accountability also aligns with national government priorities, with gaps in district management capacity and accountability seen as important influences on district performance and on planning. In Uganda, there are particular concerns around acting positions and gaps in DHMT composition, which DHSSi work on recruitment aims to address. In Malawi, capacity development for district managers was emphasised to address gaps in pre-service training, with most managers coming from a clinical background. In Tanzania, DHSSi activities are a response to government requests to

support work on management and accountability through the 'Makole model'¹⁴. In Kenya, national stakeholders pointed to changes in responsibilities and structures due to rapid devolution, and consequent gaps in county capacity and accountability.

While DHSSi activities align with national interests in all countries, the degree of government ownership varies. Ownership and government leadership is particularly evident in Malawi. On EBP, DHSSi is working with a national planning taskforce led by government, and the MoH describes the planning tools and support for district capacity as a government initiative, which other stakeholders (such as DHSSi) support. Management activities are also described as a government agenda. In Tanzania, government ownership is particularly strong for management activities: the 'Makole model' is a government-led initiative, and the government described the work in Makole as being 'purely government', rather than involving development agencies. In Uganda, the government is involved and sees the activities as relevant, but a sense of responsibility and leadership among government actors is less evident. In Kenya, some government stakeholders described DHSSi's work on planning as a government initiative, but there were also concerns about development agencies implementing parallel initiatives and approaches to planning and reviews, and difficulty in securing MoH time around other, higher priorities, at least over 2019–20 (we recognise that ability to establish government commitment was affected by government turnover and a pause in DHSSi activities, and these gaps may have been addressed through further work on institutionalisation in late 2020–21).

National stakeholders in all countries also indicated barriers to effective planning, management and health service delivery that may limit what DHSSi is able to achieve. These barriers include DHMT or sub-district staff time for planning, and the influence of more intangible issues, such as governance, power relations, and individual motivation. Governance was raised as a key issue for district performance, particularly in Kenya and Uganda, and to some extent in all countries, and included areas such as political interference in DHMT decisions and appointments, unclear reporting lines, and corruption. Training courses in planning or management may be insufficient to address these more intangible influences on performance, and these issues may hinder sustained change. (Limits to the effectiveness of training due to less tangible aspects of management and leadership were raised particularly by national stakeholders in Malawi, but are likely to apply in all countries.) This highlights the relevance of the PEA.

Health system hardware was also widely highlighted, including insufficient health workers, infrastructure, commodities, and funding. Improved planning and management can help to tackle these hardware gaps, and indeed are required to maximise use of limited funds (as discussed by some government stakeholders, for example in Kenya). However, in Uganda, DHSSi was seen as working on 'soft' areas, rather than directly addressing bottlenecks, and the limited funding available to district governments affects the scope for DHSSi activities to fully address hardware gaps. This includes the constraints of district wage budgets for DHSSi's work on recruitment in Uganda, and, in all countries, funds to implement plans.

3.1.2 Does DHSSi align with district needs and priorities?

Strengthening planning and evidence use is of interest for DHMTs in all countries, and DHSSi's support in this area is appreciated. While of interest, however, the perceived value of planning varies between DHMTs and individuals, with limited use of plans for budgeting as well as limited implementation of planned activities discouraging interest (see below). The emphasis and areas that DHMTs see as needing improvement vary between countries.

¹⁴ The Makole model is an approach to strengthening individual performance-based management that was piloted by the government in Makole health centre in Dodoma

A gap in skills was emphasised more in Malawi and Tanzania than other countries, with training and support in planning needed to address turnover and varied experience within DHMTs, as well as capacity to apply new planning tools. A skills gap received less attention from DHMTs in Kenya and Uganda, although further training was appreciated and seen as necessary to consolidate BNA skills and extend knowledge of BNA to those not yet trained. Skills for data use and analysis are also seen as a gap in all contexts.

DHMTs also saw **funding for planning** as a key challenge. In Kenya, the main gap in planning identified by DHMTs was funding for planning and review meetings, including for stakeholder involvement, as well as for implementation of plans. There was also demand for increased government responsibility for funding the planning and review process, to address declining donor support in Kenya. Linked to this, funding for planning workshops under DHSSi was appreciated, and CHMTs wanted to strengthen resource mobilisation skills to support implementation of plans. **Stakeholder involvement** was also seen as important, including stronger coordination with development agencies, and sub-district and community input.

In relation to **management**, there was less explicit acknowledgement by DHMTs of management skills being a gap, but this may reflect the focus of DHSSi activities so far on planning. Training in management was raised as important in Malawi and the recent training under DHSSi was valued, and in Kenya management training was seen as useful, particularly for new CHMT members. In Uganda, gaps in DHMT composition and staffing are a concern for district governments, suggesting the relevance of DHSSi's work with district service commissions.

In relation to both planning and management skills, some district stakeholders would like to see **training extended to sub-district levels**, including facilities. In some cases, they suggested that capacity gaps were at facility rather than DHMT level, with less need for district-level support (for example, this was mentioned in relation to data use Uganda).

In all countries, **governance and health system hardware** are concerns among district stakeholders, with adequate funding for health often a top priority for DHMTs and seen as underpinning all areas of health system performance. This again suggests the relevance of the PEA and resulting activities, as well as the relevance of positioning BNA to address hardware constraints.

Perceptions of BNA

In all countries, **BNA is seen as having benefits**, particularly for using evidence and supporting accurate **understanding of problems** and underlying causes. BNA was also discussed as supporting resource mobilisation (in Kenya and Uganda) and effective allocation of scarce resources (in Kenya).

However, several **constraints on use of BNA were repeatedly mentioned, particularly the need for reliable data, time, and skills**. Gaps in data quality and availability are well recognised by UNICEF, and are largely outside the direct scope of DHSSi's investment. On skills, BNA was widely seen as complicated and requiring training, as well as basic competencies in areas such as IT (for example, Excel in Malawi). High turnover among those involved in planning can limit opportunities to consolidate skills. BNA was also described as time-consuming, a particular difficulty because of busy DHMTs and deadlines for submitting plans. In Malawi, BNA was considered more manageable for 2020–21, due to changes in the DIP tools, workshops providing time for analysis, and CHAI support. In all countries, DHMTs were interested in further BNA training to build skills.

Another issue for relevance relates to scope for BNA to influence plans and **fit of activities identified through BNA alongside other activities considered as essential**. Core

activities may be set in national guidelines (e.g. the essential health package), or seen by DHMTs as routine and essential practice (e.g. immunisation outreach), and these activities form the bulk of district plans. Difficulty in reconciling BNA and national guidelines was emphasised in Tanzania, where CHMTs saw planning guidelines as requiring inclusion of particular activities in their plans, reducing space for activities identified through BNA. In Uganda, there was concern about insufficient budget to include activities from BNA alongside those considered as core essentials, and in Kenya BNA was seen as unnecessary for many activities, particularly those required under national policies and considered routine.

In all countries, there were concerns about the value of identifying activities through BNA without **funding to implement these activities**. There is also a wider concern about the value of developing plans in general, when activities are often not funded or implemented, which can **demotivate DHMTs and discourage investment in planning**. Lack of fit with budgeting processes, such that budget submissions use other templates or occur before annual plans can be used to inform budgeting, reduces the perceived relevance of investing time in EBP. This was particularly evident in Uganda, where funding comes through an alternative Ministry of Finance system. When BNA activities are included in plans, available funding can restrict DHMT budgets to basic administrative costs and minimal programme activity, as in Malawi.

3.1.3 How have DHSSi interventions adapted during implementation to fit different or changing contexts?

There are examples in all countries of DHSSi activities being adapted to context. Given the early stage of implementation (particularly in some countries), we include here examples of adapting during initial design phases. Key approaches taken include:

- **Adapting the focus based on findings from the landscaping exercise.** In particular in Kenya, management activities focus on the coordination of existing management training, as the landscaping found there were multiple existing training initiatives and courses but little alignment or shared competency framework. In Uganda, the focus on recruitment and accountability followed landscaping findings, and activities have also been tailored based on initial application of the progression model.
- **Aligning DHSSi to support national initiatives.** For example, in Tanzania, DHSSi has been adjusted to support the Makole model and revised CCHP guidelines, and in Malawi, work on planning is focused on supporting national government planning tools.
- **Adjusting to accommodate government feedback.** For example, in Tanzania, the ToT in EBP was expanded to include representatives from all zones to accommodate government concerns regarding the need for country-wide support.
- **Ongoing monitoring and adapting.** For example, in Uganda, additional support was provided for some DHMTs when progress on plans was slower than expected, and training materials have been updated based on feedback in Tanzania and other countries.
- **Adjusting to the data context.** For example, in Uganda, UNICEF has supported additional work to integrate DHIS2 systems to allow continued development of the BNA app around a national DHIS2. In Malawi, the national planning taskforce has considered alternative data sources and approaches to BNA when DHIS2 data are unavailable.
- **Adjusting to the COVID-19 context.** In particular, some support and training moved online in Malawi (although there are concerns about fit with high internet costs in Malawi).

There are some ongoing areas for consideration regarding fit to context, particularly the issues discussed in Section 3.1.2. These include:

- Fit of BNA with data quality and DHMT time and skills. This is an issue in all countries for application of BNA (though streamlined tools in Malawi appear to have eased this constraint).
- Fit of plans with budgeting channels and cycles, and the balance between the effort invested in planning and available funding.
- Strengthening capacity in a way that accommodates staff turnover and addresses governance issues.

