

**FORMATIVE EVALUATION OF THE INTEGRATED
MANAGEMENT OF NEONATAL AND CHILDHOOD
ILLNESSES PROGRAMME (IMNCI) IMPLEMENTED BY THE
MINISTRY OF PUBLIC HEALTH OF DPR KOREA WITH THE
SUPPORT OF UNICEF DPR KOREA 2015-2019.**

Inception Report

October 2020



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ABBREVIATIONS

CMAM	Community-based Management of Acute Malnutrition
CBS	Central Bureau of Statistics
CDMU	Child Data Management Unit
CPD	Country programme document
DPRK	Democratic People’s Republic of Korea
ECD	Early childhood development
EQ	Evaluation question
FGD	Focus group discussion
GAVI	GAVI, the Vaccine Alliance
GFS	Gravity-fed water systems
HCW	Health care worker
HMIS	Health Management Information System
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IRB	Institutional Review Board
KII	Key informant interview
MICS	Multiple Indicator Cluster Survey
MoPH	Ministry of Public Health
OECD	Organisation for Economic Cooperation and Development
SDG	Sustainable Development Goals
ToC	Theory of Change
UN	United Nations
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

1 BACKGROUND

1.1 UNICEF IN DPRK

Over three decades, UNICEF has been partnering with the Government of the Democratic People’s Republic of Korea (DPRK) in the “common pursuit of the child-related Millennium Development Goals and in joint humanitarian action”¹. UNICEF and its partners in the DPRK recognise that a healthy, well-educated and well-nourished population is a more resilient one. Since multiple dimensions of child deprivation can exacerbate disaster risks, UNICEF’s country programme focuses on expanding access to vital services to save lives; enable healthy development and reduce underlying vulnerabilities for the most disadvantaged children and communities².

Following the previous five-year plan 2011-2016, the DPRK Government and UNICEF in 2017 initiated implementation of a five-year, child rights-based and humanitarian-focused country programme of cooperation for 2017–2021 (CP). Building on the progress achieved by the Government in various areas – including universal education and reducing child and maternal mortality – UNICEF DPRK supported the Government – through various platforms – to meet all the rights enshrined in the Convention on the Rights of the Child.

UNICEF’s programme has been developed within the four strategic priorities of the United Nations Strategic Framework for 2017-2021: (1) food and nutrition security; (2) social development services; (3) resilience and sustainability; and (4) data and development management. UNICEF’s programme in DPRK focuses on current humanitarian priorities, including (a) ensuring access to life-saving assistance for the most vulnerable people who are affected by disasters; (b) reducing malnutrition (particularly among children under five and pregnant and lactating women); and (c) improving access to basic health and WASH services. There is a focus of work on “convergent programming”. UNICEF defines “convergence” as “the coming together and integration of two or more distinct entities (e.g., sectors, programmes, departments, agencies, or levels of implementation) to work towards a common goal. Convergent programming refers to meaningful programmatic linkages that work to achieve greater results.”³

It is important to note that although UNICEF has been working in DPRK for three decades, the programme is classified as “humanitarian assistance” rather than a development programme. This has had implications both in the nature and the framework of interventions that were initiated.

DPRK’s successes in achieving free universal health services, high levels of immunisation coverage, near-universal school enrolment and decreases in maternal mortality rates are offset by, among others:

- Neonatal and infant mortality combined account for 84 per cent of all under-five deaths
- Risks of multi-drug resistant tuberculosis
- Persisting child malnutrition and micronutrient deficiencies
- Insufficient access to clean water and sanitation
- Limited availability, reliability and analysis of routine statistical data

¹ UNICEF DPRK Country Programme Document 2017-2021

² *ibid*

³ UNICEF; Technical Note on Convergence Programming; April 2020; accessed at <https://www.unicef.org/media/68221/file/GP-2020-Technical-Note-Convergent-Programming.pdf>

1.2 THE IMNCI PROGRAMME

The Government of DPRK decided to introduce the Integrated Management of Childhood Illnesses (IMCI) strategy in 2002, and implementation commenced in 2004 in two counties, with the intention of expanding to twenty counties by 2007. The IMNCI protocol and guidelines were tailored to the context of DPRK in coordination with WHO and UNFPA, with additions of sections on sexual and reproductive health and childhood tuberculosis.

By 2010, the Health component of the UNICEF programme (which included IMCI) was focussed on “increasing the availability and utilisation of quality health services, with particular attention given to primary- and secondary-level health facilities, incorporating the Global Fund’s support on enhancing the prevention and case management of malaria and tuberculosis, including increased case detection and procurement and distribution of insecticide-treated nets. Through the continuum of care approach, UNICEF was planning to support the introduction and expansion in all focus counties of health-related key caring practices, such as the Community Integrated Management of Childhood Illness strategy, to address major diseases of childhood⁴. The Neonatal component of the Integrated Management of Neonatal and Childhood Illnesses (IMNCI) was added to the programme in 2016.

Efforts to expand the IMNCI programme that date back to 2005 have lagged behind schedule, partly because of lack of funding. The planned nation-wide coverage by 2011 did not occur and at present the UNICEF-supported IMNCI programme is being implemented in fifty priority counties, including nine convergence counties, addressing under-five health issues such as pneumonia, tuberculosis, neonatal conditions and undernutrition, as well as building capacity of health workers at county and Ri (clinic or hospital) level. Support for diarrhoea management is a national programme, with UNICEF providing relevant supplies to all counties. Along with the provision of essential medicine kits, the programme is training household doctors (male and female) and supplying them with essential medicines and basic equipment to provide effective preventive and curative services and health promotion.

(It should be noted that while IMNCI usually includes a focus on the management of childhood malaria, this no longer appears to be a significant problem in the DPRK: after a spike of cases in 1990, malaria incidence has reduced due to the efforts of the DPRK Government and occurs only in summer in a few of the counties).

The delivery of immunisation services is supported nationally and improved by training managers, upgrading the cold chain and enhancing monitoring systems to ensure quality services, with particular attention to hard-to-reach villages and those affected by protracted humanitarian crises. National vaccination coverage is very high with coverage rates of more than 95% for all vaccines⁵.

A costed package of evidence-based emergency obstetric and newborn care services is being implemented in nine convergence counties to demonstrate its contribution to reducing maternal and neonatal mortality and to inform scale-up by the government.

As well, UNICEF is also supporting the piloting of childhood disability early screening labs, early intervention units and reinforcing the technical capacities of newborn health care service providers in one county. This will address the early identification of birth defects, developmental delays and disabilities; assessment of early interventions; and provision of assistive aids, mobility devices and family support.

⁴ UNICEF; DPRK Country Programme Document 2011-2013; 2010

⁵ <https://www.unicef.org/dprk/health>

The main implementor is the Ministry of Public Health, which is responsible for health service delivery in the whole country. The Central Bureau of Statistics is the agency responsible for data, including health service data.

1.3 LEARNING FROM PREVIOUS UNICEF EVALUATIONS

While this will be the first evaluation of the IMNCI Programme, the WASH Programme in the DPRK was evaluated in 2017, and the Community-based Management of Acute Malnutrition Programme (CMAM) in 2018. Both evaluations resulted in a series of recommendations and the development of action plans that are guiding current programming⁶.

The WASH evaluation in 2017⁷ focused on the gravity-fed water systems (GFS) that were installed with UNICEF support. The evaluation found that “the UNICEF-supported GFS interventions in DPRK were relevant to national priorities and to people’s lives, were cost-efficient and had a substantial positive effect on beneficiary communities, especially on women and children”. There is also evidence to suggest that the GFS had some impact on child diarrhoea prevalence and thus on child health. However, this impact has been largely limited to the beneficiary communities themselves: government is willing but largely unable to replicate the GFS model on a larger scale, and international actors – including UNICEF – have limited funds to expand programmes. Two of the lessons learned were that “staff turnover in UNICEF can have significant negative repercussions on programming in the absence of a robust system to ensure an adequate institutional memory in country offices”, and that “capacity building must be a continuous process and not just limited to the short-term periods of emergency and development projects”⁸.

In 2018 the evaluation of the CMAM programme⁹ also found it to be relevant and appropriate, noting that “the underlying causes of acute malnutrition in DPRK are multifactorial and the occurrence of natural disasters imposes additional localised nutritional stressors. The programme has responded appropriately to the needs of the population in disaster-affected areas over both short- and long-term fluctuations in need”. The evaluation found the CMAM programme to be highly effective, but noted that while the programme was efficient, there was room for improvement, and called for the production of protocols to guide the treatment of children who were malnourished and ill with other conditions. Overall, the programme was found to have had a strong impact, with perhaps 7,500 lives saved as a result of the interventions¹⁰. However, the evaluation also concluded that the CMAM programme in its current form was unsustainable, in the absence of donor funding.¹¹

Of interest as well is the evaluation of the GAVI Health Systems Strengthening Project that was carried out in 2017¹². The support contributed to strengthening of the cold-chain system, human resource development and the process of planning for immunisation service delivery. GAVI support helped in maintaining high and equitable immunisation coverage and introduction of new vaccines in the country. The evaluation noted that the support “achieved many important outcomes that were not explicitly stated in the proposal, such as using the cold chain and logistical infrastructure for delivering other health services by health facilities, and the enhanced synergistic collaboration between UNICEF and WHO, the two implementing agencies, (proving that) the alliance was able to make an impact in a country with multiple geopolitical challenges”¹³.

⁶ UNICEF DPRK Country Office Summary Report 2019

⁷ UNICEF; Formative Evaluation of the UNICEF WASH Programme in DPR Korea with a focus on Gravity-Feed Water Systems Final Report; 14 January 2017

⁸ *ibid*

⁹ UNICEF; Evaluation of Community-based Management of Acute Malnutrition Programme supported by UNICEF in DPR Korea 2015–2017; July 2018

¹⁰ *ibid*

¹¹ *ibid*

¹² GAVI; Evaluation of the Gavi Health Systems Strengthening Support to The Democratic People’s Republic of Korea; October 2017

¹³ *ibid*

2 OBJECTIVES OF THE EVALUATION

The terms of reference (TORs) (see **Annex 1**) note that the reasons for the evaluation are twofold:

- an evaluation of the IMNCI programme has never been carried out and needs to be done to comply with UNICEF requirements, and to inform both the upcoming UNICEF Country Programme Evaluation and the design of the new CPD 2023-2027
- to determine whether in the face of continued infant and under-five morbidity and mortality UNICEF's current programme is relevant, effective, efficient and equitable, and to suggest ways that positive outcomes could be expanded, accelerated and made more sustainable.

Specifically, the objectives of the evaluation are:

- to assess intended and unintended implementation strategy outcomes against IMNCI objectives of child morbidity and mortality reduction for children under 5 in target areas;
- to assess the “conduciveness” of methods adopted in the delivery of the programme activities in the area of capacity development, mainstreaming equity, equality and human rights as well as intra- and inter-sectoral coherence and coordination in programme design and implementation.
- to provide recommendations on programme and outcome improvement to guide decision-makers and inform stakeholders.

These objectives will be achieved through an examination of programme activities and results using OECD criteria – relevance, effectiveness, efficiency, sustainability, and impact, as well as cross-cutting issues such as equity, gender and human rights. Section 6 below describes the evaluation questions that were crafted to address these criteria, as well as an evaluation framework within which these questions will be addressed, and results measured.

3 SCOPE OF THE EVALUATION

This evaluation has the objective of examining UNICEF's IMNCI programme, mainly looking at the achievements of the current five-year plan, but also in the context of the past fifteen years of IMNCI programming in the country. However, even a preliminary scan of the documentation and speaking with some key informants has underlined what should be obvious – that the health and well-being of children in the DPRK is inextricably linked not only to their access to immunisations and treatment for infectious diseases, but also their access to good nutrition and clean water. Thus, the evaluation will also consider the achievements of the Nutrition and WASH components of UNICEF's programme in the DPRK in relation to the achievements of IMNCI.

The evaluation will focus on the past five years 2015-2019, but activities and actions taken in the 2005-2015 period will also need to be considered. The evaluation will cover a sample of the counties where the IMNCI programme is being implemented, the nine counties where “convergent programming” is taking place, with a sample of non-programme counties also being looked at for comparison purposes.

Our approach to the evaluation will be both utilisation-focused and forward-looking. We recognise that a key component of the review outputs will be recommendations to assist in ongoing work and future projects, as well as recommendations to UNICEF of lessons learned that can be applied to other projects in DPRK or the region. We also recognise the importance of stakeholder engagement at multiple levels, capturing perspectives from a range of different groups. It would be ideal if the evaluation could also include feedback and input from some of UNICEF's prime beneficiaries – mothers with infants and children.

The objectives of this review require generation of both **summative** findings – i.e. what progress was achieved (in relation to relevance, effectiveness, efficiency, etc.) and how; and **formative** findings – i.e. how can UNICEF and its partners move forward to better achieve the project goals. In framing the review process, we see real value in exploring three elements of the project – *Are UNICEF and its partners doing the right things...in the right way...to generate the right results?*

4 PRELIMINARY DOCUMENT REVIEW

The evaluation team reviewed the documents provided online such as annual reports (both from UNICEF and the DPRK Ministry of Public Health when available), strategic documents, related evaluations, etc. This preliminary review as well as remote interviews with selected key informants provided inputs for the drafting of all elements of the inception report, including the evaluation matrix and the theory of change. The list of documents received to date is provided in **Annex 2**.

During the preliminary review the evaluation team could identify additional documents that will be necessary to provide the evidence related to the key questions covered by the evaluation. Additional information should be made accessible during the process of the desk review and the primary data collection as available.

Additional information concerns different aspects such as DPRK health-related legal framework, policies and plans, MoPH annual reports, IMNCI monitoring reports and Joint WHO/UNICEF reports. An indicative list (not exhaustive) of still-not-received (and hopefully available) documents is provided in **Annex 2**.

5 ISSUES ARISING SINCE SUBMITTING THE PROPOSAL

5.1 THE COVID-19 PANDEMIC

hera submitted the proposal to conduct the IMNCI evaluation to UNICEF in early November 2019 and was notified in early December that it had won the bid. The first conference call and email exchanges with UNICEF DPRK were in mid-January 2020, wherein a timeline was agreed for the Inception Phase, with the preliminary document review to occur in January-February and the initial five-day inception visit in the first week of March. The purpose of this first visit was to meet local officials and stakeholders, to finalise the methodology, plan the schedule of the fieldwork, develop survey instruments, and submit the proposed methodology and instruments to the DPRK government for approval. However, the emergence of the COVID-19 pandemic in China in early January, the cessation of most international air travel and DPRK's subsequent closing of its borders and evacuation of most international residents interrupted the process.

Subsequent discussions between the evaluation team and UNICEF DPRK agreed that the inception report (this document) would be submitted before the inception visit but would be supplemented by interviews with a select group of key informants, mainly composed of current and former UNICEF DPRK staff and UNFPA officials familiar with the DPRK programme. A list of people who were interviewed can be found in **Annex 3**.

More recent discussions with UNICEF DPRK have revealed that no travel to DPRK will be possible until the beginning of 2021 at the earliest. It has been agreed that an adequate evaluation that will fulfil the objectives cannot take place without fieldwork and the opportunity to visit project sites in the UNICEF-supported counties. It has been agreed that only one visit to DPRK will be necessary, hopefully in the second quarter of 2021 (May-June) or early in the third quarter. This could be a three-week visit, preceded by the development of the field visit work plan and survey instruments, which will be submitted for review and approval in early 2021. This of course will be dependent on the course of the COVID-19 epidemic, the date when international travel to

DPRK resumes, international air travel restrictions that may limit the travel of the consultant team, the receipt of clearances and approval from the government of DPRK and UNICEF DPRK's own timelines.

Given the uncertainty of predicting the course of the pandemic, it may be that no travel will be possible to DPRK for the next year or two. If so, then a "Plan B" will need to be formulated, wherein detailed interviews with local stakeholders could take place virtually, documents will be reviewed from a distance, and the evaluation will take place without the benefits of site visits.

5.2 WORKING IN THE DPRK

The evaluation team were made aware of many of the necessary procedures and processes in order to work in the DPRK, i.e. visa application, organisation of meetings with partners and beneficiaries, visits to project sites, need for an interpreter, availability of needed data, etc.

However, the interviews that were conducted with UNICEF personnel over the past weeks have clarified the possibilities and our ability to conduct a proper evaluation: we were told that meetings at different levels and visits to project sites and meetings with beneficiaries have to be arranged well ahead of time so that they can take place at the time of the evaluation team visit. As well, we were informed that the quality of data that is currently available from the Central Bureau of Statistics (CBS) is reliable, although not necessarily comprehensive, and can be made available if requested well in advance.

That being said, the proposed methodology, timeline and work plan detailed on the following pages has been tailored to take into account any organisational delays and administrative and logistical hurdles that we may encounter.

The UNICEF DPRK Office will be providing the necessary assistance in terms of organising visas and travel permits for the consultant team, as well as obtaining clearances for conducting interviews, accessing reports and data, bringing laptops in and out of the country, etc. hera and the consultant team will comply with all regulations for foreign visitors to the DPRK, and the UNICEF DPRK team have briefed the consultant team on what will and will not be possible, in anticipation of the country visit.

6 ASSUMPTIONS, LIMITATIONS AND RISKS

Obviously at this point, the main assumption underlying this report is that the COVID-19 pandemic will subside in the next six months and that it will indeed be possible for the consultant team to travel to DPRK and successfully conduct the fieldwork. COVID-19 also represents the biggest risk that might interfere with the conduct of the evaluation. Mitigating or reducing the threat of this risk or predicting the course of the pandemic, including DPRK government decisions on reopening its borders, over the next six-eight months is beyond the power of either the consultant team or UNICEF DPRK.

The TORs note the various risks involved in the proposed evaluation. We summarised those in the table below in our proposal, along with other potential risks, their likelihood and possible solutions. They are updated here, in the light of information gained from interviews with UNICEF key informants.

Table 1. Risks and mitigation

RISK	LIKELIHOOD	PROPOSED SOLUTION
Unavailability and unreliability of data	M	We are assuming that between UNICEF and the MoPH all relevant data will be available for review and analysis. It is not envisioned that the evaluation will collect new primary data (other than survey and interview results). However, the TOR notes that some data may not be available or will be of poor quality, so the team will have to deal and work with what they have. We have subsequently been informed that the data that is available is of good quality, but indeed, not all the data that we think we need may be available or accessible to us.
Unavailability of key stakeholders	M	Given the short time period of in-country data collection, securing interviews with all the key stakeholders may be challenging. We will endeavour to secure travel dates for site visits possibly in early or mid-2021, conduct stakeholder mapping and schedule KIIs and group discussions well in advance. We will be flexible when conducting remote KIIs and group discussions. UNICEF's support in this exercise and obtaining the necessary authorisations is critical.
Delays in securing approvals for travel	M-H	We are assuming that UNICEF will assist in obtaining single-entry visitors visas for the consultant team. DPRK embassies do not exist in Kenya and the Netherlands, where the consultant team is based, and hopefully this will not cause problems. For the consultant based in France, the visa may be collected at the DPRK embassy in Paris. We have been informed that a stopover in Beijing on the way to Pyongyang will be necessary to obtain the DPRK visas and this will be factored into the budget. All of this will be contingent on being able to travel at all.
Delays in securing approvals for travel in-country	M-H	We are assuming that UNICEF will assist in this. All approvals will be contingent on the government.
Delays in securing ethical approval	M	We have scheduled 4-6 weeks for ethical approval to be secured. However, there are no certainties about the length of time ethical approval bodies may take, and the fieldwork may be delayed, pushing the subsequent analysis and report-writing schedule back as well. Hopefully, UNICEF DPRK will be able to follow the trail of the Institutional approval process.
Delays due to late or contradictory comments on deliverables from different stakeholders	M	hera would expect UNICEF DPRK to play a coordinating role, and to submit consolidated comments on each deliverable within the agreed timeframe.
Political instability	M	It is both hera and UNICEF policy to ensure the safety and well-being of all employees, contracted consultants, partners and third parties affected by their work at all times. hera will assess the risks throughout the evaluation process, particularly those associated with the field missions, and develop mitigation plans accordingly to enable the evaluation to produce useful information and data. However it is very unlikely that the security will be an issue.
Change of policies	L	Given the universal acceptance of IMNCI and the importance of infant and child health, it is unlikely that policies promoting safe motherhood, infant feeding and immunisations or treatment of illness in the under-fives are likely to change.
Seasonal issues	M	At the moment, it seems possible that an Inception visit to DPRK might be possible in early 2021. However, given the difficulty of travel at the best of times, it seems unlikely that fieldwork could take place before March-April or whenever winter conditions have ameliorated, making travel to more remote areas possible.

RISK	LIKELIHOOD	PROPOSED SOLUTION
Limitations of conducting surveys	H	The conduct of surveys in DPRK is, as we were told, possible. However, on top of the financial constraints, the time necessary to train and guide enumerators, obtain clearance for the research, pre-test, supervise the fieldwork and analyse the results may be a limitation. We cannot avoid the risk of selection bias.

7 A THEORY OF CHANGE, THE EVALUATION QUESTIONS AND THE EVALUATION MATRIX

7.1 THE THEORY OF CHANGE

A well-developed theory of change is a powerful tool to enhance the planning, implementation, monitoring and evaluation of policies and programmes (Rogers, 2014; DFID)^{14 15}. It is for this reason that UNICEF has requested the evaluation team to develop/adapt the Theory of Change (ToC) for the IMNCI programme in DPRK.

The generation of the concept ToC for the IMNCI programme in DPRK has been guided by global and UNICEF's understanding of ToCs (UNICEF, 2017)¹⁶ and the programmes supported by UNICEF, WHO, UNFPA and other multilateral and bilateral agencies, and the policies, strategies and programmes of the government.

The ToC has a results-based orientation with a chain running from inputs to impact (goal). It provides a comprehensive understanding of which interventions can deliver interactively a desired outcome and impact. The steps needed to achieve the overall goal are illustrated by causal pathways between inputs, processes (through activities or interventions), outputs, outcomes and their underlying interlinked and interdependent conditions and assumptions. These assumptions represent the implicit beliefs or understandings contained in the ToC that explain the expectation of change that underlies the links between levels of results (e.g., impact to outcomes or outcomes to outputs) (ibid.).

While outputs are considered the direct and tangible results of programme interventions, outcomes are defined as the results that are generated based on the achievements of (a combination of) programme outputs taking implementation risks and assumptions into account. If these assumptions are true and risks are mitigated the outputs are likely contributing to the intended outcome. However, outcomes are also prone to confounding factors not under the direct influence of programmes. These factors can be many-fold (political, cultural, economic, social, etc) and for the sake of clarity are not initially captured in the ToC diagram. Outcomes can also be unintended and noticed post-fact and thus these are also not included in the ToC primarily. One can distinguish intermediate outcomes that contribute to a next level outcome.

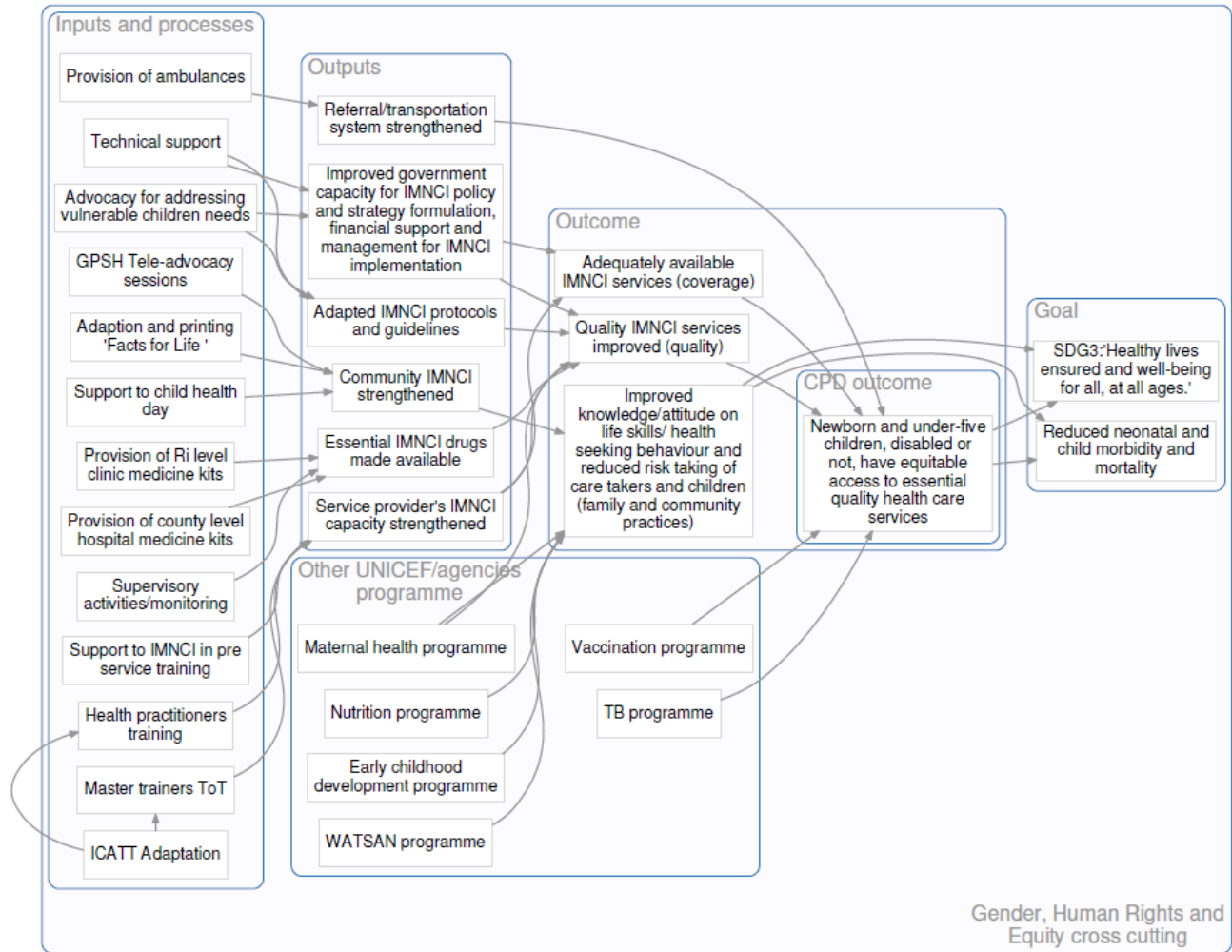
¹⁴ DFID. (no date). UK Aid Connect. *Guidance Note: Developing a Theory of Change*. Retrieved from

<https://assets.publishing.service.gov.uk/media/5964b5dd40f0b60a4000015b/UK-Aid-Connect-Theory-of-Change-Guidance.pdf>

¹⁵ Rogers, P. (2014). *Theory of Change, Methodological Briefs: Impact Evaluation 2*, UNICEF Office of Research, Florence. Retrieved from <http://www.unicef-irc.org/KM/IE/>

¹⁶ UNICEF (2017) *Theory of Change Paper, UNICEF Strategic Plan, 2018–2021 Realizing the rights of every child, especially the most disadvantaged*. UNICEF Executive Board, Second Regular Session 2017.

Figure 1. Proposed Theory of Change¹⁷



As seen in **Figure 1**, all outcomes can be considered proximate determinants of the impact or goal, which has been identified for DPRK as neonatal and child morbidity and mortality reduced and healthy lives ensured (SDG 3). Confounders or assumptions and identified risks determine whether programme goals are achieved. Assumptions for impact that are recognised at global level by UNICEF (2017) but could be applied to DPRK include i) implementation of SDG's is adequately resourced, ii) UNICEF itself is adequately resourced to contribute to SDGs, iii) availability and quality of data, including improved disaggregation, and iv) effective collaboration across the UN development system.

In most health systems ToCs outcomes are defined for i) access to services and for ii) behaviour of the direct beneficiaries, i.e. risk avoiding and health seeking behaviour of mothers/caretakers and children. The ToC in **Figure 1** shows these two outcomes for the IMNCI programme in DPRK. The UNICEF Country Programme Document 2017-2021 clearly specifies the intended outcome on access. Two intermediate outcomes are assumed to have a direct influence on access, namely the extent of coverage/accessibility of IMNCI services

¹⁷ The visual presentation of the ToC was developed using 'Theory Maker' software. Theory maker can be assessed on-line at: <http://theorymaker.info/>

and the quality of these services (related to acceptability) (WHO, 2013)¹⁸. Another determinant of access is affordability (*ibid.*), but in the context of DPRK this is not relevant.

The IMNCI programme in DPRK targets under-five children's illnesses including pneumonia, diarrhoea, tuberculosis, and neonatal conditions (see section 1.2). In the ToC visual the IMNCI programmatic inputs, processes and outputs have been captured in the likewise named boxes. The team acknowledges the influence of the many other programmes, mostly supported and/or represented by UNICEF as the largest UN agency in this sector in DPRK: maternal health, nutrition, water and sanitation, early childhood development, tuberculosis and the vaccination programmes. Each of these programmes is assumed to contribute to achievements of the (intermediate) outcomes.

For reasons of clarity and feasibility of the evaluation we suggest that the scope of the IMNCI evaluation concentrates on the IMNCI component described in section 1.2 and 3, as far as primary data collection is concerned. Secondary data sources will be consulted for the other programmes to the extent possible. For example, evaluations have already been carried out for the WASH and the Nutrition programmes.

Key outputs considered in the ToC include improved government capacity for IMNCI policy and strategy formulation, financing and management. This capacity is assumed to directly affect the quality and coverage of IMNCI services in the country. Related to this is the supply of essential medicines and goods, the adaptation of IMNCI protocols and guidelines, the capacity of service providers at provincial, county, Ri and community levels, the knowledge, attitude and practice of the community members, as well as the referral and transportation system. This may or may not be the case, as there are other elements in the DPRK related to quality improvement of services. This may be refined following the site visit or upon receipt of additional documents that clearly outline the bottlenecks to quality in DPRK.

Based on the documents studied so far and the information from the interactions with key stakeholders, the inputs and interventions (processes) were identified and connected to the outputs. For example, a range of behavioural change communication efforts (advocacy sessions, Child Health Day, facts for life materials) were identified that are expected to strengthen the IMNCI capacity at community level and influence knowledge, motivation and practice (life skills) of community members, including mothers and other caretakers. Synergy and complementarity are expected with the maternal health, nutrition, WASH and ECD programmes. Another example refers to capacity-building whereby training of trainers, pre-service training, and practitioners training are expected to improve the capacity of service providers in IMNCI, and thus improve the quality of IMNCI services in the counties where these trainings have been accomplished.

7.2 THE EVALUATION QUESTIONS

The evaluation questions fall under the OECD DAC criteria of relevance, effectiveness, efficiency, impact and sustainability¹⁹ and additional cross-cutting issues related to equity, gender and human rights. Since the impact depends on other factors beyond the scope of the IMNCI Programme, the evaluation will look at the contribution of the Programme to early signs of impact. The evaluation questions have been organised around the six criteria categories, drawing on the indicative questions of the TORs.

¹⁸ David B. Evans, Justine Hsua & Ties Boerma. (2013) *Universal health coverage and universal access*. Bulletin World Health Organisation 2013; 91:546–546A | doi: <http://dx.doi.org/10.2471/BLT.13.125450>

¹⁹ DAC Criteria for Evaluating Development Assistance. <https://www.oecd.org/dac/evaluation/49756382.pdf>

The following evaluation questions will guide data collection and analysis work throughout the evaluation process:

EQ 1. Relevance: To what extent is the IMNCI programme suited to i) the priorities and policies of the Government of DPRK; ii) the population targeted; iii) donor priorities?

EQ 2. Effectiveness: To what extent did the IMNCI interventions attain the desired objectives?

EQ 3. Efficiency: To what extent were resources allocated to supply and capacity development used cost-efficiently and timely for the achievement of IMNCI objectives?

EQ 4. Impact: What are the positive and negative changes produced by the IMNCI programme, directly or indirectly, intended or unintended?

EQ 5 Sustainability: To what extent are the benefits of the IMNCI programme likely to continue after donor funding has been withdrawn?

EQ 6. Equity, Gender, Human Rights: To what extent have crucial programming principles been integrated at all levels of the programme?

EQ 3 on efficiency requires a specific methodology that will be described in a separate section (see below section 8.3). EQ 6 aims at exploring the respect of the UN principles of promotion and protection of human rights and gender equality. This will be translated through ensuring that all groups are clearly identified, included and are in position to participate in the evaluation process with the view of assessing whether the most vulnerable groups, including girls, benefit from the interventions and whether programming has taken these principles into consideration.

7.3 THE EVALUATION MATRIX

The evaluation questions were translated into judgement criteria and indicators to guide data collection. These are included in the evaluation matrix below (see also Annex 3). The matrix presents in a synthetic manner the information needs related to the ToC and to each evaluation questions as well as the sources of information and the data collection tools used to address them. In the evaluation report, the collected information and findings will be displayed in the evaluation matrix.

The indicators mentioned in the matrix, in particular the outcome and impact indicators, are indicative at this point, as they may be difficult to assess or measure for the following reasons:

- The definition of some indicators may not be consistent with what is measured and reported by the Health Management Information System (HMIS).
- Available data may be questionable in terms of accuracy.

Therefore, the absence of data, variances in the HMIS or difficulties in measurement may require the identification of proxy indicators.