3.1.4 To what extent does the DHSSi ToC hold under implementation?

Assessment of the ToC for this evaluation round focused on information regarding the assumptions identified at inception stage. The early stage in DHSSi implementation means there is limited evidence at this point to assess the causal pathway from activities to outcomes; this pathway will be a stronger focus in later evaluation rounds. A large number of assumptions were identified at inception stage. These included assumptions related to:

- DHMTs, including motivation to apply training and develop plans, sufficient resources to implement plans, and capacity to implement roles, as well as staff turnover being at a manageable level so that trained people are not lost to the system;
- other district actors, including a functional relationship between DHMTs and the district executive (for example, executive oversight and support for DHMTs);
- national government, including commitment to EBP and support for institutionalisation and scale up of DHSSi approaches, clarity on roles and coordination between and within government ministries, and there being significant shifts in government priorities (for example, due to health emergencies);
- HMIS data, including that these data are collected and validated according to government protocols, and that there are government efforts to improve data quality; and
- other development agencies, including alignment of their activities with DHSSi.

Some country-specific assumptions were also identified during inception, and these are discussed in the country annexes where relevant.

At this stage, there are emerging issues regarding several assumptions, many of which are discussed elsewhere in the report. Examples include the following:

- Resources to implement plans are a constraint in all countries (see 3.4.1 on implementation of plans).
- DHMT concerns that plans may not be implemented, and gaps in alignment with budgeting processes, can affect motivation (as discussed in 3.1.2 in relation to relevance for district stakeholders).
- Governance concerns, which affect DHMT motivation and capacity to perform their roles, as well as relationships with the executive (see 3.4.1 on management and accountability).
- DHMT turnover, which means a need for ongoing training (noted in relevance and also discussed in 3.5.1 on sustainability).
- While there is interest in EBP and management among all national governments, and BNA is integrated in national guidelines in Uganda, Malawi, and Tanzania, national government prioritisation of DHSSi activities has varied (as discussed in 3.1.1 in relation to relevance for national stakeholders). COVID-19 has also affected government prioritisation and time for work on DHSSi, particularly in Kenya.
- Gaps in HMIS data have limited progress on the BNA app and the application of BNA (see 3.3.4 on efficiency).

- Coordination with other national development agencies has been challenging in some countries (especially Tanzania) (see 3.2.1 on coherence). In all countries, there are gaps in the willingness and capacity of district development agencies to contribute to district planning and align with DHMT plans (see 3.1.1 on stakeholder involvement in planning).

Many of these assumptions are areas of active DHSSi engagement. For example, support to encourage development agencies operating in the district to align with district plans is designed in part to address resourcing (although affected by varied agency capacity and willingness to align). Follow-up from the PEA findings should address aspects of governance and accountability for role performance, including relationships with the executive. Turnover is both an assumption but also a rationale for EBP and management training under DHSSi, and there are plans to address this risk in some countries (for example, by extending training to sub-counties in Kenya or working to integrate EBP training in pre-service curricula in Uganda). There are also ongoing efforts to support coordination with other development agencies, through bilateral discussions as well as working groups.

As above, assessment of the causal pathway will be a stronger focus for the next evaluation round. At this stage, an emerging issue relates to clarifying the processes through which DHSSi support enables more effective planning, and through which more effective planning leads to a reduction in bottlenecks. The findings indicate several ways that DHSSi support enables planning, including providing tools (such as improved national planning templates, guidelines, templates for agency mapping, the BNA App), building skills, and funding workshops that provide time to complete planning, increase team engagement or enable stakeholder input (see 3.4.1). The required processes are likely to vary between districts and countries depending on current planning practice and gaps, and affect the type of input needed (for example, the relative value of time in workshops and the required participants). In relation to the way that planning reduces bottlenecks and improves coverage, there are different views on the function of EBP, including supporting more efficient use of limited government funds through accurate targeting of resources, or mobilising additional resources (see 3.1 and 3.4). EBP might also increase commitment to implementation, through enhanced involvement of district programme staff in development of plans (suggested in Malawi, see Country Annex), or through support for regular reviews to focus attention on plans (suggested in Kenya). These different mechanisms are not incompatible, but suggest different emphases in the required support (for example, the relative focus on improved problem analysis, participation in planning, or follow on support and monitoring, and the approach to prioritisation).

3.2 Coherence: How well does the intervention fit?

Summary

- In all countries, there are other initiatives on district planning, data use and management, including in some DHSSi target districts. There is potential overlap with support provided under DHSSi.
- Initiatives by other development agencies present potential complementarities (such as support for scale-up), and risks (such as duplication or inconsistent training).
- UNICEF COs are working on coordination with other development agencies, but there are gaps in information and communication (among COs and other agencies), and scope for further links.
- Support for EBP under other UNICEF programmes provides potential for scale and cross-learning. Other UNICEF programmes in the DHSSi districts provide potential complementarities, which will be explored in the next evaluation round.

3.2.1 To what extent is DHSSi coherent with other interventions targeting district health teams?

Alignment with government processes was discussed under relevance, including coherence with government planning guidelines and templates (for example, templates are fully integrated in Malawi, whereas introduction of different planning templates by some development agencies is a concern for some government stakeholders in Kenya), and coherence with other government planning and budgeting systems (such as Ministry of Finance budgeting processes in Uganda).

We focus here on alignment with activities implemented by other development agencies (including other multilateral or bilateral development partners, or NGOs). **In all countries, there are other initiatives on district planning, data use, and management.** This is particularly evident in Uganda, Kenya, and Tanzania, where other large initiatives that include work on district planning and management are operating in DHSSi target districts. UNICEF COs have worked on coordination, for example through establishing taskforces or participating in working groups. COs have made links with some of the other initiatives, for example USAID activities in Uganda and Tanzania. However, continued efforts will be needed to avoid duplication. For example, other agencies have supported training in planning, but using different approaches in Tanzania (problem analysis and the strengths, weaknesses, opportunities and challenges (SWOC) framework, rather than BNA); and in Uganda, there is support under RBF in some districts to develop alternative district plans (the 'performance implementation plan').

In Malawi, support for planning from different agencies appears well coordinated through the MoH planning taskforce, and the management training taskforce has identified complementarities between DHSSi and other initiatives. However, there are indications of gaps in communication and understanding of each other's activities, and potential for more links to maximise complementarities and avoid misalignment (including on allowances).

3.2.2 How is DHSSi effectiveness influenced by other interventions?

While it is early to assess the influence of other agencies' interventions on DHSSi's effectiveness, there are potential complementarities. In particular, training in data management and use by other agencies could support DHIS2 accuracy and so feasibility of BNA. Other initiatives have also contributed to scale-up, including application of BNA in some non-DHSSi regions in Tanzania. There is also interest from some agencies in the progression model in Uganda and BNA in Kenya.

One area where different activities can negatively affect each other relates to government time and attention, with activities of other agencies identified as taking time from DHSSi activities at national level (in Kenya) and district level (noted in Uganda, though adjusted for through rescheduling). Where agencies focus on different approaches during planning (as in Tanzania), this could also affect institutionalisation of BNA (we recognise that the Tanzania CO wants to support EBP broadly, rather than just BNA).

RBF initiatives operate in all countries but were particularly evident in discussions in Kenya and Uganda. Their influence is an area for further investigation, and there are potential complementarities as well as difficulties. For example, RBF schemes have increased funding for districts in Uganda and Kenya, potentially enabling implementation of plans, but deadlines for RBF funding submissions affected time available for in-depth planning in Kenya.

3.2.3 How clearly are DHSSi's objectives, and the means of achieving them,

understood by key stakeholders?

Understanding of DHSSi activities varies between countries and stakeholders, partly reflecting different stages of implementation. Relatively few stakeholders are aware of the name of DHSSi, or have a complete understanding of the programme. UNICEF do not aim for stakeholders to know 'DHSSi' as a programme name, particularly given a focus on integration within government systems (for example, using government terminology). Rather than having a full understanding of DHSSi as a programme, it is more important for stakeholders to be aware of activities taking place under DHSSi in their areas of interest (for example, planning or management), as an indication of government coordination and input.

There is understanding of UNICEF support to EBP and management among national government in all countries, though the level of detail varies between individuals and countries. At district level, DHMTs in Malawi, Tanzania, and Uganda know about the support with planning, and to some extent the support with management. Delayed implementation combined with CHMT turnover has reduced awareness of DHSSi among some CHMTs in Kenya. Awareness of support from UNICEF for planning and management is more limited among the district executive (this was particularly evident in Malawi).

3.2.4 How does DHSSi align with other UNICEF strategies and interventions?

Potential complementarities with other UNICEF activities involve scale and cross-learning across districts, and connections between different interventions within districts.

In terms of scale, UNICEF has funding to support EBP in other districts in Kenya (four counties) and Uganda (17 districts); and in Malawi, CHAI is supporting planning in two further districts, and UNICEF plans support in a further 10 district with FCDO funding. This allows for sharing of learning and experience across a wider range of districts, and brings efficiencies. For example, national activities on EBP support, such as input to guidelines, work across programme districts, and some training activities have included DHSSi and non-DHSSi districts (e.g. in Uganda, as well as national workshops in Malawi). In Malawi, additional funding to support integration of COVID-19 activities in district plans (also implemented by CHAI) was able to build on work done through DHSSi and supported further district capacity and learning.

Within some DHSSi districts, UNICEF provides support through other programmes, including direct support to health activities. There are potential benefits of UNICEF involvement in other district-level health system support as well as DHSSi. For example, direct support with equipment was appreciated by DHMTs in Uganda, and so may enhance trust in the DHSSi implementing partners and consequently motivation to engage in EBP and other DHSSi activities. Other UNICEF programmes may also provide a source of funding to address bottlenecks. However, there are potential risks. For example, DHMT discussions of district partner influence on planning and use of plans to mobilise resources from other development agencies (see section 3.4) might mean that awareness of UNICEF support could reduce consideration of what DHMTs can do within their own resources and encourage a focus in plans on areas where UNICEF funding is considered likely (the latter is perhaps a particular risk in cases where COs see DHSSi as enabling inclusion of other UNICEF-supported activities in district plans, as in Kenya). Connections and mutual effectiveness between DHSSi and other UNICEF interventions will be explored further in the next evaluation round.