Table 2. Evaluation Matrix

Judgement criteria	Indicators	Source of information	Data collection methods
EQ 1. Relevance: To what extent is the IMNCI programme suited to i) the priorities and policies of the Government of DPRK; ii) the population targeted; iii) donor priorities?			
JC1.1 The global IMNCI objectives and technical frameworks are sufficiently adapted to the specific country context	1.1.1 Coherence of the IMNCI programme design to the DPR Korea context 1.1.2 Participation of the key stakeholders in the identification of needs 1.1.3 Coherence of the activities and outputs of IMNCI programme with the intended results	Situation Analysis Report Programme strategies, CPD, Result framework	Documentary analysis Interviews with MoPH, UN agencies, EU office and EU Support Units, other development partners Interviews with health authorities and health facilities personnel Focus groups with final beneficiaries
JC 1.2 The IMNCI programme implementation strategy (including capacity development component) is aligned with national priorities	1.2.1 Consistency of the IMNCI programme objectives and strategies with the national strategies and policies 1.2.2 Alignment of the IMNCI capacity development component with national human resources policies 1.2.3 Alignment of IMNCI with national equipment and medicines supply systems	National policies, plans and strategies Programme strategies	Documentary analysis Interviews with MoPH
JC 1.3 IMNCI programme is in line with the DPR Korea context and needs	1.3.1 Evidence of needs assessment /epidemiological profile/capacity assessments prior to programming 1.3.2 Assessment of communities' knowledge and practices in terms of neonatal and child health	Situation Analysis Report MICS CBS/CDMU data base (upon request) MoPH health report	Documentary analysis Interviews with MoPH, UN agencies, EU office and EU Support Units Interviews with health authorities and health facilities personnel
JC 1.4 UNICEF geographical targeting is in line with the evolved epidemiological profile and other social indicators	1.4.1 Evidence that UNICEF geographical targeting addresses epidemiological needs 1.4.1 Evidence that UNICEF convergence and extension counties selection target the most vulnerable	Situation Analysis Report MICS MoPH health report	Documentary analysis Interviews with MoPH, UN and agencies, EU office and EU Support Units Interviews with health authorities and health facilities personnel
EQ 2. Effectiveness: To what extent did the IMNCI interventions attain the desired objectives?			
JC 2.1 U5 children morbidity is reduced	2.1.1 Reported diarrhoeal diseases episodes ²⁰ <u>OR</u> Incidence of diarrhoea	MICS CBS/CDMU data base (upon request)	Documentary analysis Interviews with MoPH, CBS, UN and other agencies

²⁰ MICS indicator

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	<p>among children U5²¹</p> <p>2.1.2 Reported ARI episodes²²</p> <p><u>OR</u> Incidence of pneumonia cases among children U5²³</p> <p>2.1.3 Incidence of Child TB</p> <p>2.1.4 Evolving causes of neonatal morbidity</p> <p>2.1.5 Cure rate for severe acute malnutrition</p>	<p>MoPH health reports</p> <p>CBS/CDMU data base,</p> <p>National nutrition, TB and malaria surveillance data (upon request)</p> <p>CMAM evaluation report</p>	<p>Interviews with health authorities and health facilities personnel</p>
<p>JC 2.2 Current IMNCI protocols, guidelines and tools are adapted to the DPR Korea situation</p>	<p>2.2.1 Protocols and guidelines in adequacy to the epidemiological situation</p> <p>2.2.2 Training packages in adequacy with the existing health workforce capacity</p> <p>2.2.3 Sensitisation activities built upon existing knowledge and practices</p>	<p>Protocols and guidelines</p> <p>Training packages</p> <p>Sensitisation/health promotion strategy</p>	<p>Documentary analysis</p> <p>Interviews with MoPH, UN agencies</p> <p>Interviews with health authorities, master trainers and health facilities personnel</p> <p>Interviews with universities</p> <p>Focus groups with final beneficiaries</p>
<p>JC 2.3 Management capacity to implement IMNCI has been developed</p>	<p>2.3.1 Number of provinces having operational master trainers and supervision teams for the implementation of IMNCI</p> <p>2.3.2 Number of practitioners (by category) trained to implement IMNCI protocols and guidelines (through cascading training, via telemedicine / ICATT)</p> <p>2.3.3 IMNCI pre-service training operational in universities and medical schools</p> <p>2.3.4 IMNCI related medical supplies are available as per need</p>	<p>IMNCI strategy and plans documents</p> <p>Provincial health action plans</p> <p>Training reports</p> <p>Supervision/monitoring reports</p>	<p>Documentary analysis</p> <p>Interviews with MoPH, UN agencies, EU office and EU Support Units, other development partners</p> <p>Interviews with health authorities and health facilities personnel</p> <p>Interviews with universities</p> <p>Focus groups with final beneficiaries</p>

²¹ Indicator in CPD 2011-2015 – measurable??

²² MICS indicator

²³ Indicator in CPD 2011-2015 – measurable??

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<p>JC 2.4 Community knowledge and practice has improved</p>	<p>2.4.1 Percentage of children under age 5 with diarrhoea in the last 2 weeks for whom advice or treatment was sought from a health facility or provider 2.4.2 Percentage of children under age 5 with ARI symptoms in the last 2 weeks for whom advice or treatment was sought from a health facility or provider 2.4.3 Percentage of children under age 5 with diarrhoea in the last 2 weeks who received continued feeding during the episode of diarrhoea 2.4.4 Appropriate IYCF practices known by target population 2.4.5 Proportion of caretakers who know at least 2 signs for seeking care immediately 2.4.6 Percentage of infants <6 months exclusively breastfed²⁴</p>	<p>MICS MICS CBS/CDMU data base (upon request) CMAM Evaluation report</p>	<p>Documentary analysis Interviews with MoPH, CBS, UN agencies, Interviews with health authorities and health facilities personnel Focus groups with final beneficiaries including care takers and mothers of <5yrs children (as both rights holders and primary duty bearers)</p>
<p>EQ 3. Efficiency: To what extent were resources allocated to supply and capacity development used cost-efficiently and timely for the achievement of IMNCI objectives?</p>			
<p>JC 3.1. The resources flow for supply and capacity development was efficiently designed.</p>	<p>3.1.1. Proportion of resources reaching the actual beneficiaries 3.1.2. Proportion of resources accounting for programme overheads</p>	<p>Financial reports (Budgets and expenditure documents)</p>	<p>Document analysis, Interviews with IPs, UN agencies, MoPH etc</p>
<p>JC 3.2. The implementation of the programme in terms of resource allocation supply and capacity development was delivered timely</p>	<p>3.2.1. Proportion of expenditure against budgets (Burn rates - overall and per funding year) 3.2.2. Proportion of expenditure per cost driver of the programme (Accounting cost categories and/or programme area)</p>	<p>Financial report (Activity Budget and expenditure report)</p>	<p>Document analysis, Interviews with IPs, UN agencies, MoPH etc</p>
<p>JC 3.3. The programme was implemented cost-efficiently over the past implementation period</p>	<p>3.3.1. Cost per case treated over the programme period (Diarrhoea) 3.3.2. Cost per case treated over the programme period (Pneumonia)</p>	<p>Financial report (Activity Budget and expenditure report) results frameworks (programme reports)</p>	<p>Document analysis, Interviews with IPs, UN agencies, MoPH etc</p>

²⁴ Result framework indicator CPD 2017 - 2021

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	3.3.3. Cost per training conducted during the implementation period. 3.3.4. Cost per selected outputs e.g. trainings, procurements, etc.		
EQ 4. Impact: What are the positive and negative changes produced by the IMNCI programme, directly or indirectly, intended or unintended?			
JC 4.1 Children's lives have been saved or otherwise affected, positively and negatively, by the IMNCI programme	4.1.1 Percentage of deaths among children under five years due to diarrhoea ²⁵ 4.1.2 Percentage of deaths among children under five years (post neonatal period) due to pneumonia ²⁶	MICS CBS/CDMU data base (upon request) MoPH health report	Documentary analysis Interviews with MoPH, CBS, UN agencies, Interviews with health authorities and health facilities personnel Focus groups with final beneficiaries: mothers of U5 children (as both rights holders and primary duty bearers)
JC 4.2 Children's lives have been saved or otherwise affected, positively and negatively, by UNICEF interventions complementing the IMNCI programme	4.2.1 Percentage of national population using improved and safely managed drinking water services ²⁷ 4.2.2 Percentage (%) of under-one children fully vaccinated in targeted counties ²⁸ 4.2.3 Percentage of national population using improved and safely managed sanitation services in targeted counties ²⁹ 4.2.4 Stunting rates	MICS CBS/CDMU data base (upon request) Annual WHO/UNICEF JMP reports CMAM evaluation report	Documentary analysis Interviews with MoPH, CBS, UN and other agencies, EU Support Units
JC 4.3 Capacity developed to adequately implement IMNCI strategy	4.3.1 Percentage of village clinics applying quality IMCI for appropriate management of childhood illnesses 4.3.2 Quality IMNCI training implemented (including ICATT)	Supervision / monitoring reports Training reports including pre- and post-training evaluations	
JC 4.4 The IMNCI programme led to negative outcomes or unintended outcomes	4.3.1 Negative outcomes 4.3.2 Unintended outcomes		Interviews with MoPH, UN agencies, development partners Interviews with health authorities, care givers
EQ 5 Sustainability: To what extent are benefits of the IMNCI programme likely to continue after donor funding has			

²⁵ Result framework indicator CPD 2017 - 2021

²⁶ Idem

²⁷ Result framework indicator

²⁸ Result framework indicator CPD 2017 - 2021

²⁹ Idem

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been withdrawn?			
JC 5.1 Concrete actions undertaken to guarantee institutional sustainability of results after withdrawal of donor funding	5.1.1 National Health Policy and provincial action plans include IMNCI 5.1.2 Costed IMNCI strategy developed at national level 5.1.3 Strategy and plans include developed tools and interventions	Health Strategy documents	Documentary analysis Interviews with MoPH, UN agencies, development partners Interviews with health authorities
JC 5.2 Developed strategy, tools and promoted interventions adopted and likely to be used by MoPH in the future	5.2.1 Guidelines produced and disseminated nationwide 5.2.2 IMNCI training implemented in non-targeted provinces by MoPH 5.2.3 GPSH continuous involvement in newborn and child health promotion 5.2.4 CHD approach continued by MoPH	Health strategy documents and plans	Documentary analysis Interviews with MoPH, UN agencies, development partners Interviews with provincial and county health authorities Interview with GPSH
JC 5.3 DPRK MoPH ensures financial sustainability of IMNCI programme	5.3.1 Government's funds allocation for the implementation of IMNCI strategy beyond donors' support 5.3.2 Number of provincial and county level People's Committees that utilised their discretionary resources for trainings	Health strategy documents and plans	Documentary analysis Interviews with MoPH, UN agencies, development partners Interviews with provincial and county health authorities
EQ 6. Equity, Gender, Human Rights: To what extent have crucial programming principles been integrated at all levels of the programme			
JC 6.1 Special needs of vulnerable groups, including bottlenecks and barriers faced in accessing services have been integrated and addressed in the IMNCI setup	6.1.1 Needs analysis of vulnerable groups undertaken (including access barriers) 6.1.2 Measures undertaken to address specific needs and access difficulties for vulnerable groups	Situation Analysis Report IMNCI strategy documents	Documentary analysis Interviews with MoPH, UN agencies, development partners Interviews with provincial and county health authorities Interviews with health facilities personnel Focus groups with final beneficiaries
JC 6.2 IMNCI programming and reporting has integrated a gender equality approach	6.2.1 IMNCI programming using current data disaggregated by gender 6.2.2 IMNCI implementation integrating a gender equality approach 6.2.3 IMNCI reporting using data disaggregated by gender	Situation Analysis Report IMNCI strategy documents Programme report	Documentary analysis Interviews with MoPH, CBS, UN agencies, development partners Interviews with provincial and county health authorities Interviews with health facilities personnel Focus groups with final beneficiaries
JC 6.3 Respective and	6.3.1 IMNCI programming	IMNCI strategy documents	Documentary analysis

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specific needs of mothers, girls and boys, and children with disabilities were taken into account in a sufficiently deliberate and targeted way at all requisite levels	integrating disability		Interviews with MoPH, UN agencies, EU support Units Interviews with health facilities personnel Focus groups with final beneficiaries
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Note: Some indicators may not be all measurable as the availability of data is still unknown

Table 3 connects the ToC with the Evaluation Matrix, whereby the OECD-DAC criteria have been related to the results chain.

Table 3. Theory of Change and Evaluation Matrix

Evaluation matrix						
Theory of Change	Relevance (EQ1)	Effectiveness (EQ2)	Efficiency (EQ3)	Impact (EQ4)	Sustainability (EQ5)	Equity, Gender, Human Rights (EQ6)
Inputs & processes			✓		✓	✓
Outputs	✓	✓	✓		✓	✓
Outcome	✓	✓				✓
Goal	✓			✓		✓

8 PROPOSED METHODOLOGY

8.1 SAMPLING AND STAKEHOLDER SELECTION

8.1.1 SAMPLING FRAMEWORK

8.1.1.1. PURPOSEFUL SELECTION OF COUNTIES

The evaluation will be conducted in nine counties. For reasons of comparison, the counties will be selected purposively in three provinces³⁰, each representative of three broader regions in DPRK to be selected in consultation with UNICEF. Criteria for the selection will be discussed with UNICEF but should include epidemiologic characteristics, burden of disease and the conditions and limitations for in-country travel (see Section 6 - Limitations). Furthermore, we suggest they include socio-economic and geographic considerations (urban/rural), population density, and the level of supervision and successfulness of the programme.

To compare performance and assess the differential development with or without IMNCI support and examine the influence of multiple interventions in Convergence Counties, we identified three categories of counties:

- a) **UNICEF-supported Convergence Counties** (2017-2021 CPD). The Convergence Counties receive full support from UNICEF in all components of the country programme, including health and nutrition services (as per category #2), also including addressing undernutrition among women and girls, facilitating equitable access to WASH services and building community resilience, and emergency obstetric and newborn care services. In addition, early childhood development is promoted.
- b) **UNICEF IMNCI-supported counties** (IMNCI support 2015-2019). The programme comprises health and nutrition services; including the supply of essential medicine kits and basic equipment, training of

³⁰ Nine provinces in North Korea: Chagang, North Hamgyong, South Hamgyong, North Hwanghae, South Hwanghae, Kangwon, North Pyongan, South Pyongan and Ryanggang.

household doctors (male and female) to improve effective antenatal care, basic curative services and health promotion as well as providing treatment for acutely malnourished children.

- c) **Non-UNICEF programme-supported counties**, i.e. no convergence or IMNCI support.

Table 4. Sample selection of countries and division of the fieldwork

SAMPLING PLAN		<i>Total</i>	<i>Sampled</i>	<i>Region 1</i>	<i>Region 2</i>	<i>Region 3</i>
Provinces		9	3	1	1	1
Three types of selected counties:						
1	Convergence counties (UNICEF IMNCI support 2015-2019)	9	3	1	1	1
2	IMNCI counties (IMNCI Unicef supported 2015 - 2019)- non convergence counties	41	3	1	1	1
3	Non convergence + non IMNCI UNICEF supported counties	112	3	1	1	1
Total counties		162	9	3	3	3

The sampling plan is shown in **Table 4**. For each of the three categories three counties will be selected for the evaluation; one county per category in each region. This means that out of the nine convergence counties three are included (cat. a); out of 41 IMNCI counties three counties are selected (cat. b) and out of the remaining 112 non-programme counties also three counties are included (cat. c).

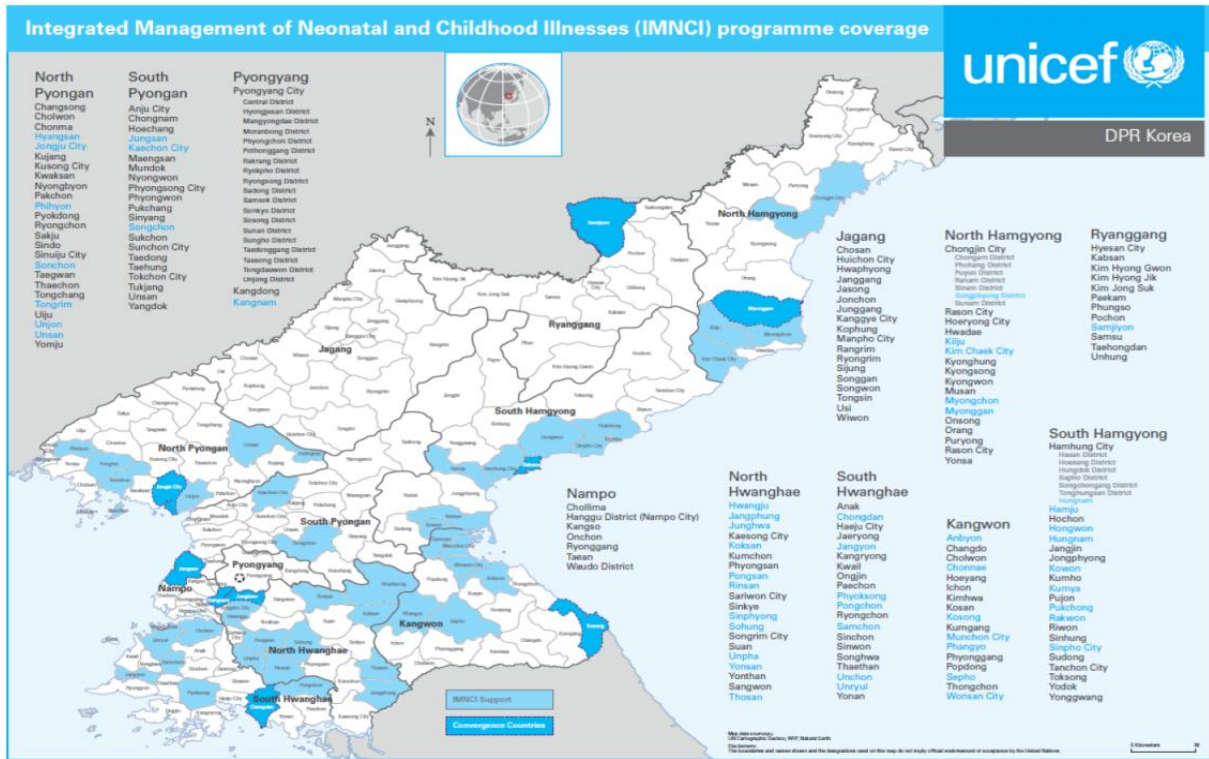
The field team will divide into three groups, each of them visiting one province and thus conducting fieldwork in all three category counties. To reduce travel time the field visits will be conducted in relatively easy to access and geographically adjacent counties. As an example, in **Table 5** we put forward a preliminary suggestion of nine selected counties, primarily based on geographical spread and proximity of the three category counties. As the ToRs point out, this is a non-experimental exercise. As a result, there is no control or experimental county. However, when selecting participating counties in the same province, similarity and comparability will be a factor to be considered in order to establish a causal relationship between the IMNCI interventions and the measured results.

Table 5. Proposed preliminary suggestion of counties for inclusion in the sample

Team	Region	Province	County		
			Convergence	Non convergence	Non programme
1	North	North Pyongan	Jongju City	Unjon	Kwaksan
2	South	South Hwanghae	Chongdan	Ponchon	Jaeryong
3	North-East	North Hamgyong ³¹	Myonggan	Kilju	Orang

³¹ This province may not be possible to visit because of the distance needed to travel

Figure 2. Map of IMNCI coverage



8.1.1.2 SELECTION OF RI'S³²

In each of the selected counties at least 2 Ri's will be visited. The selection will initially be done randomly from a list of Ri's that are being allowed to visit, provided by the government. The selection will furthermore be determined by efficiency considerations and travel distances. Consequently, each province will be represented in the sample by at least 6 Ri's. In total 18 Ri's will be visited for the evaluation.