Uganda, Tanzania, and Malawi all have funding for work on community engagement and accountability in some districts. This work was in the early stages or not yet secured, so complementarities will be explored further in the next phase.

There are also complementarities with initiatives led by DHSSi implementing partners. This is particularly evident in Malawi. Work by CHAI to map development agency funding to the health sector is being used to support stakeholder mapping and agency contributions to planning, and aggregating DIPs into a national operational plan is seen as potentially supporting agency funding for DIP implementation. SDI experience with other courses has contributed to the leadership and management training in Malawi, which can in turn inform other SDI courses.

3.3 Efficiency: How well are resources being used?

Summary

- Most planned EBP capacity development took place in Uganda, Malawi, and Tanzania. Some management activities were also implemented.
- There were unintended delays due to COVID, unavailability of government staff, limited DHSSi implementing partner capacity, and changes in HMIS systems and gaps in data quality.
- Consideration of timing, reach, content and strength does not cover Kenya, due to the pause in implementation.
- Some EBP workshops took place later than anticipated, sometimes affecting fit with budget cycles.
- Involvement of government staff in ToT and as trainers was a key strength, building an institutional platform for future training. Stakeholders suggested additional participants for inclusion in EBP training, including more DHMT members, sub-district staff, and the district executive.
- Training and workshops were largely seen as useful and well-delivered, but as too short to fully grasp or apply the material.
- Ongoing support for district teams was a key strength in Malawi. In Uganda and Tanzania, there was a need for further refresher training or additional ongoing support.

3.3.1 To what extent were DHSSi interventions implemented as planned?

DHSSi plans have evolved over time, including through the adaptations to context discussed in Section 3.1.3. In considering whether activities are implemented as planned, we look both at deliberate changes, as well as unintended delays or gaps, and consider actual activities against the June 2019 implementation plan.

In all countries, some activities proceeded broadly as planned over 2019–20, though to varying degrees. In particular, most planned activities on district EBP capacity development took place in Uganda, Malawi, and Tanzania, and some management activities were also implemented, such as work to revise district service commission guidelines in Uganda and development of a management training curricula in Malawi. Given the anticipated pause in activities during 2020 around COVID-19, this progress is significant.

There have also been delays in activities in all countries, again to varying degrees and most substantially in Kenya: initial inception meetings were held and work on the BNA app took place as anticipated in 2019, but changes in government contacts, reassignment of government and UNICEF staff to COVID-19, and COVID-19 public health measures meant most activities planned for 2020 were postponed until late 2020 or early 2021. There were

also delays in other countries, due to COVID-19 as well as due to unavailability of government staff. For example, progress on management activities in Tanzania has been slower than anticipated due to limited government time; and in Uganda, planned national training on BNA to build the pool of trainers did not take place as planned due to COVID-19 and refocusing of UNICEF staff time. Changes and challenges in HMIS have delayed progress on the BNA app (including a DHIS2 upgrade in Uganda, loss of national HMIS data in Malawi, and the involvement of multiple development agencies, together with data inaccuracies, in Tanzania; delays in Kenya have been more related to COVID-19 and government availability).

Some activities have not taken place for other reasons, including DHSSi implementing partner capacity. For example, EBP workshops did not take place in Oyam district in Uganda, and it appeared that more support was needed than had been provided. Work on accountability has also not started, and is awaiting PEA findings (which were delayed by COVID-19).

Deliberate changes to the original design involve the adaptations discussed in earlier sections, such as aligning with the Makole model in Tanzania. In Uganda, some activities indicated in the original design were not taken forward, due to a sense that they needed further conceptualisation to define the purpose and approach using the PEA (e.g. supporting health assemblies). In Malawi, there have been shifts in design for both EBP and management, including working with an NGO rather than through government zonal offices and a training institute on EBP, and, on management, supporting a residential course rather than integration of capacity development within routine DHMT activities. In Kenya, current plans appear to be largely as set out in June 2019, but may adapt as the BNA and management working groups resume.

3.3.2 Were interventions delivered with the planned and required timing, reach, content, and strength?

We focus in this section on capacity development activities in Uganda, Tanzania, and Malawi, as activities in Kenya were at an earlier stage due to the delays discussed above.

In relation to **timing**, in all three countries, EBP workshops took place later than anticipated. In Malawi and Uganda, this affected fit with the planning cycle and limited opportunities for the plans to inform district budgets. Some EBP workshops in Uganda and write-up workshops in Malawi were held after July 2020, i.e. after implementation of the 2020–21 plans should have begun. While lack of synchronisation between completion of plans and budget cycles was partly due to delays in EBP workshops, it appears to be a more systematic problem, at least in Malawi, with DHMT comments suggesting budgets are regularly submitted before plans can be developed and agreed.

In relation to **reach**, a key strength has been involvement of government staff with potential to scale up the approach to other districts. In particular, the national ToT in Tanzania led to use of BNA outside DHSSi districts. Government staff have also been involved as trainers in all countries, building a platform for sustainability.

There were requests in Uganda and Tanzania to **extend BNA training to more DHMT members**. For example, in Uganda, the main training workshops focused on District Health Officers (DHOs) and district biostatisticians, and understanding of BNA varies among the wider DHMT – affecting use in planning. In Tanzania, some CHMT staff suggested that training should include all CHMT members, to ensure adequate understanding and effective teamwork. In Malawi, the model has involved planning workshops for district teams, rather than an initial training session, so these concerns about wider DHMT training were less evident. involvement of a range of DHMT members and programme staff in the planning

workshops increased their engagement in DIP development (though with some gaps in participation, partly due to time constraints).

Widening participation to **sub-district staff** was also suggested. In Uganda, this is partly seen as a way to address turnover: the high number of acting staff and changes in DHMT positions has meant some staff trained under DHSSi have left. DHMT members are often recruited from sub-district levels, so building skills at this level could partially address turnover. In Tanzania, CHMT members who attended training were expected to provide training for facilities. This process has been variable, and in some districts the CHMT did not provide formal follow-on training for facilities (partly due to lack of time and resources), indicating limitations of the cascade model. Some CHMT members suggested that facility staff should be involved in the earlier workshops.

Involvement of the **district executive** in training and planning workshops was raised as a gap in all three countries. In Uganda and Tanzania, some DHMT members said participation of key executive stakeholders in training workshops was important to ensure their support for the EBP approach and inclusion of activities from BNA in plans and budgets. In Malawi, district planners thought they should be more involved in DHMT planning. Involvement of the executive in the management training in Malawi has been a strength, contributing to discussion between DHMTs and the executive.

In terms of **content**, training and workshops were largely seen as useful and well-delivered. For example, there were positive comments on facilitation in relation to EBP workshops in Uganda and the management training in Malawi. A common theme was that workshops were too short to fully cover material and ensure learning, particularly when the BNA concept is new. Lack of time was discussed in relation to the national ToT and management training in Malawi, the ToT and CHMT workshops in Tanzania, and the ToT for implementing partners, as well as regional and district training, in Uganda (with comments on the need for more time on practical application of the techniques).

In relation to strength, follow-up support following training workshops has been important to ensure development of plans or application of learning. Ongoing support from CHAI following the DIP workshops has been a clear strength that has helped district teams to complete the DIP tools. In contrast, delays in follow-up mentoring from the management workshop affected implementation of agreed action points (though this finding is based on minimal data and will be explored further in the next round). In Tanzania, national government commented on the need for ongoing support to CHMTs beyond training; and in Uganda, implementing partners had to provide substantial additional encouragement and input to ensure plans were developed.

3.3.3 What are the relative strengths and disadvantages of different DHSSi implementation models?

At this stage, key aspects of implementation models relate to **selection of DHSSi implementing partners** and **workshop approaches**.

In relation to partners, DHSSi has worked with NGOs to conduct EBP capacity development in Malawi, Uganda, and Tanzania (working alongside government), and directly with government in one district in Uganda. Management activities are implemented by a government training institute in Malawi, and by government with support from NGOs in Uganda and Tanzania. UNICEF Kenya country office works directly with government but also with HISP on the BNA app.

The relative advantages of working with **NGOs or government** have varied between countries depending on NGO and government capacity. In Malawi and Tanzania, NGO

partners have brought contacts and experience. This is particularly evident in relation to CHAI's experience with EBP in Malawi, and ENTAF's previous work on the Makole model in Tanzania. In Kenya, HISP has brought valued technical skills and data access.

In Uganda, NGO implementing partners were new to the EBP approach, and so required additional support. However, working through NGOs appears to have brought advantages in terms of enabling implementation, as activities moved in a much more limited way in the district where UNICEF provides direct government support. Government collaboration at national level has potential advantages for sustainability, but, as experienced in Tanzania and Kenya, it can also delay progress.

The approach to EBP workshops has also varied. In Uganda and Tanzania, workshops focused primarily on **training** in the planning guidelines and BNA, with some practical application. In Uganda, later workshops were then held in districts to complete plans. In Malawi, DIP workshops focus on **practical completion of plans** as a way to build skills and ensure DIPs are completed. This approach has potential benefits for efficient use of district staff time, as well as development of plans: it means facilitators are available to provide support as plans are being developed, and it avoids relying on busy programme staff to develop plans after a training workshop (although in Malawi some work on planning is done after the main workshop).

Some workshops have been conducted **remotely**, including DIP development in one district in Malawi. This remote support for government staff to lead facilitation of DIP workshops was effective and supported their capacity, but required commitment from both CHAI and the DIP coordinator.

The **cascade approach** to training, as with training of trainers who are then expected to train others, is applied through national and regional ToT workshops, and, in Tanzania, through workshops for CHMTs, who are then expected to train facilities. As indicated under the discussion of reach, CHMT training for facilities did not take place in all districts, and CHMT concerns that workshops were too short for them to fully understand EBP suggest gaps in their capacity to deliver training to facilities. In Malawi, the national ToT is seen as inadequate to spread skills, with additional support required to district teams.