8.1.1.3 SELECTION OF HOUSEHOLD MEMBERS

One or two stage clustered sampling will be applied to draw representative clusters using the Multiple Indicator Cluster Survey (MICS) sampling framework and population data from CBS. The sampling of eligible mothers of U5 children (as both rights holders and primary duty bearers) in the selected communities will be based on the criteria of currently having or having had a sick child under 5 years during the last half year. Sampling in the community will be guided by a screening exercise led by the authorities.

³² In total there are 6,263 primary level Ri-Clinics and 1,694 intermediate level Ri-Hospitals in the country. (source: UNICEF (2017) Primary (community) IMNCI Rolling out Plan. [JHSS2 DPRK 2014-2018 project])

8.1.2 STAKEHOLDERS/RESPONDENTS AT NATIONAL LEVEL

In **Table 6** we have listed the key stakeholders for face-to-face or remote interviews at the national level.

Table 6. Key stakeholders at national level

Institutions	Position
UNICEF	Country Representative Country Deputy Representative Chiefs of Health (former and present) IMNCI Programme Officers
WHO	Country Representative or Deputy Representative Maternal, Neonatal and Child Health in Charge
UNFPA	Country Representative or Deputy Representative Reproductive Health in Charge
MoPH	Child Health Division Representative Maternal and Neonatal Division Representative MNCH focal point Nutrition Division Representative Health Promotion Division Representative
Other government offices	National Coordinating Committee Central Bureau of Statistics - Child Data Management Unit (CDMU) Grand People Study House (GPHS) Medical University & Colleges Institute of Child Nutrition Academy of Medical Science Committee of the Rights of the Child? Ministry of Urban Management (MoUM) Education Commission
Other development partners ³³	GAVI representative International Federation of Red Cross and Red Crescent Society (IFRC) representatives European Union Programme Support Units (EUPS) representatives (Handicap International and Save the Children have stopped activities in 2016 and 2019 respectively) – Première Urgence Internationale, Concern Worldwide, Triangle, Deutsche Welthungerhilfe. EU representative Italian Development Cooperation representative Finnish Development Cooperation (ceased activities in 2019) representative Swiss Development Cooperation (SDC) representative Global Fund representative – Portfolio manager Geneva

³³ For international development partners, alternative data collection methods will be considered if face-to-face interviews are not feasible. There is no local presence for Gavi, EU and the GF and these interviews will be conducted remotely.

8.1.3 STAKEHOLDERS/RESPONDENTS AT PROVINCIAL, COUNTY AND RI LEVEL

The selection of indirect beneficiaries and relevant other stakeholders at the level of the provinces, counties and Ri's for key informant interviews and focus group discussions will be agreed upon with government officials and UNICEF. **Table 7** shows the minimum number of beneficiaries/stakeholders that are eligible for KIIs.

Table 7. Minimum number of selected stakeholders at Provincial, County and Ri level (surveys not included)

Beneficiary/stakeholder	Method	Number of interviews/discussion groups	Number of key participants per method	Total number of persons required
Provincial level				
Representative of People's Committee Health Department	KII	3	1	3
Provincial Health Director	KII	1	1	1
Provincial IMNCI Master Trainers	KII	2	1	2
Director Provincial Hospital	KII	1	1	1
Paediatric ward chief and practitioner Provincial Hospital	KII	3	1	3
Total number of persons per province				10
County level				
Representative of People's Committee Health Department	KII	3	1	3
Director County Hospital	KII	1	1	1
Paediatric ward chief and practitioners County Hospital	KII	3	1	3
Patients (mothers)	(F)GD	1	8	8
Total number of persons per county				15
Ri level				
Representative of People's Committee Health Department	KII	1	1	1
Household doctor (Ri clinic)	KII	2	1	2
Nurse or midwife (Ri clinic)	KII	2	1	2
Mothers with a sick child who have been seeing a household doctor during the last month	(F)GD	1	8	8
Kindergarten, nursery in charge	(F)GD	1	6	6
Community members / caretakers (mothers, fathers, others)	(F)GD	1	8	8
Total number of persons per Ri				27

8.2 DATA COLLECTION METHODS

The methodology is based on the Theory of Change and the evaluation matrix. Both primary and secondary data sets will be collected. The methods of secondary data collection include desk reviews, documentary analysis, and database reviews. The primary data collection methods include key informant interviews, (focus) discussion groups, site visits including observations, and structured interviews with stakeholders and beneficiaries.

8.2.1 SECONDARY DATA COLLECTION

8.2.1.1 PRELIMINARY DESK REVIEW AND REMOTE INTERVIEWS

The evaluation team reviewed the documents provided by UNICEF and those available online, including annual reports (both from UNICEF and the DPRK Ministry of Public Health) where available, strategic documents, related evaluations, presentations, guidelines, etc.

In addition, the team interviewed selected key informants from UNICEF, WHO and UNFPA remotely. These informants have mostly been or are directly involved in the UNICEF programme in DPRK or are indirectly involved and provided contextual information. Both the preliminary review as well as the remote interviews provided inputs for the drafting of all elements of the inception report, including the evaluation matrix and the theory of change.

8.2.1.2 DOCUMENTARY ANALYSIS

The preliminary work will be followed-up by more detailed documentary analysis in relation to the evaluation questions (see the list of available documents in **Annex 2**). Additional documentation to which the team did not yet have access is listed in Annex 2. Any other documentation that appears before or as a result of the fieldwork will be taken into account.

Besides studying the relevant sources on DPRK the team will also review the IMNCI situation in relation to global child health issues and UNICEF's global strategy, thus situating the work of UNICEF DPRK within the larger universe of UNICEF activities globally and in the region.

The team is well aware that there have been challenges in knowledge management and system continuity. Consequently, certain programme documentation related to earlier years of the evaluated period may be difficult to locate and certain programmatic decisions may not have been documented.

8.2.1.3 DATABASES AND TABULATIONS

Both routine and non-routine data will be accessed to the extent possible, either in digitalised or tabulated formats. **Table 8** provides an overview of both types.

Table 8. Database sources

Routine data collection systems	Non routine data sources
Health Management Information System (HMIS)	National Census (2019)
National TB and Malaria Surveillance System	Demographic Health Survey 2014
	Multi Indicator Cluster Survey 2007/8, 2017
	National Nutrition Status Survey
	Coverage Evaluation Survey
	Water Assessment Survey

The Central Bureau of Statistics is the key counterpart for all data that are collected. In particular this is important for IMNCI relevant data that are being collected after 2017, when the last MICS was held. UNICEF has been supporting the Child Data Management Unit (CDMU) of the CBS. The evaluation will review the outputs of this Unit and will endeavour to find out what IMNCI data has been collected, compiled and at what frequency. In addition, the team will find out what indicators are being monitored by the CBS and CDMU. The review will include the 2017 MICS data, projected census data, administrative/routinely collected data after 2017.

Furthermore, relevant historical data sets will be requested from CBS with appropriate breakdown (gender, age, location, etc), although the evaluation will not adopt a full synchronic perspective, that is, considering the programme at a moment in time without taking its history into account.

The team has been informed that most official data, if not all data, are not available in digitalised format. Instead they are presented in tabulated formats. For the data that are required for the evaluation the team will prepare detailed data requirements to be requested from CBS via the appropriate channels.

8.2.2 PRIMARY DATA COLLECTION

8.2.2.1 KEY INFORMANT INTERVIEWS

Key informant interviews will be central to our approach to data collection. Interviewees have been identified, see the **Tables 5 and 6**. They will include UNICEF staff and the main stakeholders in the country including government staff at central and peripheral levels, representatives of People's Committee Health Department at the different levels, donor agencies, other implementers, hospital and clinical staff, and community members. In addition to the preliminary interviews with international experts, a selected number of other staff and experts will be interviewed on a needs basis to provide further information or insights. To increase efficiency and coverage, and in the case of the non-availability of specific stakeholders, we will also explore the conduct of interviews and follow-up by Skype or telephone. The final list of stakeholders to be interviewed will be agreed in consultation with UNICEF and its partners.

8.2.2.2 SITE VISITS

As per the sampling plan (see section 8.1.1) nine counties in three provinces will be visited. In each province the counties to be visited would include a Convergence County, a county where IMNCI is being supported, and a county where no IMNCI programme is in place.

The site visits will provide the opportunity to meet provincial, county and Ri level authorities, the government management team, hospital and clinical staff, and community members to get a sense of the "on-the-ground" reality and day-to-day challenges that UNICEF faces in supporting programme implementation. The site visits to health facilities will include interviews with local staff, examination of documents and registers, group discussions with staff and a selection of beneficiaries and observation of the overall functioning, milieu and apparent effectiveness of the site being visited. Overall, the facility will be observed with reference to the supervisory reports that in turn should relate to the IMNCI protocol (2018)³⁴.

8.2.2.3 (FOCUS) GROUP DISCUSSIONS

Group discussions in a selected number of locations will be an opportunity to compare beneficiary impressions of the IMNCI and other programs with what the evaluation team is being told by health personnel or reading in programme reports. Of similar importance are group discussions for exploring health services access barriers, knowledge and attitudes on health and key practices - including health seeking behaviour and risk avoiding practices by mothers/caretakers for newborn children, infants and children under five. Group discussions with ultimate beneficiaries will include 8-12 participants in a group.

The group discussions will be focussed, however will face some methodological limitations in terms of recording, translation, transcription, analysis and interpretation.

³⁴ IMNCI Protocol (2018) issued by Ministry of Public Health DPRK, UNICEF, WHO, UNFPA
hera /Inception Report/August 2020

The group discussions will mainly be conducted among the ultimate beneficiaries, but also include health and auxiliary personnel from clinics when appropriate. While discussion guides will be developed for the community/household member groups (after the Inception Phase), the more ad hoc group discussions among health personnel will follow the semi-structured questionnaires prepared for key -informant interviews.

8.2.2.4 STRUCTURED INTERVIEWS

The application of structured interviews with few questions will be a useful means of collecting quantitative information on selected indicators, as well as knowledge, motivation and practice from a larger group of stakeholders or beneficiaries, with the added advantage that they can be anonymous, allowing for collection of sensitive data.

Two types of structured interviews will be conducted:

- 1) Interviews among household doctors: this will be done in addition to the semi-structured key informant interviews with the same respondent. The aim is to collect IMNCI service-related statistics.
- 2) Interviews among mothers in their communities: the aim is to collect data on access to services. Sampling in the community will be guided by a screening exercise led by the authorities. The criteria for an eligible respondent will be the presence of a sick child under 5 during the last 6 months. The feasibility of this approach will need to be further assessed (see also section 8.1.1.3).

The evaluation will make use of experienced enumerators (from CBS) that are available for these structured interviews. These are subject to further discussion with UNICEF as there will need to be budget allocations for developing the instrument, training of enumerators, pretesting the questionnaires and analysing the results.

Furthermore, UNICEF's involvement or international observers in terms of monitoring the questionnaires will need to be discussed. Field monitoring is regarded an essential tool for quality assurance, as the verification of data can only be done at household level, i.e. re-visiting the household for verifying the answers collected by the enumerators. The team has been told that this is possible. Once the data is collected it goes to the county statistical office. From that point on it is considered official data and cannot be altered.

Table 9 contains an overview of the methods of data collection applied for selected beneficiaries and stakeholders. Surveys, interviews, and focus group discussions with sampled groups will be anonymous, in Korean language and documented with consent of the interviewees.

Table 9. Programme beneficiaries/stakeholders by method of data collection

Stakeholders	Secondary data			Primary data		
	Documentary review	Data & database analysis	Key-informant semi-structured and in-depth interviews	(Focus) Group Discussion	Site visits	Structured interview
Direct beneficiaries						
Households with children under 5 (neonates < 1 month, infants <1 year and children 1-4 year).	✓	✓		✓	✓	✓
Indirect beneficiaries						
MoPH departments and	✓		✓			

representatives responsible for governance, coordination and management of the IMNCI programme in the country						
Service providers responsible for the implementation of IMNCI programme, most notably Household Doctors³⁵	✓	✓	✓	✓	✓	✓
Local authorities (People's Committees)	✓		✓			
IMNCI stakeholders outside of Government	✓		✓			

8.2.3 DATA COLLECTION TOOLS

Data collection tools for key informant interviews (KIIs), beneficiary discussion groups, as well as the questionnaires for the structured interviews will be developed after the approval of the inception report; thus, finding their base in the agreed evaluation questions and indicators. Given the envisaged short and intense nature of the data collection period, it is not anticipated that the interviews will be verbatim transcribed; however, detailed notes will be taken during the interviews.

Data collection tools (questionnaires, interview and FGD protocols etc.) will be checked to ensure they are culturally appropriate. Moreover, disaggregation in terms of gender, age, etc. will be feasibly applied.

The form and contents of the data collection tools should be sufficient for capturing and triangulating correct information on the main indicators of the programme and deliver an adequate level of analysis that will illustrate a measurable change.

8.2.4 PRACTICAL CONSIDERATIONS

8.2.4.1 Ethical clearance

In practical terms ethical clearance of tools and methods could take time and there is a need for further discussion on how to handle likely time lags in the plan. The proposed methodology and data collection instruments will be submitted for Institutional Review Board (IRB) approval at least 2-3 months before the field visit. Informed consent will be obtained before each key informant or beneficiary interview, with the purpose of the evaluation being explained. Verbal consent should be sufficient, but UNICEF may require a written informed consent, in which case a consent form will be drafted and translated into Korean.

8.2.4.2. FACILITATORS AND INTERPRETERS

The methodology includes interviews and group discussions with stakeholders, health personnel and beneficiaries which means that the consultant team will require facilitators and interviewers with local language capacity. It is noted that enumerators are available to conduct household surveys, but interview translators require a separate set of skills.

³⁵ There are three HHDs per one Ri-Clinic and 6-8 HHDs per one Ri-Hospital. The total number of 44,760 HHDs are currently registered in the country. The IMNCI programme targets training of 5000 HHD in 50 IMNCI supported counties (972 HHD in 9 convergence counties and 4,028 in 41 IMNCI counties). (source: UNICEF (2017) Primary (community) IMNCI Rolling out Plan. Page 2/3 [JHSS2 DPRK 2014-2018 project]).

8.2.5 DATA AND FIELD LIMITATIONS

- The proposed baseline assessment for IMNCI was not executed.
- E.g. data on morbidity in diarrhoea and pneumonia are available only at national level before 2015, and at province level since then;
- Since 2018 disaggregated data exists additionally for Convergence Counties;
- There are perceived challenges in terms of unmediated access to the target groups. Travel within the country is regulated by national authorities and international humanitarian agencies need to obtain clearance, normally seven days in advance, for field visits outside of Pyongyang, as do DPRK nationals.
- National counterparts, including health staff, are not available for interaction with international agencies on Fridays, and this needs to be taken into account in the planning of any field visits and data collection in the field.
- Limited reliable secondary data from national routine statistics and absence of proper documentation at the lower health system levels may pose challenges in the evaluation process.

8.3 EFFICIENCY EVALUATION APPROACH

Based on the documents reviewed so far, the efficiency approach seeks to assess the optimal use of available resources to address the IMNCI in DPRK under the programme. Two main levels of efficiency assessment are proposed and seem feasible within the context of the evaluation. Firstly, at the level of design or strategic level, a qualitative review of the **strategic or design efficiency** will be conducted. This is a review of the design approach adopted in the programme against feasible alternatives to achieve the same outputs. It will focus on the review of the activities funded and the targeted population groups. It will provide an understanding of the resources available and spent during the IMNCI scale-up phase with support from UNICEF. The analysis will explore the distribution of these resources between actual programme activities and overheads costs. The initial inception review suggests that there are not many alternatives for the design of IMNCI programmes, hence this will be more formative in approach. Expected results of this exploration of the design phase include:

- Proportion of resources reaching the actual beneficiaries
- Proportion of resources accounting for overheads over the entire period of evaluation
- Distribution of resources per programme area of support and comparison with the overall gaps for the IMNCI programme. Current document reviews suggest that funding is provided for a) training of health providers; b) supply of essential commodities and basic equipment; c) support for the monitoring system of the IMNCI programme.

The second level will be to review the **implementation efficiency** of the IMNCI programme. This will be guided by the three levels:

- Understanding of the **financial flows of the IMNCI programme** to provide an understanding of expenditures against budgets (burn rates associated with UNICEF's IMCI programme).
- The main **cost drivers** will be used to compute the cost-efficiency analysis. The document review suggests that the main cost drivers are Health Care Worker (HCW) trainings, essential medicines supplies and basic equipment, as well as support for the monitoring systems.
- In line with the results (achievements) under the effectiveness section, we will compute the total **cost per the outcomes/impact** achieved over the period of support.
- Subsequently **benchmarking analysis** of the cost per result area for the selected results. In the absence of alternative (or similar) programmes benchmarking may prove difficult hence a **trend analysis** is an alternative approach. The benchmarking and trend analysis will be compared with suitable alternatives.

Annex 5 demonstrates some tables that will be populated to assist in the efficiency analysis – assuming that the data is available.

Attribution of results and costs for cost-outcomes analysis

Document reviews done to date suggests that UNICEF is the main funder of the IMNCI scale-up phase in DPRK. WHO provides technical support, standards and guidelines while UNFPA provides training of health workers. The contributions of other funders do not add significantly to the overall funding. Government, through the MoPH, delivers services at all levels of care. It is with this background that the results achieved cannot wholly be attributed to UNICEF funding which is more contributory in nature. We will use expenditure data to estimate the share of UNICEF’s results in the entire IMNCI programme. We will therefore use the following data:

- Total UNICEF’s expenditure to the IMNCI programme between 2015-2019 inclusive
- Total expenditure (all funders) for the IMNCI programme during the same period (2015-2019).