3.3.4 What factors enabled and inhibited DHSSi to be implemented as planned?

Key factors that have affected implementation at this stage include the following:

- The availability and commitment of **government partners**: In Tanzania and Kenya, issues with the availability of government partners, as a result of COVID-19 and other events, as well as changes in government positions, have delayed progress, whereas continued availability in Malawi has helped activities to move forwards. At district level, DHMT motivation and commitment are seen as important for implementation in Uganda, and DHMT turnover has also affected progress. CHMT governance and changes in membership have also affected progress in designing implementation plans in one district in Kenya.
- **Implementing partner experience** has been important, as discussed above in relation to working with NGOs.
- The **data landscape** has affected implementation and progress on the BNA app. Issues vary between countries, but include multiple organisations being involved in HMIS systems, gaps in data availability and quality, loss of data, and changes in HMIS systems. Delays in developing the app mean that BNA has relied largely on Excel tools.
- **COVID-19** has affected implementation in all countries, particularly Kenya, where most

activities were postponed due to unavailability of government and UNICEF, as well as physical distancing measures. However, there are examples of COVID-19 bringing potential benefits. In particular, in Malawi, some workshops relied primarily on government facilitators as UNICEF or CHAI could not attend (i.e. the SDI training and Nkhata Bay DIP workshop). Both workshops were conducted effectively, and government facilitation has advantages for sustainability.

3.4 Effectiveness: Is the intervention achieving its objectives?

Summary

- DHSSi made a clear contribution to development of 2020–21 plans in Uganda, Tanzania, and Malawi, including support for use of data and BNA, wider and stronger district team engagement, completion of plans, and stakeholder input.
- DHSSi influenced planning through new guidelines, input to revised planning tools, training for new skills, and funding workshops that provided time for planning or stakeholder involvement.
- DHSSi is also contributing to review of plans, through funding workshops and new monitoring tools.
- The extent of change with DHSSi support varies between countries and districts, depending partly on previous EBP support and DHMT planning practice.
- Other factors (such as growing DHMT experience) and interventions by other development agencies have also supported improvements in DHMT planning.
- In all countries, there was some consideration of underserved groups during planning for 2019-20 and 2020-21, especially remote location but also examples relating to underserved groups such as people with disabilities, youth, mobile populations, refugees, and those affected by conflict.
- No district plans showed systematic consideration of access or coverage for different groups or by gender as part of BNA or other steps, and there was little indication of change between the 2019–20 and 2020–21 plans. Equity is included in the standard DHSSi EBP training but has received less emphasis than other aspects of planning, and stakeholders saw consideration of equity as an area for further support.

In considering effectiveness, the evaluation assesses intermediate outcomes in the DHSSi theory of change, specifically improved data use for planning, monitoring and course correction, and improved execution of health operational plans. These intermediate outcomes are expected to support the primary outcomes of a reduction in bottlenecks and improved coverage (which will be considered in relation to impact).

We focus in this evaluation round on the contribution of DHSSi activities to date to stronger district health planning, including development, implementation, and review of plans; stakeholder involvement in planning; and consideration of underserved groups. Use of BNA in planning, EBP, community involvement, review of plans, and implementation of activities to tackle bottlenecks are all outcomes in the DHSSi results framework. For Malawi, Tanzania, and Uganda, baseline is considered as development, review and implementation of 2019–20 district plans (as these plans were developed before DHSSi implementation began), and development of 2020–21 district plans is considered as Year 1. In Kenya, county-level implementation had not started due to the pause in DHSSi, so 2020-21 plans constitute the baseline, and this evaluation round only provides baseline information of planning and management rather than assessing DHSSi Kenya's contribution

We focus on EBP rather than management activities because at the time of fieldwork district-level implementation had been primarily related to EBP, with some management training in Malawi. The effectiveness of management and accountability activities will be assessed in later rounds, considering change in practice between the evaluation rounds. Evaluation sub-questions related to the relative significance of different DHSSi components in contributing to outcomes, associated mechanisms, and positive or negative unintended consequences will also be explored further in later rounds, when the effects of DHSSi activities have had more time to develop.

3.4.1 To what extent is DHSSi contributing to stronger district health planning and management practice?

Assessment of planning and management is based on interviews, PAMAT discussions, and the available documents. The ability to assess use of BNA, causal analysis, and prioritisation is affected by planning templates and available documentation, as discussed under limitations (see 2.5).

The contribution of DHSSi to EBP

In Uganda, Tanzania, and Malawi, support through DHSSi had a clear impact on development of the 2020–21 plans. The contribution is both direct via training and support, and indirect via the influence of new guidelines and planning tools. DHSSi has contributed to use of data and BNA, wider and more considered engagement in planning, and the completion of plans. Other factors have also supported planning, and the extent of change varies between countries.

In Tanzania, CHMTs used BNA for the first time for the Year 1 2020–21 plans, and in each district, this was related to training through DHSSi in late 2019. Beyond use of BNA, training was seen as contributing to more emphasis on data in general for the 2020–21 CCHPs. The new CCHP guidelines (to which UNICEF contributed) also influenced use of BNA and data. Training was also seen as increasing CHMT teamwork and engagement in planning, with more thought and less copying of activities from previous years. While DHSSi has contributed, other interventions have also supported more effective planning: CHMT members described changes as being due to DHSSi training and the new CCHP guidelines, but also due to training from Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and others.

In Malawi, support through DHSSi has been significant in supporting completion, and quality, of planning for 2020–21. In particular, technical advice from CHAI has helped to build capacity, and planning workshops have provided time to complete the DIPs and enhanced involvement of programme coordinators. In some districts, plans were not completed in 2019 due to gaps in capacity and workshop time, and CHAI's support was seen as significant for completion of the DIP tools in 2020–21. The revised DIP tools (which CHAI has worked on via the national task team) were also seen as making planning easier in 2020–21. Planning teams also had more experience in 2020–21, further contributing to a stronger process in year 1 compared to baseline.

In Uganda, DHMTs saw EBP training as bringing an appreciation of BNA and building capacity to apply the approach, and workshops provided space to work on plans. Support seems to have enabled continuation of the Integrated plan and EBP approach, rather than a major change in planning since baseline: there were minor improvements in application of BNA and causal analysis in one district (Lamwo), but in another (Kasese) the 2020–21 plan was largely identical to that of 2019–20, with minimal evidence of new analysis. BNA was applied before DHSSi began, and DHMTs said there was not a significant change in planning between 2019–20 and 2020–21. In Oyam, DHSSi did not provide support for

development of the plan due to the delays discussed earlier.

DHSSi has also contributed to district stakeholder engagement in planning, specifically involvement of other development agencies that operate in the target districts (such as NGOs or other bilateral or multilateral initiatives). This has been particularly evident in Uganda and Malawi, where DHSSi has supported stakeholder meetings. In Malawi, the partner mapping template and workshops contributed to increased information on stakeholder activities for development of the Year 1 2020-21 plans. In Uganda, the idea of an 'integrated' annual plan focuses on coordination of district stakeholder activities.

Key aspects of plan development, review, and implementation for the four countries are outlined in Annex K. In summary:

- **Use of BNA:** BNA was applied for some key reproductive, maternal, neonatal, and child health (RMNCH) areas in all countries and districts for 2020–21, except in Kenya. Increase from baseline was clearest in Tanzania, where BNA was not used for 2019-20 plans. The extent of use varies between districts and countries.
- **Causal analysis:** DHMTs discussed use of the five whys process for 2020-21 plans in Malawi, Tanzania and Uganda. There is some improvement since baseline, for example with some DHMTs reporting more identification of underlying or actionable causes, particularly in Malawi and Tanzania, and some additional detail documented in Uganda. The logic and detail of documented causes remains varied between districts and countries, and there is scope for more specificity and alignment with evidence in all countries.
- **Prioritisation:** Criteria for prioritisation are applied in some countries, and there is some consideration of resources. There is little clear change in the process since baseline, although some discussion of more focus on prioritisation in Tanzania. Prioritisation generally remains broad, with long lists of activities.
- **Inclusion of activities identified through BNA or problem analysis in the plan:** There is a clear link between activities identified through BNA and planned activities in Malawi due to the template structure (with improvement since baseline in some districts, primarily due to the planning process being more complete in 2020-21). Links are less evident or harder to follow in other countries, with activities from BNA or other problem analysis sometimes not clearly included in the plan. There is minor improvement in documented links between BNA and planned activities in some districts in Uganda since baseline. In Tanzania, BNA was not used at baseline (as above), and some activities from BNA were included in plans for Year 1. In all countries, many planned activities tend to be routine rather than based on BNA or other problem analysis.
- **District stakeholder involvement:** There is increased involvement of other development agencies in formal district planning meetings in Malawi and Uganda, through DHSSi support. This stakeholder input has not been a focus for DHSSi in Tanzania, and there was little indication of change since baseline. Involvement is often to provide information on stakeholders' activities, with limited input to problem analysis and prioritisation. There are concerns about some development agencies not sharing information or aligning with district plans.
- **Community involvement:** There are some structures for community input, such as facility committees, but such input is generally seen as limited, for example due to gaps in committee functionality. There is no clear change since baseline, and community input is not a focus for DHSSi support
- **Review of plans:** The focus and regularity of reviews vary between countries and districts, affected by funding, guidelines, leadership. Change since baseline will be assessed in the next evaluation round, comparing review of 2019-20 and 2020-21 plans, but there are indications of DHSSi support facilitating reviews (for example, funding review meetings and supporting use of the action tracker).

- **Implementation of plans:** Implementation of 2019-20 plans was limited in all countries, and affected by funding, COVID-19 and other emergencies, staff time, lack of ongoing focus on plans, and leadership. Change since baseline will be assessed in the next evaluation round, comparing implementation of 2019-20 and 2020-21 plans.

The contribution of DHSSi to management and accountability

As indicated earlier, this evaluation round focused on DHSSi's contribution to EBP as there had been less work on management with DHMTs at the time of evaluation fieldwork. In Tanzania, management activities had not been implemented at district level; in Uganda, support for recruitment had focused on selected districts, and not the evaluation sample districts; and in Malawi, three districts had undergone leadership and management training (including two evaluation sample districts), but this was very recent at the time of fieldwork. Consequently, information on management below is generally provided as baseline information, with only preliminary indications of DHSSi contributions. Information on management came from PAMAT discussions about role clarity and performance, regular DHMT meetings, and relationships with the district executive (the PAMAT management domain was not applied in Kenya, following discussion with UNICEF Kenya CO); and from comments on DHMT performance during key informant interviews. Respondent openness is a particular difficulty in relation to questions on management and accountability, and varied across contexts (for example, participants in some districts were more vocal about governance challenges); findings should therefore be considered with some caution.

Descriptions of management varied between countries and districts, as well as between individual interviewees. Coordination among the DHMT was generally seen as effective, though with gaps in some countries and districts on regularity, documentation, and coordination leading to action. There are structures for regular coordination with the district executive, and most reported this relationship as working well, though the link with the executives appears weaker in Malawi. There were many positive comments on DHMT teamwork and commitment, but role performance is affected by unfilled positions (especially in Uganda) and lack of time, capacity, and motivation. Some concerns about governance or accountability were raised in all countries, but particularly in Kenya. Findings from each country are summarised in Table 5.

DHSSi has made initial contributions to effective management in Uganda and Malawi.

In Uganda, training on information systems in Oyam supported DHMT capacity in human resources management and plans for collaboration between the DHMT and district executive, and action planning based on the progression model was seen as enhancing management in Kasese. Several other factors have also enhanced DHMT coordination, teamwork, and role performance in Uganda, including support from other development agencies and the executive, and the need to work together on COVID-19. In Malawi, the leadership and management training was seen as helping to strengthen relations between the DHMT and the wider council, and one manager reported that although the impact of training had been limited by lack of follow-up (as discussed in Section 3.3.2), some of their management skills had improved, and the DHMT had identified areas for improvement through the training workshop. As above, these are preliminary indications based on limited data, and the effects of training will be explored further in the next round.

Table 5: DHMT management performance

Uganda	Tanzania	Malawi	Kenya
Relationships with the district executive were seen as effective, with	CHMTs are represented on higher council structures, with	District executive members feel there should be closer	Varied comments (likely to partially reflect openness in key

Uganda	Tanzania	Malawi	Kenya
regular representation in district meetings. DHMTs reported effective coordination (especially through regular meetings), and this was an area of recent improvement. Role performance is hampered by unfilled positions and high workloads.	regular meetings. CHMTs meet regularly, though meeting documentation is a gap. Performance of roles was generally considered good, but with some gaps around orientation for new CHMT members and adequate resourcing for role performance in some programme areas. Teamwork and leadership vary between CHMTs.	working relationships with the DHMT. DHMTs were reported as having job descriptions and in most cases performing their roles, although with gaps related to capacity, funding, and commitment. DHMTs meet fairly regularly, though some meetings are missed when DHMT members are busy.	informant interviews and variation between counties). Some reports of effective teamwork, commitment, and functional relationships with the county executive. Concerns about unplanned changes in CHMT composition, unclear reporting, political influence on CHMT decisions, and some positions not being based on merit.

3.4.2 What aspects of individual, district, and national contexts influence the effects of DHSSi activities on district health planning and management practice and bottleneck reduction?

A range of factors at individual, district, and national levels affect DHMT planning and management. We focus here on key factors identified as affecting development and implementation of plans, in line with the emphasis on EBP during the first evaluation round. (Factors affecting stakeholder involvement and review are indicated in Annex K and discussed in detail in Country Annexes.) We look in more depth at BNA templates and guidelines, as these are a clear area of variation between countries and so cross-country comparison adds value to the country annexes. We also briefly outline other factors that were frequently identified as affecting development and implementation of plans.

Planning templates and guidance

National guidelines and planning templates affect use of BNA, causal analysis, prioritisation, and inclusion of activities identified through BNA in the final plan. Planning guidelines promote use of BNA for Integrated Plans in Uganda and the district plans in Malawi. BNA is optional in Tanzania but is recommended for RMNCH and nutrition. BNA is not part of the Kenya guidance (at the time of fieldwork). This influences DHMTs' use of BNA: CHMTs commented that they used BNA partly due to the guidelines in Tanzania, and in Kenya, CHMTs commented that BNA was not required.

Templates and guidance affect documentation and use of BNA, including areas where BNA is applied, documented depth of causal analysis and prioritisation, and the inclusion of activities from BNA in the plan. The Malawi DIP tools are a standardised Excel file, with automatic linking between sheets and space for completion. Provided district teams have capacity to follow the tools (as provided through CHAI support), these tools ensure that bottlenecks and causes are identified, activities are prioritised, and activities are then included in the plan and budget.

The tools include space for identification of bottlenecks in relation to 34 standard indicators for national targets. DHMTs are advised to focus on identifying bottlenecks for indicators that are off track (with some discussion about applying BNA in other areas if needed). This approach means the range of areas where BNA is applied is similar between districts. The Uganda Word template includes a section for identification of bottlenecks. DHMTs are

advised to focus on areas of underperformance based on the scorecard, and there is more variation between districts in selection of interventions for BNA, compared to Malawi, because BNA is not restricted to a standard set of indicators. In Tanzania and Kenya, there is no designated space for BNA within the planning templates.

In relation to causal analysis, templates for Malawi, Tanzania, and Uganda include space to show root causes, with more space and detail in Uganda, and the least space in Tanzania. Similar variation is seen on prioritisation, with templates for Malawi and Uganda including space for prioritisation matrices (we could not access these for Tanzania), although inclusion of matrices and the approach to completing them varies between districts.

Templates also affect clear documentation of the flow from BNA or problem analysis to prioritisation and action plan. In Malawi, inclusion of activities from BNA in the prioritisation matrix and plan is automated. In Uganda and Tanzania, the link between tables for problem analysis and plans (and for Uganda, the prioritisation matrix) relies more on how DHMTs complete the plans, and was often hard to follow, particularly in some districts. Planning templates and tools also affect planning through their degree of complexity and ease of use. In Tanzania in particular, CCHPs involve 28 tables, and DHMTs saw planning as a time-consuming process. The online system was seen as helpful for ongoing checks, but there are also difficulties with missing data and system functionality.

Beyond templates, planning guidelines have an important influence on designated **space to include activities identified through BNA alongside other health activities** that come from the guidelines (for example, the essential health package). This is a particular issue in Tanzania. CCHPs are scored by decision makers at higher levels, and must obtain a sufficient score to secure funding. Scoring considers criteria such as timely submission and correct completion of different sections, whether the budget aligns with set ceilings, and whether a set list of intervention areas is included. As discussed under relevance, CHMTs reported tension between following priorities identified through BNA, and meeting the CCHP scoring criteria. In particular, including activities stipulated in the guidelines can mean the plan includes activities that are not considered a priority for the CHMT, and other local priorities are then cut to fit budget ceilings. This appears to be at least in part an issue of CHMT understanding regarding flexibility in the guidelines, but it affects use of BNA and motivation to invest time in problem analysis. The Malawi tool integrates activities from the national policy and packages, but with flexibility, and this was not raised as a concern. Across countries, many activities in plans are considered routine or essential, and are not developed through BNA.

Other factors affecting planning

Planning and implementation are also affected by DHMT capacity and motivation; interests and resourcing among other development agencies; data availability; COVID-19 and funding for implementation.

Use of BNA is affected by **understanding and skills**. As discussed under relevance, DHMTs see BNA as complex and requiring training. DHMT members with more training and experience are better placed to apply BNA for their programme areas or to support others. Understanding of BNA is often greater among a few DHMT members, such as the biostatistician or health information officer (linked with reach of training, as discussed under efficiency), and this reduces wider application of the approach. Linked with this, BNA is more likely to be used in programme areas covered in DHSSi's training and support (this was discussed in Tanzania, where training was seen as focusing on staff working in UNICEF priority programme areas, and this restricted the interventions for which BNA was used). Experience and DHSSi support are seen as building capacity. For example, district teams in Malawi felt their skills, and the associated quality of steps such as causal analysis, were

stronger in 2020–21.

The **time** required for planning, busy DHMT workloads, and submission deadlines also affect the quality of planning and use of BNA. For example, time constraints were discussed as one factor limiting use of BNA in Tanzania and Kenya, and the involvement of DHMT members and programme coordinators in planning in Malawi is affected by their workloads.

The time involved in, and effort of, planning can also affect the quality of work. For example, in Malawi, a lack of energy towards the end of planning was identified as reducing detailed consideration of prioritisation and the link to budgets; and in Uganda, an implementing partner noted that people are tired by the stage of discussing solutions.

Motivation and leadership are also significant. As discussed under relevance, there are concerns among some DHMT members about the value of investing time in plans which are insufficiently funded or implemented. A sense that many activities are routine and have to be included also discourages investment in problem analysis; for example, this was given as a reason for not using BNA in Kenya. Support for EBP from district leaders is also significant: in Oyam, limited DHO or district leadership familiarity with BNA was identified as contributing to the DHMT not developing an Integrated plan. CHMT governance affected planning in Kenya, particularly unplanned changes in CHMT composition, which disrupted the usual process and meant the plan was developed quickly by a small group of senior managers.

As discussed under relevance, the **availability of data** affects application of BNA. In general, BNA is only used where DHIS2 data are available, although there has been some use of other programme data in Malawi.