This proportional approach to attribution of the results is subject to the availability and quality of expenditure information for the period under review.

9 DATA ANALYSIS

In response to the evaluation questions, the adopted approach will be both **qualitative** and **quantitative** in nature. The primary analysis will be quantitative in nature using data extracted from the documents provided and reviewed and will depend on the availability, quality and organisation of data. Qualitative triangulation will be done to support the results of the quantitative analysis. This qualitative analysis will be done in the form of KIIs of selected key informants (virtually or in-person where feasible) mainly to verify, gather additional insights and identify the contextual approaches to address inefficiencies and weaknesses.

The detailed evaluation matrix, based on the evaluation questions, is presented in **Section 7.3** and forms the basis of the formative and summative analysis (see sections 7.2 and 7.3). All data will be managed in accordance to sound procedures for data management. Across the objectives of the evaluation, there will be balance in terms of level of effort and analysis (both quantitative and qualitative).

An exploratory analysis of the IMNCI programme through document reviews informs the basis of understanding the context. A list of documents for this review is found in **Annex 2**, showing a general split into UNICEF country programme documents and Government (MoPH) documents. The following analyses are expected to be produced;

- Analysis of the Programme design in the context of the Theory of Change
- Analysis of Relevance, Effectiveness, Efficiency, Impact and Sustainability.
- Analysis of Gender, Equity, and Human Rights

We will triangulate information obtained. Various methods of triangulation will be adopted to ensure that the findings of the evaluation are robust, and that our lines of enquiry are validated via multiple sources.

1. **Data triangulation** – Findings from the evaluation matrix indicators and the key informant interviews will be triangulated systematically with existing sources, reports, programme-specific surveys and research evidence (if any), national surveys such as MoPH reports, HMIS reports, Annual WHO/UNICEF

JMP reports, CMAM reports, Situation Analysis Reports, IMNCI strategy and programme reports, National Nutrition Survey reports, MICS and grey literature available through desk review.

2. **Methodological triangulation** – Through the proposed mixed methods approach, evidence from both qualitative and quantitative data will be used to validate the credibility of hypotheses and to construct plausible explanations for the formative approach.
3. **Investigator triangulation** – The main data will be analysed independently by core team members and subsequently discussed by the whole team in the synthesis of the evaluation findings.

We propose to prepare a formative analysis of the collected information, focusing on recommendations for future directions of the IMNCI Programme in DPRK. This will include summarising the results and drawing lessons from this analysis.

The review will take a balanced approach in using existing and new information, although this will depend to a large extent on the specific results and the indicators defined in the evaluation matrix. We are aware that the programme has a results framework with direct IMNCI indicators and other indirect indicators. It is anticipated that around half of the effort will be on reviewing existing data and documents with an approximately equal effort allocated to qualitative interviews and discussions for triangulation and verifying information and gathering information as needed for specific issues.

10 PROPOSED TIMELINE AND WORK PLAN

The original plan of the evaluation was that it would take twelve months, which included approximately three months from the signing of the contract to the initial Inception visit. With this report, the work has proceeded up to the time of that initial visit. Given current uncertainties and the agreement that only one visit to DPRK will be possible, we propose the following schedule of activities, with the next two months consisting of the approval of the Inception Report and further discussions with UNICEF DPRK. Subsequently, the timeline will be dependent on the easing of travel restrictions to DPRK. Once notice of that has been received, the schedule of activities would be approximately as follows:

- Month one to two – interviews with UNICEF and local stakeholders, finalising the detailed methodology and development of the instrument(s), submission of methodology and instrument(s) for ethical approval to IRB
- Month three to four – awaiting IRB approval, finalising survey instruments
- Month five (possibly June-July 2021) – fieldwork – it is envisaged that the fieldwork would take three weeks, with the first week in the capital. Subsequently, each of the three members of the evaluation team would visit one province, and the schedule for each would be: 10 days in the province and 5 days follow up in the capital³⁶.
- Month six – further document review, analysis, drafting the report, submitting the draft report
- Month seven – feedback received on the draft report, revision and submission of second draft
- Month eight – feedback and in-country validation of the second draft report
- Month nine – revision and submission of final report
- Month ten – dissemination activities

³⁶ If travel to DPRK is not possible, this will be the month of long-distance data collection.

The above schedule gives leeway for unexpected delays, delay in the IRB approvals, delays in feedback from stakeholders to the draft reports, and the unpredictable travel schedules of the consultants and key informants. A Gantt chart with the detailed work plan will be developed during the run-up to the field visit.

11 DELIVERABLES

The proposed deliverables for this assignment have changed slightly, mainly because this inception report is being submitted before the originally planned inception visit. It contains the results of the initial literature review and of virtual meetings with UNICEF stakeholders, a Theory of Change and linked evaluation matrix. However, it does NOT include the results of meetings with local stakeholders that would take place during the country visit.

Prior to the country visit, we will submit the data collection tools and a detailed workplan, including site selection, sample size calculations, and analysis plan for approval by both UNICEF and the DPRK Government.

What will follow will be according to what was originally proposed in the TORs:

- **A draft report and PowerPoint presentation** generated in light of the findings of the literature review, data collection phase and the feedback on preliminary findings. The structure for the review report is noted in the TOR and will be finalised during consultations in the inception phase and will be reviewed and commented on by UNICEF and selected partners. It will include a systematic compilation of all data collected, and documents consulted in audit trail
- **Final report** – conforming to UNICEF standards³⁷
- **Evaluation brief** – with the permission of DPRK
- **Consultancy report** - for UNICEF, outlining issues arising and lessons learned in the conduct of the evaluation.
- **Dissemination materials** – to be agreed upon by UNICEF and DPRK

12 THE CONSULTANT TEAM

The consultant team has not changed since the submission of the proposal in November 2019:

Dr. Lawrence Gelmon – Team leader, biomedical interventions, public health
Isabelle Cazottes – Community development, health promotion, public health
Ronald Horstman – Governance, policy, health economics, public health
Travor Mabugu – Finance, costing analysis, public health.

The team had regular meetings via Skype in January and February until the plans for the March inception visit were halted and has been back in regular communication for the past two months, as plans for conducting interviews with some key informants (see **Annex 4**) and drafting this report took shape. The team has also expressed its willingness to await the eventual reopening of travel to DPRK and will be available to conduct the inception and field visits according to the agreed methodology.

As noted, the plan is that only Gelmon, Cazottes and Horstman will conduct the inception visit and fieldwork in DPRK, while Mabugu's work will be desk-based.

³⁷ UNICEF; UNICEF-Adapter UNEG Evaluation Reports Standards; Updated June 2017

13 STRUCTURE OF THE FINAL REPORT

The final report will conform to UNICEF standards³⁸ and consist of the following sections:

- Executive summary
- Background
- Objective of the evaluation, purpose and scope, including:
 - The scale and complexity of the evaluation, geography, timeline, resources, components of the evaluation
 - The logical model and expected results chain, including the theory of change
 - Stakeholders and beneficiaries
 - Context of key social, political, economic, demographic and institutional factors
 - Relevance to UNICEF's goals and priorities
 - Justification for the scope
- Evaluation methodology, including:
 - Evaluation criteria
 - Evaluation framework
 - Design and methods, including data collection and data analysis
 - Data sources
 - Stakeholder participation
 - Ethical issues and considerations
 - Limitations and constraints
- Findings, including:
 - Credible evidence, findings respond to the questions under five evaluation criteria
 - Triangulation of data
 - Quantitative and qualitative analysis
 - Gaps and limitations reported
 - Gender and human rights - analysis of disaggregated data
 - Causal factors identified
- Conclusions and lessons learned (Including Best Practices)
- Recommendations
- Annexes, including:
 - TORs
 - List of persons interviewed, and sites visited
 - List of documents consulted
 - Data collection instruments
 - Evaluation matrix
 - Results framework

³⁸ *ibid*

ANNEX 1 TORS

Formative Evaluation of the Integrated Management of Neonatal and Childhood Illnesses programme (IMNCI) implemented by the DPR Korea Ministry of Public Health with the support of UNICEF DPR Korea 2015-2019

CONTEXT AND DESCRIPTION OF OBJECT OF THE EVALUATION

Current situation related to children

Despite an extensive network of primary and secondary health-care facilities, essential drugs for the treatment of common childhood illnesses and basic equipment are , especially for obstetric and neonatal care. In 2016, according to the DPRK Ministry of Public Health (MoPH) there were 37 doctors per 10,000 population. In the Democratic People’s Republic Korea (DPRK), maternal and child mortality rates remain high. Although the indicator is better than in many countries of the region there is preventable mortality and disparities between urban and rural areas as well as between provinces. According to the MoPH Annual Health Report (2014), infant mortality rates and under-five mortality rates were 1.2 times higher in rural than urban areas¹.

According to the United Nations Inter-Agency Group for Child Mortality Estimation, between 2000 and 2017, the DPRK under-five mortality rate decreased steadily from 60 to 19 deaths per 1,000 live births, while the national official estimate puts it at 18 per 1,000 live births. The probabilities of dying during the first 28 days of life and before reaching age 1 have also lowered. Yet neonatal and infant mortality combined account for 84 per cent of all under-five deaths, implying a need to strengthen emergency obstetric and neonatal care (EmONC) and integrated management of neonatal and childhood illnesses (IMNCI) to further reduce child mortality.

Sustained high and equitable vaccination coverage of more than 96 per cent across the country for the last three years helped DPRK achieve measles-free status, attested by the World Health Organization (WHO) Regional Verification Committee in 2018. To date, WHO has defined DPRK as one of the countries most affected by tuberculosis (TB). In the fight against malaria, the shift from disease control to decisive malaria elimination status was achieved in 2017. The Global Fund withdrew unexpectedly in mid-2018 with reference to risk control. People, including a large number of women and children affected, notably by TB are at high risk of discontinuing treatment. Multi-drug resistant (MDR) TB remains as a major concern in DPRK.

¹ 2017 MICS presented mortality rates, but with high confidence intervals, due to small number of cases in the sample: 10–20 deaths per 1000 live births for the under-5 mortality rate and for the infant mortality rate 7-17 deaths per 1000 live births. The results need to be used considering this. For the under-five mortality rate, the 2017 MICS shows 16 deaths per 1000 live births in urban, and 13 deaths per 1000 live births in rural areas.

Between 2000 and the latest United Nations estimate for 2015, maternal deaths due to complications from pregnancy or childbirth decreased from 128 to 82 deaths per 100,000 live births. However, this is still higher than the estimates of the 1990s. While the 2017 DPRK Multiple Indicator Cluster Survey (MICS) showed high coverage for the requisite four antenatal care visits, further reducing the maternal mortality rate will depend on improving service quality and focusing on the 13 per cent of deliveries still taking place outside of a health facility in rural areas.

In 2019 around 140,000 children are estimated to suffer from undernutrition and need treatment annually; of these, 30,000 face an increased risk of death. Over 1.7 million under-five children and around 700,000 pregnant and lactating women are estimated exposed to micronutrient deficiencies which affect growth, development and well-being. There has been overall improvement in nutrition among children under 5 years of age: wasting improved from 4 per cent to 3 per cent, and stunting levels went from 28 per cent to 19 per cent between the National Nutrition Survey of 2012 and the 2017 MICS. Stunting in under-five children, a key indicator of malnutrition, dropped from 45 to 19 per cent between the MICS survey rounds of 2000 and the 2017. Progress was supported by improvements in early initiation of breastfeeding and relatively high exclusive breastfeeding, at 71 per cent in 2017. However, inadequate dietary diversity is still a reality for over half of all children under 5 years of age, and only one in three receive both the right number of feedings and combination of foods.

Significant disparities exist between geographic locations and provinces, and among wealth groups. On most social indicators related to children, including health, gender disparities are statistically insignificant. The prevalence of severe acute malnutrition (SAM) in the lowest wealth group is, for instance, three times the prevalence in the highest wealth group. In Ryanggang Province, 32 per cent of children are stunted compared with 10 per cent in the capital Pyongyang. Both chronic and acute malnutrition are much higher in rural than in urban areas. Another risk to the cognitive development of children is that only one in five households uses iodized salt.

Rights to safe drinking water and sanitation are still largely unrealized. WASH indicators are an important determinant of the incidence of diarrhoea, which is among the top childhood killers globally. The 2017 MICS revealed that almost four out of 10 people in the country (over 9.7 million people) do not have safely managed drinking water. Overall, 23.5 per cent of the population drink water from contaminated sources. Excreta from 90 per cent of on-site sanitation facilities are used unsafely for agricultural fields in rural areas. Children under 5 years of age living in households that drink contaminated water are three times as likely to be wasted as children living in households with access to safe drinking water. Under-five children using unimproved sanitation also have diarrhoea 36 per cent more often than those using improved sanitation. Half of all schools and health facilities lack adequate water and sanitation facilities.

DPRK's Early Child Development Index score increased from 75 to a comparatively high 88 between the MICS 2009 and 2017 rounds. Some 73 per cent of children aged 36–59 months attend early childhood education, with no disparity observed between urban and rural areas, girls and boys or wealth index groups. However, there are significant disparities between provinces, with North Hamgyong at 53 per cent attendance and Jagang at 88 per cent displaying the widest difference. Access to primary – and even secondary – education is near-universal, and parental support for learning measured by the 2017 MICS is high at 96 per cent. The 2017 MICS results for learning outcomes were favourable for reading (95 per cent), while numerical skills (82 per cent) can be improved. DPRK has newly prioritized human capital development through learning outcome assessments and curriculum revision, aiming to shift from rote learning to modern teaching methods; yet the demand for technical assistance in these areas, as well as disaster risk reduction (DRR) in schools, remains unmet.

Reduced data availability and limited management capacity of partners were key bottlenecks to the analysis, planning, monitoring, evaluation and reporting of results for children according to the 2016 Situation Analysis (SitAn) and addressed by the DPRK-UNICEF Country Programme Document (CPD) for 2017–2021. According to the updated SitAn 2018 (unpublished), major progress could be achieved with UNICEF support in the availability of child-relevant evidence and analysis, but gaps remain in the reliability, periodicity and disaggregation of routine statistical data.

UNICEF DPRK humanitarian cooperation

The Country Programme of Cooperation (2017 – 2021) between the Government of the People’s Democratic Republic (DPRK) and UNICEF DPRK Country Office was approved by the Executive Board in September 2016. The country programme has been developed within the four strategic priorities of the United Nations Strategic Framework (UNSF) 2017-2021: (1) food and nutrition security; (2) social development services; (3) resilience and sustainability; and (4) data and development management.

The country programme focuses on current humanitarian priorities, including (a) ensuring access to life-saving assistance for the most vulnerable people who are affected by disasters; (b) reducing malnutrition (particularly among children under five and pregnant and lactating women); and (c) improving access to basic health and water, sanitation and hygiene (WASH) services. Based on lessons learned from the 2011- 2016 country programme, the country programme identified the need for (a) improved data use and management; (b) strengthened evidence-based advocacy for scaling up of low-cost, high-impact life-saving interventions; and (c) improved programming involving all sectors to address multidimensional vulnerability. Thus, the country programme emphasises stronger cross-sectoral linkages and balances the urgent supply component with the required technical assistance to support hands-on training, policy work and programme communications.

The 2017-2021 CPD adopted a multilevel geographic targeting scheme, with so-called Convergence Counties at the centre of the theory of change and narrative for scaling up. Nine vulnerable counties² (one per province) of the DPRK total of 210 were selected with the Government for convergent programming. These convergent counties were initiated as programmatic testing and learning sites, with increased focus on planning and monitoring capacity development of sectoral practitioners at decentralized level. Programme convergence is advanced through application of ‘the first 1000 days of life’ approach, which links nutrition, health, WASH and behaviour change communication interventions. Further levels of geographic prioritization are applied to specific programmes, ranging from partial to nationwide coverage.

Per the 2017-2021 CPD “limited data management capacity hinders the analysis, planning, monitoring, evaluation and reporting of results for children and makes it challenging to understand the distribution and depth of disparities, risks and humanitarian needs”. Under the Social Inclusion programme, UNICEF supports equity focused social policy development and planning and reporting on the rights of children and women, notably through a Memorandum of Understanding with the Central Bureau of Statistics on joint evidence generation and analysis.

² Kosong (Kangwon), Myonggan (North Hamgyong), Junghwa (North Hwanghae), Jongju City (North Pyongan), Kangnam (Pyongyang), Samjiyon (Rygang), Rakwon (South Hamgyong), Chongdan (South Hwanghae), Jungsan (Pyongan).

After a programme cycle with no evaluation, DPRK completed two evaluations of the WASH and Community Management of Acute Malnutrition programmes in 2017 and in 2018 respectively, with external quality ratings going from 'fair' (2017 WASH) to 'highly satisfactory' (2018 CMAM). Three key lessons from previous CPD a) Need for improved data use and management b) strengthen evidence-based advocacy for scaling up of low cost, high impact life-saving interventions; and c) improved programming involving all sectors to address multidimensional vulnerability remain active challenges despite progress made in terms of evidence generation, including the production of a high-quality MICS, credible evaluations, and the cooperation on data availability with the Child Data Management Unit of the Central Bureau of Statistics. Efforts are still needed to improve the availability and reliability of sufficiently disaggregated of child-related data across sectors.

IMCI/IMNCI Programme history

In 1995, World Health Organisation (WHO) and UNICEF developed the Integrated Management of Childhood Illness (IMCI) as a global strategy to promote health and provide preventive and curative services for children under five in counties with more than 40 deaths per 1000 live births. In 2003, care for newborns under one week of age was added and the strategy was renamed as IMNCI in many countries, with N standing for neonatal. Since then, over 100 countries have adopted IMNCI and implemented to varying degrees its three components: 1) improving health worker skills, 2) strengthening health systems and 3) improving family and community practices.