Development agency and stakeholder interests also affect planned activities. Activities led and funded by development agencies are often included in plans; this is part of a deliberate strategy for coordination, but also means some activities come from these agencies rather than through DHMT prioritisation. Several DHMTs also discussed political influences on planning from local councillors or politicians.

Partly linked to development agency engagement, the perceived purpose of planning also affected the approach. Plans are seen partly as a strategy for mobilising resources, from government as well as agencies. This affects prioritisation: activities are not prioritised to fit available government resources because DHMTs hope to obtain additional funding, and scoring is sometimes high to encourage agency support.

COVID-19 affected planning in 2020, particularly by restricting stakeholder involvement. This was particularly evident in Kenya. For example, planning meetings moved online in at least one county, and this was seen as reducing input.

In relation to **implementation of plans**, all DHMTs described barriers to implementation and reported that many activities (sometimes the majority) are not implemented, primarily due to **funding**. Issues include low overall ceilings that do not cover all activities; delays in receiving funding, particularly from government; funding from government and development agencies being less than expected; unrealistically low costs being indicated in submitted budgets; and diversion of funds for unexpected emergencies. Implementation is also affected by regulations and bureaucracy around disbursement of funding, the time required to implement activities for those responsible; and, in 2020, by COVID-19. There were indications of **effective management and leadership enabling implementation** in some districts, including by identifying ways to save resources or working to secure additional funds.

3.4.3 To what extent does district planning and management consider

underserved groups?

In all countries, **there was some consideration of underserved groups during planning** for 2019-20 and 2020-21. Remote **location** was widely mentioned, but there are also examples of plans referring to groups such as people with disabilities, youth, mobile populations, refugees, youth, and those affected by conflict. In general, consideration of different groups was lower in Malawi, where district and national stakeholders reported that equity had not been an area of focus. However, equity was also seen as an area that requires more attention in other countries (particularly Uganda and Tanzania). In relation to gender, district planning (and UNICEF support) has a strong focus on women's health through consideration of RMNCH, in some cases including Gender-based violence (GBV). In Uganda, some districts consider gender equity in the situation analysis and include gender disparity as part of prioritisation criteria (this is seen for Kasese but not Lamwo, in 2020-21). In some districts, causal analysis refers to gender relations (for example, lack of male involvement is given as a cause of low ANC attendance in some district in Malawi). However, overall consideration of the influence of gender is limited; for example, gaps in RMNCH coverage are often described as relating to lack of awareness among women or aspects of service provision, with no discussion of the influence of gendered power relations (a significant influence on, for example, contraceptive use as well as access to maternal and other services).

For 2019-20 and 2020-21, no district plans showed systematic consideration of access or coverage for different groups or by gender as part of BNA processes or other steps in planning. Equity is one of the criteria in prioritisation matrices in Malawi and Uganda, but as discussed above, prioritisation is applied broadly, sometimes rushed, and with uncertain logic for scoring on equity (and other criteria). In addition, when equity is raised as part of planning discussions or indicated within the situation analysis, there is not always follow-through to identifying and funding solutions, and budget caps are seen as affecting inclusion of relevant activities.

Attention to equity and gender has not changed significantly between the 2019–20 and 2020–21 plans, although DHMTs in Uganda felt it was improving. Equity is included in the standard DHSSi EBP training, but has perhaps received less emphasis than other areas. While all UNICEF support for health systems aims to address gender equity and there is a particular focus on RMNCH, EBP training also appears to provide limited detail on consideration of gender as part of planning. In general, while location is widely considered, more systematic and consistent attention to equity and gender in proposed activities and budgeting appears to be an area requiring further support. This is a particular gap in Malawi, where some district teams indicated uncertainty about how different groups should be considered, but equity was also discussed as a newer concept in Uganda.

Analysis on underserved groups is affected by available data. Information on gender is available in DHIS2, suggesting that more disaggregated analysis is possible. However, information on status on dimensions such as disability or income is generally unavailable, and DHIS2 does not provide sufficiently detailed information for all areas of interest (for example, in Tanzania, age data are limited and do not specify adolescents). Some DHMTs discussed obtaining information from other sources, including direct experience from communities and information from social welfare or community departments.

Planning guidelines and templates affect consideration of equity. In Tanzania, there is a dedicated priority area on social welfare (*CCHP Priority Area 7: Strengthen Social Welfare and Social Protection Services*), which specifies activities for adolescents' and women's sexual and reproductive health, people with disabilities, vulnerable children, older people, and exemptions and waivers. Discussion of equity focuses on groups considered within this priority area as well as location, and the inclusion of this priority in the CCHP guidelines means some activities are incorporated in plans. In Kenya, World Bank RBF requirements

have contributed to attention to marginalised groups, as this is part of the scoring criteria. In Malawi, the DIP Excel tools do not include specific sections for equity beyond the prioritisation criteria, and as planning focuses on completing these tools, this seems likely to reduce consideration of different groups.

3.5 Sustainability: will the benefits last?

Summary

- Inclusion of BNA within national planning guidelines is an important step in national institutionalisation. Embedding government support requires wide government engagement, beyond specific individuals or teams.
- Government see funding from development agencies as necessary to scale up EBP. There is some interest from other agencies, but clear government direction is needed to encourage their support.
- Continued EBP at district level depends on DHMT motivation and capacity. At this stage, some DHMTs are concerned about the complexity and time required for BNA, and about the value of detailed problem analysis. Further training is needed to reinforce skills and address turnover. Growing EBP training capacity among government staff can potentially support future ongoing training.
- Workshops are a core part of planning and review in most countries and they rely on funding from development agencies. DHMT skills are insufficient to sustain EBP without time and motivation, which are often addressed via workshops.
- All UNICEF COs are taking steps to promote sustainability and have further plans to institutionalise EBP and management support, for example working closely with government, building a pool of national EBP trainers, and aligning with government planning tools.

In relation to the DHSSi ToC, evaluation questions on sustainability relate primarily to the intermediate outcome of an enhanced enabling environment for good district management practices, including institutionalisation. As DHSSi is in the early stages, assessment of sustainability for this evaluation round focuses on preliminary indications of factors that may enable or hinder sustainability. We also focus more on EBP, as management activities were largely in an initial phase of development.

3.5.1 To what extent can expected results be sustained independently of UNICEF support?

Independent continuation of EBP results and activities depends on national support, DHMT capacity and motivation to undertake EBP, and ongoing availability of the tools that underpin BNA and EBP. National support is discussed under national institutionalisation and DHMT capacity and motivation are discussed under district integration.

In relation to the **tools**, ongoing development and refining of the BNA app has required technical expertise and time, supported through DHSSi. The app will need reconfiguring with changes in the DHIS2 tools. In Malawi, it was also indicated that updates will be needed each year because some data come from outside the DHIS2 and need to be sourced and added manually. Continued use of the app therefore depends on a system to manage these updates within government (this is being supported in Malawi).

3.5.2 Is there evidence of institutionalisation of DHSSi interventions at national level?

Institutionalisation can be considered in terms of integration in guidelines and national ownership, and scale-up. In Tanzania, Malawi, and Uganda, **inclusion of BNA within national planning guidelines** is an important step in national institutionalisation. BNA is part of templates in Malawi and Uganda (so encouraging or requiring inclusion), but there is not specific space for BNA within the Tanzania PlanRep system and templates. This means the national government (or others) cannot check whether BNA is used or provide feedback as part of checking plans. In Kenya, integration of BNA within planning guidelines was a key focus for late 2020. At the time of fieldwork, there were mixed opinions on this within government.

Positive views of EBP among national government staff in all countries also support **national ownership**, although as discussed under relevance, there are reservations about complexity and time requirements, and the degree of ownership varies between countries.

In some countries, **wider government engagement** may be needed to sustain support. DHSSi often works with particular individuals or teams. While focal points are needed, this is a risk for sustainability due to possible turnover, or when institutionalisation requires support from other teams. For example, in Tanzania, UNICEF has worked closely with the national government, but only a small number of PO-RALG staff are directly involved and familiar with the activities, and DHSSi has not had a constant Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) contact for the EBP work. CHMTs and the national government suggested that familiarisation with and awareness of BNA among those approving plans and senior national government would be needed to support sustained use of EBP.

National guidelines and government ownership support **scale-up**, but in all countries funding from development agencies was seen as necessary to roll out EBP more widely (and likewise the management training in Malawi). In particular, support is needed to provide training and support capacity to apply planning tools, and to fund the management training workshops.

There is some interest from other development agencies, and one agency supported some BNA activities in Tanzania. However, agency priorities vary, and some have reservations about some DHSSi activities. In several countries, some stakeholders mentioned that a strong national government signal would be needed to encourage support from other development agencies.

3.5.3 Is there evidence of integration of DHSSi interventions at district level?

DHMTs generally indicated plans to continue use of BNA, due to guidelines and because BNA is seen as supporting accurate understanding of problems. In Uganda, some DHMTs referred to BNA as now 'routine'. However, as discussed under relevance, DHMTs have concerns about applicability of BNA, given lack of data, time constraints, and complexity. Continued EBP by DHMTs will depend on motivation and capacity, including adequate skills, and allocated time through workshops.

Skills and turnover

In relation to skills, as previously discussed, exposure to EBP varies between and within DHMTs. Particularly in Tanzania, but to some extent in all countries, DHMTs felt further training is needed to reinforce skills among those who have been trained, and to extend skills to the wider district team. Turnover also reduces capacity and means further training is

needed, at least while skills are not widespread among district staff.

Training approaches that rely on government staff and routine systems could address turnover and continued skills development. There are indications of scope for this continued support through growing EBP training capacity among government staff. In Malawi, DIP coordinators are strong in some districts and led much of the workshop facilitation. While they thought further support was needed, and changes in positions mean at least one coordinator has left, growing skills among coordinators provide an opportunity for ongoing training and facilitation without support from DHSSi or other initiatives. In Tanzania, the national government suggested that because BNA is included in the CCHP guidelines it could and should be integrated in regular annual CHMT discussions and capacity development on planning. In addition, the ToT included government staff in Mbeya, and as their skills and confidence grow with further refresher training, they will be in a position to train others.

Workshop funding

Workshops are a key part of the EBP process in most countries, including planning workshops, stakeholder coordination meetings, and review meetings. District governments do not have (or do not allocate) funding for these workshops, so they rely on support from development agencies. Particularly in Kenya and Malawi, DHMTs suggested that even once skills are built, funding for workshops is needed to apply the techniques and conduct planning. In Kenya, reflecting a decline in donor funding, CHMTs and others felt there should be advocacy for more government funding for the planning process itself. In Tanzania, there are stakeholder meetings as part of pre-planning, but the development of plans appears to be done primarily in small groups rather than through a large or multi-day workshop. There will be benefits and disadvantages of different approaches, but the workshop model (while expected by DHMTs in Uganda, Kenya, and Malawi) is unlikely to be financially sustainable.

Motivation

As discussed under relevance, there are concerns among some DHMTs about the value of investing in problem analysis when funding for preferred solutions is often unavailable and plans are not implemented. DHSSi is working to support funding and implementation of plans – for example, through stakeholder mapping, review, and management capacity development – which may increase the perceived value of the planning process. Alignment with budgeting systems is also likely to affect sustained use. For example, a separate Ministry of Finance budgeting system in Uganda makes development of Integrated plans a lower priority for DHMTs, as discussed under relevance.

3.5.4 How has sustainability been considered as part of DHSSi processes?

All UNICEF COs are taking steps to promote sustainability, including work to include BNA in national guidelines, and working with government on DHSSi plans and implementation. Other strategies started or planned include building a pool of national EBP trainers and training government staff who can then support district capacity; widening training to sub-county/district levels to mitigate turnover; integrating training on EBP in key management training activities and government training curriculums; working with government training institutes for management training; and aligning with government planning tools.

4 Conclusions

In the first year of the programme, despite some delays and disruptions due to COVID-19, there was notable progress in most DHSSi contexts. Overarching conclusions with reference to the evaluation criteria are presented below.

Relevance:

In all contexts, support for EBP and management aligns closely with national government priorities. The four countries have invested in national planning systems and health management capacity (supported through UNICEF and other development agencies) to facilitate the production of standardised district plans and budgets. This is in recognition of devolved health service delivery and the role of sub-national health teams in decentralised planning and management. Health information systems have enabled greater access to data, with potential to drive performance and monitoring. Within this broader context, EBP and BNA are recognised as aiding analysis and prioritisation, to varying degrees.

At district level, interest in EBP and management was more mixed. Some DHMTs were uncertain about the value of EBP and annual planning more generally. There were concerns with data quality, fit with the planning cycle and budget system, and limited decision and fiscal space. System hardware, such as infrastructure, human resources, essential medicines, and supplies, is the primary concern in most contexts. While DHSSi activities and EBP were seen as helpful for more accurately identifying specific problems, they were sometimes viewed as limited in actually addressing hardware constraints or other district bottlenecks due to insufficient funding and implementation of the identified solutions.

Coherence

In all countries, **other development agencies and initiatives support district planning and management**, including in DHSSi target districts. This presents opportunities for DHSSi, but also risks of duplication or inconsistency. While there have been efforts to coordinate, there are gaps in information and communication, and scope for further coordination.

Efficiency

Despite COVID-19, **most planned activities on district EBP capacity development took place in Uganda, Malawi, and Tanzania, and some management activities were also implemented.** Previous work on EBP and BNA through precursor projects and training conducted pre-pandemic facilitated progress. The delay in operationalising the BNA app was a feature in all country contexts due to various data and configuration issues. UNICEF has recognised that a longer time horizon is needed to address these issues and to embed the app in planning and management practices. In general, delays and disruptions have resulted in staggered implementation across contexts, which may reinforce the advantage of regional coordination to share lessons across countries and adapt approaches.

Effectiveness

Findings suggest that DHSSi activities have resulted in stronger district health planning and management practice. In Uganda, Tanzania, and Malawi, support through DHSSi has had a clear impact on development of the 2020–21 plans, including use of BNA, while in Kenya this support was delayed due to COVID-19. The contribution was both direct through EBP training, support for DHMTs, and funding for workshops, and indirect through the development of national guidelines and planning tools. Impact on consideration of equity in planning is less evident: annual workplans do not show systematic consideration of access or coverage for different groups as part of BNA processes, and this is an area where

greater guidance is needed.

There are notable differences in how BNA is incorporated within national guidelines and planning templates across contexts, and this affects the planning approach and use of BNA. In Malawi, national planning templates are structured for a consistent flow between BNA, prioritisation and budgets, while in Uganda, formats are more varied and there is sometimes a disconnect between BNA and other sections. In Tanzania, where BNA is one of several recommended approaches to EBP, there is no designated space within the web-based planning document to cater for its application. In Kenya, BNA is not currently recognised within national planning guidance, which presents an additional hurdle to its effective inclusion. While new templates were seen as facilitating BNA in Malawi, in all contexts there were constraints in relation to DHMT time, skills, and data.

Sustainability

Preliminary indications of factors that may enable or hinder sustainability have emerged. In Tanzania, Malawi, and Uganda, the inclusion of BNA within planning guidelines is an important step in national institutionalisation. However, while national and district respondents in all countries are generally positive about EBP, there are reservations about complexity and time requirements, and the degree of government ownership varies between countries. Wider government engagement may also be needed to sustain support, as DHSSi often works with particular individuals or teams, making it reliant on individual championing and vulnerable to staff turnover. In all countries, funding from development agencies was also seen as necessary to expand EBP, and (in Malawi) management training, particularly given reliance on expensive workshop models and residential courses. In several countries, some stakeholders mentioned that a strong signal from national government would be needed to encourage agency support. All UNICEF COs have taken steps to promote sustainability and address some of these factors.

5 Lessons learned

Alignment of EBP with government budgeting systems, and DHMT understanding of how BNA can be used effectively within existing decision and fiscal space, are important for the influence of BNA on resource allocation. Although BNA is recognised within national planning contexts and used in some way by most of the target DHMTs, a substantial influence of BNA on resource allocation is currently less evident. While activities identified through BNA are often included in plans, there is less evidence of these activities being prioritised in the budgeting system, due to both the dominance of routine activities and varied alignment between the district health plans supported through DHSSi and the systems used to allocate district resources. Limited fiscal and decision space also reduce DHMT motivation to invest in the development of evidence-based plans using BNA. Motivation to apply BNA and the influence on budgets and consequent implementation may be facilitated by aligning EBP with budget systems, and supporting DHMT understanding of how BNA can be usefully applied within existing constraints (and indeed can help to address financial constraints).

District government leadership, engagement and stability affect the quality of planning and management and the effectiveness of support for district capacity. Health management team instability undermines sustainability of the planning and management investment made through DHSSi and other development agencies. Where district leadership and management teams are more stable and actively engaged, planning and management practice is more valued and more likely to be routinised. In particular, the significance of leadership for EBP reflects the extra work implied by these approaches, and highlights the importance of PEA and of aligning EBP with district team motivations and incentives.

In all contexts, key bilateral and multilateral agencies are invested in strengthening data systems and planning and management capacity, with potential synergy with DHSSi investment. Addressing the fragmentation of development agency support is a key feature of DHSSi, particularly in relation to leadership and management. Coordination of agency support to district capacity involves work at national level, but is equally relevant at district level given the overlay of agency support for district teams. Agencies working to support district health planning and management include the World Bank, USAID, and GIZ, among others. More deliberate engagement with these agencies, at national and district levels, could optimise collective investments in leadership, management, and planning practice. This would also serve to optimise government time and attention, given that the activities of other agencies were identified as taking time from DHSSi activities in some contexts.

Engagement of district development agencies in planning has potential to support joint analysis and coordinated implementation, but there are also concerns among DHMTs about agencies' influence on plans and inclusion of activities that may not match DHMT priorities. This suggests that effective engagement of development agencies in planning requires open discussion and a flexible approach from agencies. In relation to DHSSi and internal coherence with other UNICEF CO investments, this implies that while other UNICEF support may address some of the hardware concerns of DHMTs (such as additional funding and supplies), there is a risk that DHSSi is seen as facilitating a focus on areas where UNICEF prioritises funding (such as RMNCH), with less attention to other programmatic areas. This may affect DHMT planning and prioritisation, and the relevance of EBP and BNA for other development agencies. This will be explored further in other evaluation rounds.

Different DHSSi implementing partners have different advantages and trade offs in

relation to speed of delivery, technical expertise and sustainability. The relative benefits do not appear inherently linked to particular types of partner, and vary more with individual organisations. For example, some NGO partners have brought stronger technical expertise than others, and some have been able to build government capacity and so support sustainability. Likewise, some government partners have had time and motivation to push forward DHSSi activities, whereas capacity has been more limited for others. Complementary partner programmes can support effectiveness, for example through widening learning or providing relevant knowledge and information. There are comparative advantages of the implementing partners in each context, and all have been selected based on their capabilities, for example, experience working with government and local relevance (Tanzania); expertise in planning and budgeting, and geographic coverage (Malawi); and established relationships within specific districts supporting priority health programmes and addressing district 'hardware' issues (Uganda).

Understanding and clarifying the underlying assumptions for EBP and BNA in each context may help to ensure its relevance and to secure its position and value within country review, planning, and budgeting cycles. The findings suggest that there are a range of stakeholder views on the purpose and utility of plans, and on the problem that EBP seeks to solve. In terms of the purpose, EBP is variously seen as supporting, for example, more efficient use of resources, additional resource mobilisation, harmonised implementation, or more considered planning. These different aims affect the process (as seen with prioritisation, with a focus on obtaining government or development agency funding reducing strict prioritisation). In relation to utility, limited use of plans for budgeting and limited implementation reduce DHMT interest in planning in some contexts. Clarifying rationales, and ensuring different rationales are consistent, could support further decisions on the appropriate planning process. The rationale for EBP may vary between contexts.