The Government of the Democratic People's Republic of Korea decided to introduce the Integrated Management of Childhood Illness (IMCI) strategy in 2002. WHO supported the adaptation of the generic version of IMNCI to meet DPR Korea's specific needs and assisted in orientation and training of trainers. WHO also supported the participation of several national experts in international IMNCI training programmes and workshops related to IMNCI. Study visits of national health officials to countries implementing IMNCI were also arranged. Drawing from these preparatory activities, the Government decided to initiate IMNCI in two counties in 2004. Training of practitioners started in June 2005 and was done in Phyongwon county in South Pyongyan Province and Hwangju county in North Hwangwae Province. In each of these counties around 100 staff were trained.

In September 2006, two WHO staff members, one from the Department of Child and Adolescent Health WHO/Headquarters and the other from the Child and Health and Development unit WHO/South and East Asia Regional Office visited DPR Korea to make an on-site assessment and provide recommendations to assist the IMNCI expansion process. The recommendations for the IMNCI expansion, in Annex I with recommendations/assessment at programmatic milestones, included that 20 counties should start the programme by 2007, up from 2 pilot counties in 2005, and that subsequently 50 counties join the programme annually. This was planned to result in a nation-wide coverage of IM(N)CI by 2011 but it did not materialise as planned, due in large parts due to lack of donor funding and domestic public budget allocations. Neither was the proposal for a baseline, mid-term and end-line evaluation to assess impact implemented.

Starting 2015 the IMNCI programme targeted 50 counties which were defined finally in August 2016 and are home to around every fourth child under five in DPRK. Over the four-year period 2015-2018, UNICEF's support to the IMNCI programme was around US\$10.7 million, constituting 10.6 per cent of total expenditure on programmes in DPRK over the same period.

Table 1. Coverage and expenditure of UNICEF IMNCI support:

Year	DPRK Population of U5 children ('000s)	No. of areas with IMNCI coverage	Population of U5 children ('000s)	% of all U5 children	UNICEF IMNCI expenditure (millions)	% of total UNICEF expenditure
2015-2018	1,684*	50**	412	24	10,726,019	10.64%***

* Population figures are from CBS and based on CRVS as of Nov. 2018. With prevailing demographic trends, they can be taken as indicative of the period.

** Comprises 43 counties, 6 cities, and 1 district of a major city.

*** Total UNICEF Expenditure 2015 to 2018 was 100,836,997 US\$. Indicative figures, subject to revision.

Currently, the UNICEF-supported IMNCI programme is being implemented in 50 priority counties and addresses the commonest causes of under-five mortality and morbidity pneumonia, diarrhoea, childhood tuberculosis (just introduced), neonatal conditions and undernutrition. The IMNCI programme has focused on capacity building of health workers at county and Ri levels for proper assessment, classification & management of sick children suffering from more than one illness at a time; and the provision of regular IMNCI related supplies and medicines in the form of Essential Medical kits and Household doctor bags and refill kits to address acute drug shortages. The Indicative output of the CPD is that MoPH and health system have enhanced capacity to provide equitable access to quality immunization and IMNCI services, particularly in those regions affected by the protracted humanitarian crisis. The measurement of the output is however challenged by the absence of a sufficiently sensitive monitoring system with limited access to related health data, beyond the mere provision of inputs and insights from field monitoring and follow-up after training. The CPD 2017-2021 envisages that, along with the provision of essential medicine kits, the programme is implemented in 50 priority counties affected by the protracted humanitarian crises. A map showing the location of the 50 counties is included as Annex IV. In these counties, household doctors (male and female) are trained and supplied with essential medicines and basic equipment to provide effective antenatal care, basic curative services and health promotion.

Monitoring systems are also supported to ensure quality services, with particular attention to hard-to-reach villages and those affected by the protracted humanitarian crisis (on data availability see also section 3.1 Methodological Design). Based on further needs assessments and availability of resources, a total of 89 counties may also receive the essential medicine kits. This latter provision has not been activated due to consistent insufficiency of required funding for the geographical scale-up of services.

Policy context

In DPR Korea, the Ministry of Public Health (MoPH) is directly in charge of the implementation of the Public Health Policy. It is responsible for treatment, prevention, and central and specialist hospitals. Sub-nationally, there are Health Bureaus at the Provincial People's Committees and Health departments at the County and Ri People's Committees.

The policy environment for child survival is generally well-developed and favourable. The extent to which they are being implemented, linked evidence generation and decision making on budget allocations is less well documented and this is one of the areas in which the present evaluation is expected to make a significant contribution. A number of supportive laws and policies to support child and maternal health are in place. The legal framework includes laws on Public Health; Nursing and Upbringing of Children; Prevention of Communicable Diseases; Public Hygiene and Sanitation and on Medical Treatment. Policies and plans relevant to the evaluation include: DPRK Constitution; National Guidelines for maternal and child health interventions (1999); Plan for Child Health Improvement (2001-2010); Strategy for Expansion of IMNCI (2005-2020); and, Strategy and Action Plan to control Child and Maternal Mortality (2014-2018).

However, there is room for further improvement based on the outcomes of operational research and international best practices. Health strategies are reflected in the Medium-Term Strategic Plans for Health (MTSP). From the side of humanitarian partners, crucial references are the WHO Country Cooperation Strategies (CCS) for 2000-2004, 2009-2013 and 2014-2019 and UNICEF CPDs for 2010-2016 (extended) and 2017-2021.

The first MTSP, covering 2010-2015, has been implemented and a second plan covering 2016-2020 is currently being implemented. These documents highlight many of the challenges faced by children and women throughout DPR Korea and have allowed the MoPH, its national partners (including the Academy of Medical Sciences and the Institute of Child Nutrition), along with its humanitarian partners, including UNICEF and Gavi, the Vaccine Alliance, to better assess and target children's health, nutritional, and WASH needs within the country.

Key health sector partners include UN agencies, notably WHO, UNICEF and UNFPA; the International Federation of Red Cross and Red Crescent Societies (IFRC), Italian Development Cooperation, Finnish Development Cooperation (ceased activities in 2019), Swiss Development Cooperation and European Union. International partnerships have been established with Global Health Initiatives (Gavi and the Global Fund), as well as with the multilateral programmes for improving Women's and Children's Health in DPRK. While only UNICEF, WHO and UNFPA have a direct role in relation to the IMNCI programme, the joint efforts of Government and its partners have improved the enabling environment for progress with respect to child survival (Situation Analysis of Children and Women, UNICEF 2019, unpublished).

While UNICEF is the central agency supporting the IMNCI implementation and capacity development in DPRK, WHO has played a critical role in the preparatory phase of the introduction of the IMNCI strategy in DPRK as far back as 2000. WHO supported the adaptation of the generic version of IMNCI to meet DPR Korea's specific needs; assisted in orientation and training of trainers; supported the participation of several national experts in international IMNCI training programmes and workshops as well as field visits of nationals to countries implementing IMNCI. Additionally, WHO provided technical assistance to review the lessons learned in the pilot phase and to guide the process of IMNCI expansion and have continued to play a key advisory role in IMNCI implementation including the recent inclusion of management of childhood TB into the IMNCI protocol.

UNFPA have played a key role on the technical review board for IMNCI and supported together with WHO, UNICEF and MoPH the revision and development of the new IMNCI guidelines. UNFPA programmes currently focus on supporting training and family planning and providing life-saving medicines and equipment for maternal and newborn health. Current programmes aim to sharpen expertise in data analysis and population studies to inform policy development, implement reproductive health care standards, and provide critical supplies, equipment and training.

In the current MTSP, IMNCI, together with immunization and CMAM, forms a key approach under Focus Area 3, Mother and Child Health:

During the last Cycle the IMNCI strategy has expanded nationwide. After piloting the integration of the IMNCI in the paediatrics training curriculum in the capital's medical university is now expanded to cover all medical schools in the country and to nursing and midwifery schools. The introduction of the IMNCI strategy showed an improvement in the quality of child care.

For the 2016-2020 MTSP, it is envisaged to ensure the quality of IMNCI strategy through regular supervision and feedback, ensure regular equitable supply of essential drug, equipment & consumables and to continue community education & involvement (MTSP 2016-2020, page 27).

Per the current MTSP, DPRK has an extensive infrastructure of hospitals at central, provincial, county and ri levels, in addition to 6,263 Ri clinics, where 45,000 household doctors are based and provide preventive and curative services, each serving about 130 households in his/her section.

In terms of financial resources for IMNCI, information on domestic allocation of public finances is scant.

Periodically expenditure on the overall health sector as a share of total Government expenditure is communicated, but the latter is not made public. Thus, per the available 2017 Annual Health Report, Government expenditure on health increased from 6.0 to 6.4 per cent between 2014 and 2017. According to MoPH, in verbal communication, this share has remained constant since. UNICEF's actual expenditure on IMNCI support 2015-2018 has been close to US\$11 million and represents around a tenth of UNICEF expenditures for DPRK over this period.

OTHER INFORMATION ON THE OBJECT OF THE EVALUATION

IMNCI stakeholders and evaluation stakeholders

The key IMNCI Stakeholders are the MoPH, as ministry in charge of the programme; UNICEF, as the main funder and supporter of IMNCI in DPR Korea; as well as WHO, in its quality of standard setter for IMNCI globally. UNFPA is associated to training on IMNCI and linkages to sexual and reproductive health services. Other members of the Health Sector Working Group, comprising UN agencies, bilateral development agencies and international NGOs, have secondary interests and inconsequential stakes in the programme.

Rights holders, children under 5, will not be directly involved in the evaluation. Mothers, who are both rights holders and primary duty bearers for children under 5, as well as health system staff at all levels as duty bearers will be systematically involved in the evaluation.

Key stakeholders of the evaluation comprise, in addition to the above: The Central Bureau of Statistics (CBS) with its Child Data Management Unit (CDMU), as Government focal institution for evaluation and with a key role on provision and/or collection of data for the evaluation; Ministry of Urban Management (MoUM), Education Commission (EC) and Grand People's Study House (GPSH), respectively partner agencies of UNICEF's country programme for WASH, Education and Behaviour Change Communication and operationalising in practice the programme convergence around the first 1000 days of life targeted by DPRK-UNICEF cooperation.

PURPOSE, SCOPE, OBJECTIVES AND EVALUATION FRAMEWORK: PRELIMINARY EVALUATION CRITERIA AND QUESTIONS

Evaluation purpose, intended use and audience

During the last decade, UNICEF has been supporting integrate management of childhood illnesses and the capacity building of household doctors for early identification and treatment of maternal and childhood illnesses.

Firstly, a long period of programme implementation without evaluation and substantive financial investment require the conduct of a rigorous evaluation in line with UNICEF evaluation policy. UNICEF evaluation coverage norms stipulate furthermore the conduct of five thematic evaluations per programme cycle for programmes with an annual budget of over US\$10 million and three thematic evaluations for offices with a budget of under US\$10 million. The formative evaluation of the IMNCI programme is stipulated within the Costed Evaluation Plan (CEP) of the 2017-2021 CPD and initiated now to provide implementers with recommendations for programmatic improvement along OECD DAC evaluation criteria, to inform the UNICEF Country Programme Evaluation planned in 2020 and design of the next CPD for 2022-2026 as well as the MTSP 2020-2024.

Secondly, despite all efforts at reducing child mortality and morbidity in paediatric pneumonia and diarrhoea, the death rates due to complications of the pregnancy, pediatric pneumonia and diarrhoea

among children under five years of age in the country remain relatively high. There is therefore a need to conduct an evaluation to understand whether UNICEF's health programme is relevant, effective and efficient, to what extent it contributes equitably to reducing maternal and paediatric mortality, pediatric pneumonia and diarrhoea and, crucially, how positive impacts could be practically strengthened, results accelerated and rendered sustainable.

In terms of evaluation use, DPRK has a record of proactive practice-oriented follow-up on evaluations, including recent modifications made to the MoPH's UNICEF-supported nutrition programme. In line with the key objective of identifying improvements to the IMNCI programme, the primary audience for the evaluation are the MoPH, UNICEF and health sector partners, and the secondary audience comprises other Government institutions, the international donor community and academic/practitioner circles concerned with IMNCI. A broader dissemination and advocacy plan has been outlined under point 4.5 below.

Temporal and geographical scope

The period to be covered by the evaluation is 2015-2019, the time of roll-out of the IMNCI until the last year for which data will be available in full, but the preceding roll-out preparations in 2014 shall be assessed and reflected as and where relevant to the analysis of the period under evaluation. Geographically, the evaluation shall focus on a purposively selected subset of counties where IMNCI was implemented during this period, the 9 Convergence Counties of the current CPD, and on a number of control counties in non-programme areas. Further detail on the proposed sampling is provided under point 3.1 below on methodological design.

Initiated in the early 2000s in pilot areas and subsequently expanded based on adapted global IM(N)CI guidelines, the programme is in a phase of maturity, has however not gone to national scale, as warranted by the needs of beneficiaries, due to resource constraints or different allocation priorities on the side of DPRK Government and UNICEF. The IMNCI programme is included in the results frameworks of CPDs for 2010-2015/16 and 2017-2021 and some related indicators were included in annual workplans and planning documents for IMNCI rollout, but a dedicated results framework has not been developed. IMNCI is similarly part of the broader Theory of Change (ToC) in the Programme Strategy Note (PSN) for the Health programme component of the CPD 2017-2021 and does not have a formal ToC of its own. As ToC and PSN were not mandatory at the time the 2010-2015/16 CPD per then applicable organisational guidance, there was no ToC during the previous CPD. The full ToC, specific to IMNCI, will need to be reconstructed and documented by the evaluation through outcome harvesting or similar techniques.

Evaluation objectives

The evaluation will make a systematic and objective effort to determine the relevance, effectiveness, efficiency, impact and sustainability of MoPH's IMNCI programme in areas supported by UNICEF compared to non-programme areas during the period 2015-2018. Based on evaluation criteria agreed among key partners and stakeholders, the evaluation will answer stipulated evaluation questions relating to each of the UNEG evaluation criteria through rigorous, systematic and objective process in the collection, analysis and interpretation of information. As an evaluation of a programme initiated in 2005 and which will continue for the foreseeable future, the evaluation will be formative and prioritise:

- I. the assessment of intended and unintended implementation strategy outcomes against IMNCI objectives of child morbidity and mortality reduction for children under 5 in target areas;
- II. the assessment of the conduciveness of methods adopted in the delivery of the programme activities, notably capacity development, and in mainstreaming equity, equality and human rights as well as intra- and inter-sectoral coherence and coordination into the programme design and implementation;
- III. the provision of actionable lessons and recommendations on programme and outcome improvement to guide decision-makers and inform stakeholders. In doing so, the evaluation will use evaluation questions outlined below to examine to what extent and how UNICEF has addressed health needs of the most deprived children; how girls and boys have been addressed

and affected differently by the programme; and whether or not, the programme has helped girls and boys gain more access to rights of survival and fuller development of their potential, from the human rights perspective.

Evaluation Questions

In a one-day evaluation design workshop facilitated by UNICEF DPRK's PM&E Section, key stakeholders from MoPH and UNICEF Health programme identified the following preliminary questions to be answered by the evaluation:

Relevance: the extent to which the IMNCI is (still) suited to the priorities and policies of the Government of DPRK and the population targeted as well as donor priorities.

- I. Were global IMCNI objectives and technical frameworks sufficiently adapted to the specific country context and is this still valid, i.e. are the activities and outputs of IMNCI consistent with the intended impacts and effects?
- II. How well is the IMNCI implementation strategy including (capacity development component) aligned to national priorities?
- III. Are the current IMNCI protocol and guidelines adapted to the epidemiological/morbidity profile in DPR Korea?

Effectiveness: the extent to which IMNCI activities attain the desired objectives

- IV. Were the IMNCI objectives of reducing morbidity in diarrhoea and pneumonia of under 5 children achieved in targeted areas or are they likely to be achieved? What were the major factors influencing the achievement or non-achievement of the objectives? What are the comparative results for children under 5 living in areas receiving different levels of support and no support from UNICEF?
- V. If possible to model/infer, what is the contribution of IMNCI to the overall reduction in child mortality rates? If not, how can the MoPH and UNICEF adequately measure the IMNCI contribution to reducing child mortality rates?
- VI. To what extent is the geographical targeting of UNICEF support in line with the evolved epidemiological profile and other social indicators?
- VII. To what extent has the programme helped girls and boys gain more access to rights of survival and fuller development of their potential?

Efficiency: the extent to which resources allocated to supply and capacity development were used cost-efficiently and timely for the achievement of IMNCI objectives.

- VIII. To what extent was IMNCI implemented in the most efficient way as compared to possible alternative allocative approaches?
- IX. How can identified strengths related to efficiency be further and systematically enhanced and how can identified weaknesses be addressed?

Impact: the positive and negative changes produced by the IMNCI programme, directly or indirectly, intended or unintended.

- X. How many children's lives have been saved or otherwise affected, positively and negatively, by the IMNCI programme? In line with an agreed set of scenarios for IMCNI development in terms of decreased/continued/increased investment by 2030, how would modelled impact look like? What are recommendations to maximize and accelerate positive changes from the IMNCI programme?
- XI. To what extent can the achieved results be directly attributed to UNICEF support to the IMNCI programme?

Sustainability: whether the benefits of the IMNCI programme are likely to continue after donor funding has been withdrawn.

- XII. What were the major factors which influenced the achievement or non-achievement of sustainability of the programme?
- XIII. Which are recommended pathways for further improvement/remedial action on factors that are under the influence of the IMNCI stakeholders?

Equity, Gender, Human Rights: the extent to which crucial programming principles have been integrated at all levels of the programme

- XIV. To what extent have special needs of vulnerable groups, including bottlenecks and barriers faced in accessing services, been integrated in the IMNCI setup?
- XV. Have the respective and specific needs of mothers, girls and boys, and children with disabilities been taken into account in a sufficiently deliberate and targeted way at all requisite levels?