6 Recommendations

Recommendations presented here are based on the evaluation conclusions and lessons learned. Draft recommendations were discussed with UNICEF COs and ESARO. This first evaluation round was necessarily broad and a number of areas require further investigation (see country annexes). In addition, DHSSi is in the early stages, so the consequences of different strategies are not yet fully evident. Consequently, the recommendations below should be considered as areas to explore at this stage in DHSSi activity. Suggested timing is based on consideration of priority for DHSSi effectiveness, and feasibility.

Table 6 Recommendations

Rationale for recommendation	Specific steps and actors	Suggested timing
<p>Greater alignment between EBP and district budgeting systems is needed to reinforce the underlying rationale (and motivation). In Uganda, for example, this should consider IFMIS requirements, and in Malawi, timing in relation to district council budgets. In Tanzania, district health teams were unclear how to balance national directives with local priorities, and concerned about the implications of using BNA for CCHP scoring.</p>	<p>UNICEF COs:</p> <ul style="list-style-type: none"> - Engage with all relevant government ministries and departments (e.g. Ministry of Finance) to ensure support for EBP is aligned to other district planning and budgeting systems. <p>UNICEF COs/implementing partners:</p> <ul style="list-style-type: none"> - Involve local government departments engaged in planning and budgeting systems in discussions on EBP (e.g. District finance officers), to understand other relevant district processes and support alignment - Ensure timing of support for EBP is aligned with budget cycles <p>ESARO:</p> <ul style="list-style-type: none"> - Support learning on approaches to alignment between countries 	<p>Higher level engagement over next one year</p> <p>Guidance for DHMTs with next planning cycle (2021-2)</p>
<p>Earlier and wider engagement of other district development agencies in district planning may strengthen prioritisation and causal analysis; build collectiveness ownership of plans and identify resources to address bottlenecks; and reinforce demand for good district practice through transparency regarding DHMT prioritisation and</p>	<p>UNICEF COs and implementing partners:</p> <ul style="list-style-type: none"> - Discuss and experiment with different models of district stakeholder engagement in earlier stages of planning, focusing on agencies that show the most interest and greatest complementarities. <p>ESARO:</p> <ul style="list-style-type: none"> - Support learning on approaches to stakeholder engagement between 	<p>Next planning cycle (2021-2)</p>

Rationale for recommendation	Specific steps and actors	Suggested timing
<p>expected implementation. Models of early engagement should balance feasibility and utility , for example, considering whether agencies need to be engaged as part of planning workshops, or through other (lower cost) processes. Relevant agencies may include RBF implementers under the World Bank, USAID health system strengthening initiatives, and agencies who have been traditionally less engaged but who are voicing an interest (such as NGOs working at district level in Malawi). Different agencies may bring different contributions – for example, local or technical knowledge that can support analysis, or funding to address bottlenecks – and this will affect appropriate mechanisms and timing for engagement.</p>	<p>countries</p>	
<p>A number of other development agencies support district planning and management capacity, with potential synergy with DHSSi investment (for example, the World Bank, USAID, and GIZ). More deliberate engagement with these agencies, at national and district levels, could optimise investment in leadership, management, and planning, and facilitate government time and attention, given that the activities of other agencies were identified as taking time from DHSSi in some contexts.</p>	<p>UNICEF COs: - Continue and increase engagement with other development agencies working in planning and management, to ensure mutual understanding of activities and identify opportunities for alignment.</p> <p>UNICEF COs and implementing partners: - Map district-level support to local government planning and management, to avoid duplication and identify complementarities.</p> <p>ESARO: - Alert COs to information on any relevant regional initiatives, and share information on complementarities identified by UNICEF COs that may be</p>	<p>One year</p>

Rationale for recommendation	Specific steps and actors	Suggested timing
	<p>applied in other DHSSi countries (for example, where another development agency also has a multi-county initiative).</p>	
<p>Effective district planning and management is affected by district governance and leadership. This signals the importance of planned work to address leadership and accountability using the PEA findings. This work will be carefully assessed in future evaluation rounds. As above, several other development initiatives aim to support leadership, management, monitoring, and accountability at national and district levels, creating potential for complementarity in strengthening district capacity and motivation for effective performance.</p>	<p>UNICEF COs and implementing partners:</p> <ul style="list-style-type: none"> - Carefully consider the implications of the PEA findings (in Kenya, Malawi, and Uganda), and implement relevant recommendations. In Tanzania, where a PEA is not available, existing literature or knowledgeable informants might provide additional understanding of district incentives that could inform DHSSi plans. - Given the complexity of addressing governance, leadership and accountability, closely monitor DHSSi activities in these areas to adjust support as needed. - Engage with other development agency initiatives that aim to promote effective governance, leadership and accountability, to identify complementarities. 	<p>Review of PEA findings and engagement with other activities over next year. Prioritisation and timing for specific activities depends on PEA conclusions and recommendations.</p>
<p>Lack of funding is widely identified as a constraint to applying BNA and implementing annual plans. Resource constraints link to the different rationales for planning, including prioritising scarce resources or mobilising additional resources. In addition, DHMTs may be discouraged from investing time in BNA by an assumption that action identified through BNA requires additional resources. Greater emphasis on domestic resources and efficiency as part of planning and</p>	<p>UNICEF COs and implementing partners</p> <ul style="list-style-type: none"> - Clarify the rationales for EBP and ensure different rationales (e.g. efficiency and resource mobilisation) are consistent with each other, and with the formal and informal planning process (e.g. approaches to prioritisation). For example, to ensure plans provide a realistic guide to use of DHMT budgets and so action during the year, an unfunded section of plans might be retained as a resource mobilisation tool, but distinct from the funded elements of the plan. - In support to DHMT planning 	<p>Clarify rationales and emphasise efficiency as part of next planning cycle (2021-2)</p> <p>Explore alternative funding sources and support adaptive capacity: over remaining DHSSi period</p>

Rationale for recommendation	Specific steps and actors	Suggested timing
<p>prioritisation could reinforce the rationale for district planning and distinguish it from resource mobilisation from development agencies. Alternative funding sources (such as RBF) may also provide ways to secure additional resources. An emphasis on efficiency and domestic resources is particularly relevant where donors are transitioning support, either through reduced or redirected funding allocations.</p> <p>Uncertain funding requires changes to planned activities during the year. Implementation is also affected by unexpected events (such as COVID-19), or unplanned costs such as maintenance. This uncertainty requires an ability to adapt plans and accommodate unexpected events during the year.</p>	<p>capacity, increase the emphasis on identifying efficiencies and strategies to address bottlenecks within existing fiscal space, and share learning about effective approaches between DHMTs.</p> <ul style="list-style-type: none"> - In the Kenyan context, explore options for greater use of demand-side financing through the National Hospital Insurance Fund and related entitlement schemes. While these were not mentioned during the evaluation, there is recognition that these sources of income are increasingly being forecast and utilised by some CHMTs as part of annual workplans. - Consider ways to support DHMTs' adaptive capacity to enable continued implementation in the event of unexpected costs or changes in funding, for example contingency funding and ability to reprioritise during the year (perhaps as part of quarterly reviews and regular DHMT meetings). <p>ESARO</p> <ul style="list-style-type: none"> - Consider and document experience from within UNICEF on supporting DHMT adaptive capacity to enable adjustments in the face of unanticipated costs and uncertain funding. 	
<p>There are emerging findings regarding the relative merits and drawbacks of implementation models, including the type of implementing partner, approach to workshops and other capacity development activities, and planning tools. In relation to implementing partners, this</p>	<p>UNICEF COs and implementing partners</p> <ul style="list-style-type: none"> - Consider the costs/benefits of expensive workshop models, and whether these can be optimised through joint sessions that combine training on EBP and BNA with practical application and development of plans (as in Malawi), or options for smaller programme-based group work 	<p>Workshop and management capacity model: ongoing review.</p> <p>Balancing time for later stages and consideration of equity, and consistent use of trackers, for next planning cycle (2021-2)</p>

Rationale for recommendation	Specific steps and actors	Suggested timing
<p>includes potential for NGO partners to emphasise a leading role for government, as in Malawi and Tanzania. In relation to workshops, issues include high costs that affect sustainability, and a need for adequate time on later stages of planning, before energy is lost. Consideration of equity in planning was identified by stakeholders as an area requiring further support. Links between district plans, BNA excel sheets and action trackers were sometimes unclear, affecting clarity on use of BNA for planning and potentially affecting integration in review processes. Several challenges for effective management capacity were identified in the country landscaping and evaluation findings, including mentorship, turnover, and how training fits around other responsibilities. These issues create ongoing challenges for sustainability, but there are plans in some countries to address these.</p>	<p>(to avoid large workshop costs).</p> <ul style="list-style-type: none"> - Ensure that workshops or other forms of support to planning balance the time required for bottleneck and causal analysis with the time needed for solution identification and prioritisation. - Support systematic consideration of equity and gender in problem analysis and identification of solutions. - Ensure that BNA Excel worksheets and the Action Tracker are aligned with the planning and review process and used consistently, to enable effective monitoring of bottleneck reductions. - Consider how the model for management activities will address issues such as turnover and avoiding taking DHMTs from other activities (for example, by expanding training to staff likely to move into DHMT positions, or integrating training within routine DHMT activities). <p>ESARO:</p> <ul style="list-style-type: none"> - Share learning on different models between COs, for example providing opportunities for discussion among implementing partners on workshop approaches, or exchanging information on ways to address turnover. - Review EBP guidance to ensure sufficient support for consideration of equity and gender. - Support COs and IPs in ensuring that BNA Excel worksheets and Action Trackers are used more consistently to provide agreed monitoring information. 	

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