METHODOLOGY**Methodological Design**

Methodological rigor will be given significant consideration in the assessment of proposals. Bidders are invited to interrogate the approach and methodology proffered in the terms of reference and improve on them or propose approaches they deem more appropriate. In their proposal, bidders should refer to triangulation, sampling plan and methodological limitations and mitigation measures. This section details the current outcome of consultations between UNICEF, MoPH and CBS on the suitable methodological approach and may be revised either at the stage of contracting for the evaluation and/or after the inception mission, which will focus inter alia on assessing the availability of evidence against evaluation questions laid out above.

The methodological design for the evaluation should be non-experimental, based on mixed-methods, participatory, gender and human rights-based approaches as well as equity- and utilization-focused, including in geographical targeting of assistance provided through the IMNCI programme. Besides the central institutional and policy environment, it is proposed that the evaluation be conducted in at least nine counties, which are to be selected purposively in three provinces, each representative of three broader regions in DPRK.

In each province the respective Convergence County of the 2017-2021 CPD; a county consistently receiving UNICEF IMNCI support 2015-2019; a county without IMNCI programme will be included to allow an assessment of the differential development with or without IMNCI support and in function of different intensity of capacity development and supportive supervision between convergence and non-convergence counties. The selection of counties will be purposive in line with conditions for in-country travel (see section 3.3 on limitations) and the rationale of selection will be documented by CBS. In each county, the evaluation will reach to the ri level and the evaluation team may randomly select ris and ri level health facilities from an exhaustive list that will be provided. The sampling of households and persons for focus group discussions and/or interviews remains to be discussed and agreed as part of the inception mission.

The evaluation will involve two types of data and a number of data collection methods and tools: Primary data will be collected through qualitative and quantitative methods, such as small-scale survey questionnaires³,

³ For survey activities, experienced CBS enumerators are available to be trained by the evaluators and employed in the data collection under their supervision. Monitoring of such data collection may furthermore be monitored by UNICEF staff, as required.

key informant interviews, observation of clinical practice, outcome harvesting with stakeholder groups and assessment of changes in knowledge and behaviours through Focus Group Discussions with

beneficiaries (FGDs). Not listed methods deemed needed to answer all the evaluation questions and ensure complete, fair and unbiased assessment may be proposed additionally by bidders.

Data will be collected at least from the following target groups, in numbers that will be defined by the evaluators in conjunction with the key IMNCI stakeholders:

- i. Households with children under 5
- ii. Relevant ministry/Government representatives and other service providers responsible for the implementation of IMNCI programme, most notably Household Doctors
- iii. Local authorities (People's Committees)
- iv. IMNCI stakeholders outside of Government

Secondary data may be collected from the programme documents and following sources:

- v. Health sector routine data from the Central Bureau of Statistics Multiple Indicator Cluster Surveys (2017) and Social Demographic and Health Survey (2014)
- vi. UNICEF Supply distribution and training plans
- vii. UNICEF field monitoring reports, annual and donor reports
- viii. UNICEF Evaluations of WASH (2017) and CMAM (2018) programmes

Data against indicators of the two CPD's results frameworks, ToC and DPRK-UNICEF Annual Work Plans mostly exist, but limitations exist as outlined below and either full time-series or sufficient disaggregation may not be available ex ante. E.g. data on morbidity in diarrhoea and pneumonia are available only at national level before 2015, and at province level since then. Since 2018 disaggregated data exists additionally for Convergence Counties. For the evaluation, specific data requests may be submitted to CBS and MoPH to process historical routine data with requisite breakdown. In other cases, such as when prior data points on service quality or behaviors of duty bearers do not exist or are too far in the past, the evaluation will have to adopt a synchronic perspective. As a full, targeted ToC does not exist, it will have to be reconstructed as part of the evaluation.

Data Collection Tools and Data Analysis

Data collection tools (questionnaires, interview and FGD protocols etc.) must be culturally appropriate. The form and contents of the data collection tools should be sufficient for capturing and triangulating correct information on the main indicators of the programme and deliver adequate level of analysis that will illustrate a measurable change. The partially reconstructed ToC shall be used to analyse the sufficiency of planned and used pathways of action to bring about the intended change. Surveys, interviews, and focus group discussions with sampled groups must be anonymous, in Korean language and documented with consent of the interviewees.

Data must be disaggregated by gender, location, ethnicity, income, language and ages of respondents. Data analysis must measure the extent to which the programme is contributing to the increase in equitable access for children to free and quality education. The analysis will cover findings according to determined evaluation criteria and questions yet should also triangulate socio-economic and other contextual or statistical and survey data on variables like assumptions and perceived risks that could have had effect on the course of the planned results.

Limitations

While the programme is evaluable, there are sizeable limitations and the final methodology for the evaluation will need to include sufficient mitigating measures against the following and other, possibly not yet identified, limitations.

There are several challenges in terms of unmediated access to the target groups. Travel within the country is regulated by national authorities and international humanitarian agencies need to obtain clearance,

normally seven days in advance, for field visits outside of Pyongyang, as do DPRK nationals. Overnight stays of international staff are approved in a specific list of suitable accommodation. Itineraries must be planned in advance, and international staff must always be accompanied by their national agency staff.

National counterparts, including health staff, are not available for interaction with international agencies on Fridays, and this needs to be taken into account in the planning of any field visits and data collection in the field.

Additionally, limited reliable secondary data from national routine statistics and absence of proper documentation at the lower health system levels may pose challenges in the evaluation process. Certain limitations in data collection to consider are connected to the sensitive geopolitical context of DPRK.

Due to elevated levels of turnover among UNICEF international staff and national seconded personnel, as well as challenges in knowledge management and system continuity, certain programme documentation related to earlier years of the evaluated period may be difficult to locate and certain programmatic decisions may not have been documented.

The proposed baseline assessment for IMNCI was not executed. The programme is partially lacking a developed Theory of Change.

Ethical procedures

The evaluation will be conducted according to UNEG (United Nations Evaluation Group) Code of Conduct for Evaluation in the UN System and UNEG Ethical Guidelines. Other documents to review before starting the evaluation are listed with their online location in Annex – III, Resources for inception and evaluation reports, including the applicable UNICEF procedure for ethical standards in research, evaluation, data collection and analysis.

Evaluation methods and data collection tools involving children and sensitive topics must be approved by an external Institutional Review Board (IRB). The evaluation object and data collected will be checked against the Criteria for Ethical review Checklist (by UNICEF) to determine whether it requires ethical review. Ex ante, it is not expected, as data collection will not involve children directly and any personal data collected will be anonymised before use in the evaluation.

Evaluators are required to identify any potential ethical issues and must disclose in writing any past experiences with and their relationships, including of their families and friends, to the object of the evaluation. Evaluators must exercise independent judgement and not be influenced by statements of view of any party, including:

- I. Be impartial and produce a comprehensive presentation strengths and weaknesses of the policy, programme and take due account of the view of stakeholders based on unbiased findings;
- II. Illustrate evidence with verified findings and lessons learned;
- III. Exercise honesty, integrity and respect for dignity and diversity;
- IV. Produce evaluation reports based on fair representation of knowledge, vulnerable groups, gender and ethnic groups.

Evaluators are required to receive consent from participants before involving them in the data collection process and respect their right to provide information in confidence. Evaluators must inform participants about the scope and limits of confidentiality and ensure that their information cannot be found by any other party. It is mandatory to prepare risk management plans to minimize potential harm to participants before starting the fieldwork.

EVALUATION MANAGEMENT AND WORKPLAN

Deliverables

The list of products that will be delivered by the evaluation team, shall comprise at least:

- I. Inception Report and power point presentation thereof
- II. Full methodology and data collection tools
- III. Successive and final drafts of the Evaluation Report, designed and print-ready, and a power point presentation thereof
- IV. Evaluation Brief
- V. Systematic compilation of all data collected, and documents consulted in audit trail

All deliverables must be in professional level standard English and in compliance with [UNICEF Style Book 2019](#) and [UNICEF Brand Book 2019](#).

Structure of the evaluation report

On a length of not more than 40-60 pages, exclusive of annexes, the Evaluation Report must be compliant with UNICEF-adapted UNEG Evaluation Report Standards (2017) shall comprise at least the following sections:

- VI. EXECUTIVE SUMMARY
- VII. BACKGROUND
- VIII. EVALUATION PURPOSE, OBJECTIVES AND SCOPE
- IX. EVALUATION METHODOLOGY
- X. EVALUATION FRAMEWORK
- XI. EVALUATION FINDINGS
- XII. EVALUATION CONCLUSIONS & LESSONS LEARNED
- XIII. RECOMMENDATIONS

Team composition

The team should be composed of one Evaluation Team Leader and a sufficient number of international team members to ensure the successful implementation of the assignment. It is suggested that the Team Leader, with a specialization on conduct of rigorous evaluations in complex contexts, shall be joined by at least one team member with specific health sector expertise and focus on evaluating clinical practice and capacity development programmes, and another team member with specific social science/sociological expertise and experience in evaluating integration of equity, gender equality and empowerment and/or effectiveness of channels of communication and other demand-side interventions for vulnerable target groups. International team members proposed in any bidding document must be available for the duration of their assigned tasks.

In view of the context, the Evaluation Team will not comprise national experts as members. It will be technically assisted by one officer from the DPRK Central Bureau of Statistics. In addition, the evaluation process and data collection will be facilitated, including translation, by one national officer from each the UNICEF Health and Planning, Monitoring & Evaluation programmes.

Evaluation Team Leader (ETL) will be in charge of leading the entire process through working with team members and the UNICEF Evaluation Manager. The ETL will be responsible for timely and quality deliverables. The ETL must have the below qualifications. Exact qualifications of team members are not given, so as to give bidders the opportunity of availing the requisite set of skills and expertise outlined above with a combination of specific individuals. The proposed team composition should be gender-balanced and culturally diverse, while including evaluation expertise from East Asia as an asset to be considered in assessing bids.

- XIV. Advanced degree in medicine, public health, sociology, and other social science related field. Academic specialization in evaluation an asset.
- XV. At least ten years' experience in managing, designing and conducting complex evaluations of large scaled programmes on health and related interventions in increasing children's and women's access to health; increasing girls' access to health and development;
- XVI. In-depth knowledge of and experience in evaluations compliant with the UNEG Norms and Standards;
- XVII. At least 10 years of international experience in the health sector and evaluating health programmes in development and emergency/humanitarian contexts;
- XVIII. In-depth knowledge of and experience in the work of UNICEF and/or other similar UN organizations or development agencies working on health, ideally IM(N)CI programmes;
- XIX. In-depth knowledge of and experience in human and child rights, equity and gender-based approaches to health programming;
- XX. Demonstrated ability to deliver high-quality written work in the English language, and to engage effectively with stakeholders at all levels.

Evaluation Management and quality assurance

The evaluation will be managed by the M&E Specialist under the supervision of the Deputy Representative, and under the overall oversight and guidance of the Representative of the UNICEF Country Office. UNICEF DPRK will lead the evaluation process and will ensure the quality and independence of the evaluation process, and that it is conducted according to UNICEF Evaluation Policy and UNEG Norms and Standards. UNICEF DPRK M&E Specialist will act as Evaluation Manager (EM) and facilitate exchanges between the evaluation team and stakeholders from two bodies constituted to support the evaluation process: An Evaluation Management Group (EMG), including the UNICEF East Asian and Pacific Regional Evaluation Advisor and UNICEF DPRK senior management, will guide and support the evaluation manager in major

decision making and quality assuring the evaluation process in line with UNICEF Evaluation Policy and UNEG Norms and Standard by quality reviewing milestone documents and suggesting remedial action on salient issues and challenges during the evaluation. A broader Evaluation Reference Group (ERG) will be constituted from the primary evaluation stakeholders identified above and include UNICEF staff members from regional and global headquarters and/or peer reviewers from relevant country offices, representatives from MoPH and other Government institutions, and representatives of WHO and other sector partners. The ERG will review evaluation deliverables, help corroborate findings and provide comments regularly on the evaluation's scope, methodology, findings, conclusions and recommendations, including through face-to-face meetings during three in-country missions of the evaluation team and through remote consultations facilitated by the Evaluation Manager. The ETL will be accountable to EM and EMG as to how ERG comments are addressed.

Dissemination and advocacy for the evaluation findings and recommendations

Evaluators must obtain permission from UNICEF to disclose any evaluation materials and keep raw data and protocols in concealment. Data must be securely retained or disposed according to UNICEF's policy on the disposal of records. All materials collected and evaluation products remain the property of UNICEF and the contractor must not share this information without explicit consent of UNICEF.

The communication strategy to disseminate evaluation findings to promote the use of evaluation findings among relevant stakeholders includes:

- XXI. Publishing an evaluation report and distributing it among partners.
- XXII. Publishing an evaluation brief. If agreed by DPRK, publish an evaluation brief in video format.
- XXIII. Holding briefings for donors and integrate evaluation findings into resource mobilisation tools.
- XXIV. Publishing an article or story covering evaluation findings on UNICEF DPRK website and share point.
- XXV. Taking part in knowledge exchange mechanisms with relevant stakeholders to share

evaluation findings, including specialised journals, global/regional newsletters, evaluation learning events.

- XXVI. Ensuring presentation and integration in programme cycle milestones such as CPD mid-term review, evaluation or development.

The evaluation results should contribute to evidence-based policy making and programming for children. Per UNICEF policy, an Evaluation Management Response plan of policy and programmatic follow-up actions will be established by the key stakeholders MoPH and UNICEF, in relevant consultation with secondary stakeholders and its implementation monitored and reported over a two-year period. UNICEF Country Management Team will be responsible for monitoring the dissemination of evaluation products and the uptake of evaluation findings and recommendations by Government and implementing partners.

Indicative Workplan, Deliverables and Payment Schedule

The timeframe for the evaluation will be up to 12 months from the start of the contract and proceed from one stage to another following the satisfactory completion of the previous stage and deliverables. Sufficient time shall be allotted for interaction with EMG and/or ERG at all stages and for the process of obtaining and incorporating comments on inception and draft reports

In line with the methodology proposed by the bidders, the envisaged level of further effort for the Team Leader and each of the included team members needs to be separately indicated in the proposal submitted. This means that the number of days in-country and worked remotely as well as the respective daily all-inclusive fee shall be stipulated in a matrix against the workplan phases and items below for applicable team members.

#	Item	Timeframe	Duration	Payment
1	Inception Phase			30%
	- Desk review and inception mission preparations	Nov. 2019	2 weeks	
	- In-country inception mission	Nov. 2019	2 weeks	
	- Inception Report	Dec. 2019 – Feb. 2020	3 weeks	
2	Data Collection Phase	Mar. 2020	5-11 weeks*	30%
	- In-country data collection with full audit trail of data collected	- May 2020		
3	Data Analysis Phase, Report Writing & Presentation	June – Sept. 2020	4 weeks	40%
	- Drafting of Evaluation Report and integration of successive inputs from quality assurance process			
	- In-country mission for the presentation of the final Report to stakeholders			

* These indicative minimum and maximum figures are computed respectively based on an approach where the evaluators would work in parallel implementing the same methodology in different counties (3 weeks fieldwork, preceded and followed by a week in the capital) and an approach where the team would work together implementing each specific parts of the methodology and sequentially visit all counties (9 weeks fieldwork, preceded and followed by a week in the capital).

All payments will be made upon the satisfactory receipt of deliverables by UNICEF, and payment may be withheld with no financial compensation if deliverables are not submitted in full quality and scope.

Submission and assessment of proposals

Institutions with relevant expertise and capacities are invited to submit proposals to UNICEF, including a methodological proposal, CVs of proposed team members and a detailed financial offer against workplan and deliverables. The financial offer shall use all-inclusive daily fees factoring in any in-country subsistence costs for all team members. International travel and logistics costs shall be quoted separately, while in-country transportation and logistics costs, including rent for workshops etc., will be organised by UNICEF and need not be included in the financial calculation.

The technical quality, comprising the methodological approach and qualifications of team members, shall be awarded 60 per cent of the points in the assessment of proposals. The financial offer, including individual all-inclusive fees for team members and the total offer, shall be awarded 40 per cent of the points in the assessment of proposals. A process for clarifications and competitive negotiation with bidders is envisaged given the complexity of proposals.

Annex I – Recommendations/assessment at programmatic milestones

2006 WHO Recommendations for IMNCI expansion

- Phased expansion implementation;
- Identify Nodal institutions and cascade training;
- Target provinces with highest mortality first. In the absence of mortality data for provinces, use malnutrition rates as proxy indicator;
- Aim for at least 60% of household doctors in selected counties to be trained in a given time frame;
- Align expansion to provinces/counties with WHO ROK project activities. All efforts will be made to include the UNICEF focus counties (7 already assigned, 3 to be assigned) in IMNCI expansion plans;
- Introduce Essential Newborn Care training and strengthening in counties included for IMNCI and rename as IMNCI;
- Plan to introduce supervision for IMNCI concurrent with IMNCI training in provinces/counties;
- Plan for baseline, mid-term and end-line evaluation to assess impact;
- Pre-service IMNCI training to be introduced gradually in provinces that implement IMNCI services;
- Identify 2 Universities where pre-service IMNCI will be introduced in 2007.

2015 -2016 DRPK-UNICEF Joint Mid-Year Review priorities for IMNCI

- Procurement of IMNCI essential package for different level hospitals and clinic;
- Capacity building of MoPH officials and technical experts through exposure visit on IMNCI and MNH;
- Provision of telemedicine equipment for Pyongyang Maternity Hospital as requested;
- Provision of mobility support for monitoring of IMNCI and MNH activities in field;
- IMNCI training for all HHDs in 50 counties;
- Printing of IMNCI guidelines;
- Field trainings on community IMNCI in the planned 25 counties as per the proposal within this year immediately after the guidelines are printed.

2017 priorities at work planning stage and challenges/way forward from DRPK-UNICEF Joint Annual Review:

Priorities

- Revision of the primary IMNCI guideline and protocol, updating and upgrading it in consultation with MoPH, WHO, UNICEF and UNFPA
- Capacity building activities:
 - a) Expansion of the pool of national IMNCI master trainers
 - b) Training of the household doctors in “convergent counties” (9) and other 41 target counties

Key challenges and constraints

Enabling environment

- National IMNCI protocol is endorsed but not published
- National IMNCI guidebook is under revision of the MoPH and has not been released yet
- IMNCI programme is underfunded
-

Supply

- 1,128 household doctors in 9 convergence counties and 1,604 in 16 counties trained (totally 2,732 out of planned 3,000 in 2017)
- 70% of IMNCI trained HHD received HHD bags

Demand

- Undeveloped communication, social mobilization and raising of awareness activities in communities

Quality

- Impact of the IMNCI training programme is not studied
- Supportive supervision and IMNCI service quality improving activities are undeveloped

Way forward

- Publish IMNCI protocol integrated with SRH and Child TB
- Approve the IMNCI guideline and prepare it for Master Trainers
- Fund raising
- Continue training of HHD in the next 25 counties (planned 50 counties in 2017-2018)
- Distribute HHD bags for all trained HHD
- Develop and approve the communication, social mobilization and raising of awareness activities in communities
- Formative Evaluation of UNICEF's support to HHD
- Develop external (by national master trainers) and internal (by provincial master trainers) FUAT (Follow Up After Training) and Supportive Supervision
- Introduce iCATT in postgraduate medical education through Tele-education

2018 Joint DPRK-UNICEF Annual Review year assessment of challenges and achievements for IMNCI

- Main challenge in integration of MCH and NTP [Tuberculosis programme] Achievements including
- IMNCI protocol with Pediatric TB module printed and distributed to the counties 100%
- Refresher training of master trainers conducted on 24 July in Pyongyang, 35 master trainers trained 100%
- Availability of IMNCI protocol on national intranet: 100%
- Revision of curriculum at medical schools / colleges for inclusion of IMNCI approach: not done
- Cascade training in 25 counties completed-2510 HHDs/Pediatricians trained
- iCATT integration to the National Tele-education system for healthcare- iCATT Korean software introduction launched with central level training
- Procurement and distribution of supplies (HHD Bags/EMKs/ORS) = 50% of target
- FUAT activities done, resulting knowledge and quality service improvement among HHDs

Annex II – MoPH Terms of reference for Household Doctors, as established by in 2016

“The socialist health system of the DPRK is the people-centered health system embodying the immortal Juche Idea created by the great leader President Kim Il Sung under which the people’s health and life is valued and protected ahead of all other issues at any cost, socio-politically, institutionally and financially ensured. Our health system based on the preventive medicine is providing complete and universal free health care, under which the population without exception is leading the happy life in good health without any worries of access to the treatment.

DPRK proclaimed the enforcement of the complete and universal free medical care in the whole area of the country in the 7th session of the 2nd Supreme People's Assembly in Feb 1960, and in this very session, the household doctor system was legally declared. Household doctor system is defined and characterized as follows;

The health of the whole population in all the parts of the whole country is absolutely protected under the government, since all the residential areas are covered by the HHDs.

Preventive medicine is embodied through this system since the HHDs are focusing on the prevention of the disease occurrence/outbreak.

All the civil servants and working masses are timely accessed to the medical care even at their working places, since the residential area and the production facilities are organically interlinked. Timely specialized medical care is ensured, since the specialized medical care is outreached down to the peripheral level.

The TORs of the HHS firstly, to protect the health of the families and population in charge in accordance with the preventive medicine polity by providing health education and IEC activities on major diseases such as hypertension, cancer, respiratory diseases, diarrhoea, etc., EPI calendar-based vaccination, secondly, to conduct the medical services for the household population in charge such as medical examination, detection of the CD suspects, registration and collaboration with the secondary level hospitals for periodic intensive examination, treatment and management of the outpatients to the Ri hospitals/ clinics and family rounds (routine & ad-hoc).

In DPRK one HHD covers around 130 families; one clinic has around 3 HHDs and one Ri hospital has 6-8 HHDs, counting up to around 44760 HHDs in the country. We have 6263 policlinics and Ri clinics, 1694 city, county, Ri hospitals. The graduates from the 15 medical universities are providing the health services in the various levels of health facilities including the peripheral level. As of 2014, we have the cohort of 87780 medical [...ends]."

Annex III – Resources for inception and evaluation reports

- United Nations Children's Fund. 2015. *UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis* (<https://unicef.sharepoint.com/teams/OoR/Shared%20Documents/UNICEF%20Procedure%20on%20Ethics%20in%20Evidence%20Generation%20092015.pdf>).
- United Nations Children's Fund. 2015. *UNICEF Procedure for Quality Assurance in Research*, (<https://unicef.sharepoint.com/teams/OoR/SiteAssets/SitePages/Procedures/UNICEF%20Procedure%20for%20Quality%20Assurance%20in%20Research.pdf>).
- Graham, A., Powell, M., Taylor, N., Anderson, D. & Fitzgerald, R. 2013. *Ethical Research Involving Children*, Florence: UNICEF Office of Research-Innocenti.
- The best UNICEF evaluation reports and good practices: https://www.unicef.org/evaluation/index_60807.html
- Global Evaluation Reports Oversight System and handbook: https://www.unicef.org/evaluation/index_GEROS.html

Other useful documents:

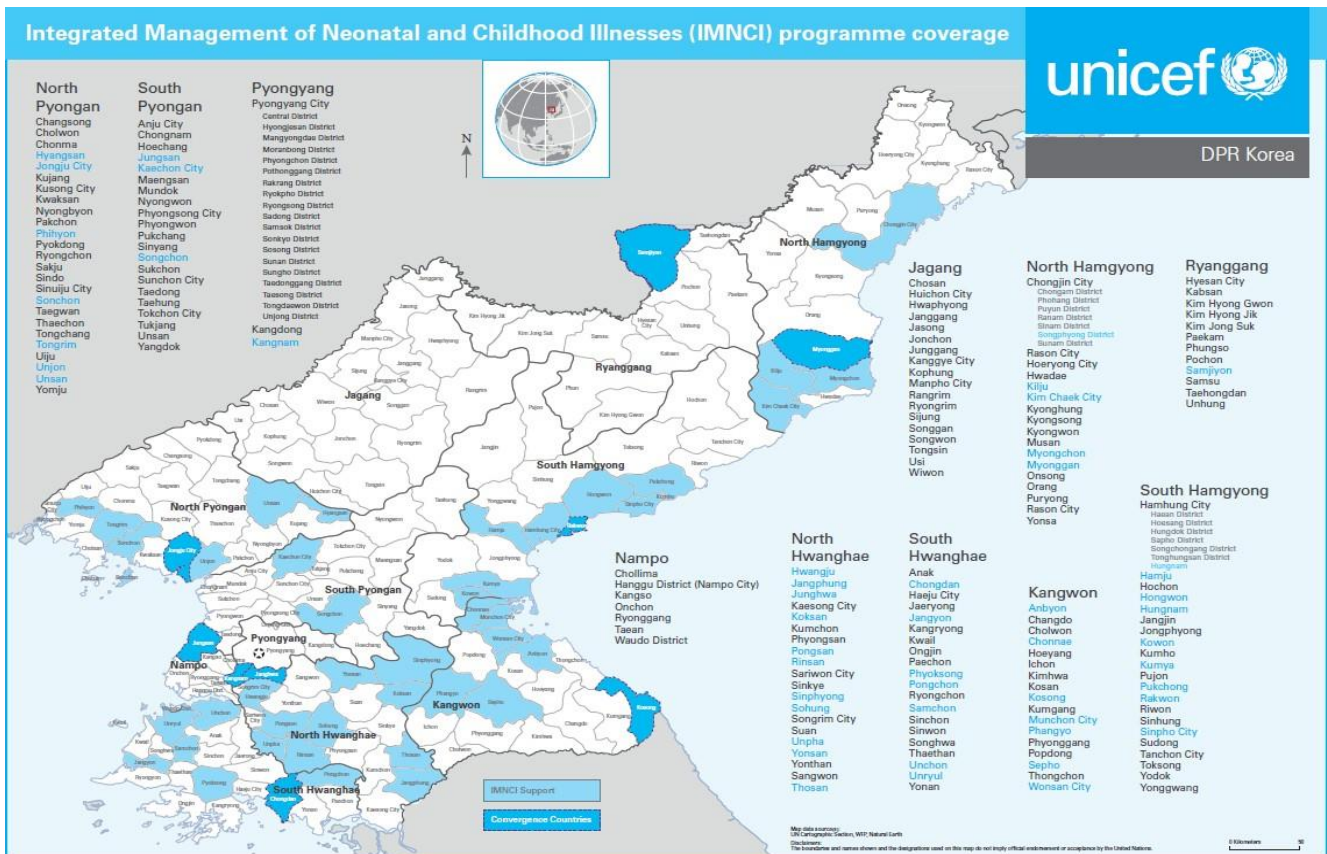
- United Nations Evaluation Group. 2008. *Ethical Guidelines for Evaluation in the UN System*, (<http://www.uneval.org/document/detail/102>).
- United Nations Evaluation Group. 2014. *Integrating Human Rights and Gender Equality in*

Evaluations,

(<http://www.uneval.org/document/detail/1616>).

- United Nations Evaluation Group. 2016. *Norms and Standards for Evaluation*, (<http://www.unevaluation.org/document/detail/1914>);
- United Nations Evaluation Group. 2018. *UN-SWAP Evaluation Performance Indicator - Technical Note and Scorecard*, (<http://www.uneval.org/document/download/2148>)

Annex IV: Map of IMNCI coverage



ANNEX 2 DOCUMENTS

DOCUMENTS RECEIVED TO DATE

UNICEF CPD

- Country Programme Document - Democratic People’s Republic of Korea. 201 – 2015 + Result Matrix + Extension decision
- Country Programme Document - Democratic People’s Republic of Korea. 2017 – 2021

CPAP

- Country Programme Action Plan between the Government of The Democratic People’s Republic Of Korea and The United Nations Children’s Fund (2011-2015) Democratic People’s Republic of Korea

COAR

- UNICEF Annual Report 2015. Democratic People's Republic of Korea
- UNICEF Annual Report 2016. Democratic People's Republic of Korea
- UNICEF Annual Report 2017. Democratic People's Republic of Korea
- UNICEF Annual Report 2018. Democratic People's Republic of Korea
- UNICEF DPRK CO Summary Report 2019 Draft 100220 Final

Management plans

- DPR Korea UNICEF Primary (community) IMNCI rolling out plan (2017), 2017
- UNICEF DPRK Rolling Biannual Management Plan 2017-2018
- UNICEF DPRK Rolling Biannual Management Plan 2019-2020
- UNICEF DPRK 2020 Annual Management Plan

Strategy note

- UNICEF-DPRK Programme Strategic Note Country Programme 2017 – 2021 (Feb 2016) ✓

Review / Evaluations

- Evaluation on IMCI in DPRK. Power Point. No date.
- DPRK – UNICEF Country Programme Cooperation 2011 – 2015. Draft Mid Term Review Report. 2013
- UNICEF DPR Korea Country Programme of Cooperation 2017-2021 Mid-Term Review Report. August 2019
- Costed Evaluation Plan 2017 – 2021
- UNICEF Country Office, Democratic People's Republic of Korea. Community-based Management of Acute Malnutrition Programme supported by UNICEF in DPR Korea 2015–2017. Evaluation Report. July 2018
- Formative Evaluation of the UNICEF WASH Programme in DPR Korea with a focus on Gravity-Feed Water Systems. 2016

IMNCI divers

- Sampling framework for the IMNCI counties. January 2020
- 93 counties before 2017 for IMCI
- DPRK IMNCI Map
- DPRK IMCI Plan 2005 – 2006. No author
- Presentation CAH Programme DPRK 2006- 2007
- DPR Korea UNICEF Primary (community) IMNCI rolling out plan (2017), 2017
- Report of Mission and Plan. SEP 2006 (Dr. Malhotra)
- Stake Holders Matrix_C_IMCI_28_Oct_08
- Hand Over Note Dr. Mohammad Younus Chief of Health. 2016

MOPH**STRATEGY / ACTION PLANS**

- Ministry of Public Health in partnership with WHO. Medium Term Strategic Plan for the Health Sector DPR KOREA. 2016 – 2020
- Every Newborn Action Plan 2016-2030 (ENAP) (2016) issued by the Ministry of Public Health DPRK
- The Democratic People's Republic of Korea National Nutrition Strategy and Action Plan (NNSAP) for Women and Children 2019 – 2023, by Ministry of Public Health DPRK
- Five Year WASH Sector Implementation Strategy in DPR Korea 2020-2040 by <no author>(2019)

Reports/presentations

- Annual Health Report, DPR Korea 2017. Ministry of Public Health. Juche 107(2018)
- Mid-Year Review Health Program DPR Korea. 18 August 2016
- Annual Review (Health). 7 December 2015. Power Point.

- Sectoral Review Health Programme 13 December 2012. Power Point.
- IMCI assessment 4 September 2006. Power Point.
- Mid Term Review Health Programme. August 2016. Power Point.
- Adaptation Site Results. Power Point. No date.
- Implementation of IMCI in DPRK. March 2008. Power Point

Guidelines

- Final Diarrhoea Guidelines DPRK. June 2005
- MOPH DPRK. IMCI Adaptation in DPRK. May 2007. Power Point.
- WHO. UNICEF. IMCI Preservice training. Global Paper. 1999
- IMCI pre-service. No date. No author.
- Supervisory Checklist for the Monitoring/Supervision of IMCI Activities. Power Point. No date.
- IMCI. No date. No author.

Survey

- MICS 2017

OTHER DEVELOPMENT PARTNERS

- United Nations, The Strategic Framework for Cooperation between the United Nations and the Government of the People's Republic of Korea 2011-2015
- United Nations, The Strategic Framework for Cooperation between the United Nations and the Government of the People's Republic of Korea 2017 – 2021
- WHO DPRK. Country Cooperation Strategies (CCS) 2014-2019

DOCUMENTS THAT WOULD BE USEFUL TO REVIEW IF AVAILABLE

DPRK Legal framework, laws on:

- DPRK Constitution
- Public Health
- Nursing and Upbringing of Children
- Prevention of Communicable Diseases
- Public Hygiene and Sanitation
- Medical protocols

National Policies and Plans:

- Medium-Term Strategic Plans for Health (MTSP) MTPS 2010-2015
- National Guidelines for maternal and child health interventions (1999)
- National Plan for Child Health Improvement (2001-2010)
- Strategy for Expansion of IMNCI (2005-2020)
- Strategy and Action Plan to control Child and Maternal Mortality (2014-2018)
- National Health Promotion strategy

MoPH reports

- Annual Health Report (only 2017 available)
- HMIS reports

UNICEF

- CPAP 2017 -2021: Annex A: Results Matrix and Annex B: Integrated Monitoring and Evaluation Plan
- CPAP 2011 -2015
- Detailed monitoring framework that shows the milestones/achievements each year per plan and the overall results
- IMNCI monitoring reports

- WHO/UNICEF JMP reports

Other development partners

- WHO Country Cooperation Strategies (CCS): 2000-2004 / 2009-2013
- UNFPA Country programmes documents for the period 2011 - 2019

Financial information

- Detailed activity budgets for the period above (2015-19)
- Detailed financial expenditure reports for each implementation period. (2015-19)
- Implementation arrangements (sub-contracts or outsource implementation?)
- National expenditure tracking for MoPH for past period

ANNEX 3 - PEOPLE INTERVIEWED

Name	Organisation
Odile Bulten	UNICEF DPRK, Deputy Representative for Programmes – since September 2018
Elena Cerdan	UNICEF DPRK, Chief of Health, March 2017 – September 2019
Ridwan Gustiana	UNICEF DPRK, Immunization programme – Ag. Chief of Health since Sept 2019 (Arrived July 2019)
Ngozi Kennedy	UNICEF DPRK Chief of Health – newly appointed, has not yet relocated to DPRK
Bakhodir Rahimov	UNICEF DPRK, Health specialist, IMNCI programme 2017-2018
Silas Rapold	UNICEF DPRK M&E Specialist, June 2017 – April 2020 (left DPRK in March)
Murat Sahin	UNICEF DPRK - WASH chief 2005-2009; Dep Rep 2016-2018 (left June 2018)
Kundur Sathyanarayana	UNFPA DPRK – Technical Specialist working with Central Bureau of Statistics
Nagi Shafik	Monitoring for UNICEF in 2017, 2018, 2019 involving intensive travel in DPRK

ANNEX 4 – EFFICIENCY ANALYSIS TABLES

Below are some of tables that will be populated to assist in the efficiency analysis – assuming that the data is available.

Funding Year	Budget	Expenditure	Variance	Percentage
2015				
2016				
2017				
2018				
2019				
			Average	

Programme area	2015	2016	2017	2018	2019
Training					
Supplies (medicines)					
Supplies (Basic equipment)					
Monitoring Systems					
Etc					
Etc					

Cost driver	2015	2016	2017	2018	2019
HR					
Utilities					
Transport					
etc					
etc					
etc					

Expenditure	2015	2016	2017	2018	2019
UNICEF level					
Central MoPH					
Regional Level					
Country level					

Efficiency Indicator	Cost (UNICEF)	Result	Attribution (%)	Attributed Outcome	Cost per result
Cost per cases averted (Pneumonia)					
Cost per cases averted (Diarrhoea)					
Cost per reduction in stunting					
Cost per HCW trained					
Cost of selected equipment					
Cost per selected medicine procured					