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Evaluation of UNICEF Zambia's Capacity Development Interventions

Inception Report

APRIL 2019

Aisalkyn Botoeva | Claude Kasonka | Hannah Ring | Varsha Ranjit

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AMERICAN INSTITUTES FOR RESEARCH®
1000 Thomas Jefferson Street NW
Washington, DC 20007-3835
202.403.5000

www.air.org

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Acronyms

AIR	American Institutes for Research
ACC	Area Coordinating Committee
CD	Capacity Development
CLTS	Community-Led Total Sanitation
CWAC	Community Welfare Assistance Committee
DHIS2	District Health Information System 2
DWAC	District Welfare Assistance Committee
EHT	Environmental Health Technicians
FGD	Focus Group Discussion
HMIS	Health Management Information System
HMISS	Health Management Information System Strengthening
ICT	Information and Communications Technology
IRB	Institutional Review Board
KII	Key Informant Interview
M&E	Monitoring and Evaluation
M2W	Mobile to Web
MCDSS	Ministry of Community Development and Social Services
MIS	Management Information System
MoCTA	Ministry of Chiefs and Traditional Affairs
MoGE	Ministry of General Education
MoH	Ministry of Health
MoLG	Ministry of Local Government
MWDSEP	Ministry of Water Development, Sanitation and Environmental Protection
ODF	Open Defecation Free
SCT	Social Cash Transfer
TaRL	Teaching at the Right Level
ToT	Training of Trainers
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
ZSHP	Zambia Sanitation and Hygiene Programme

Introduction

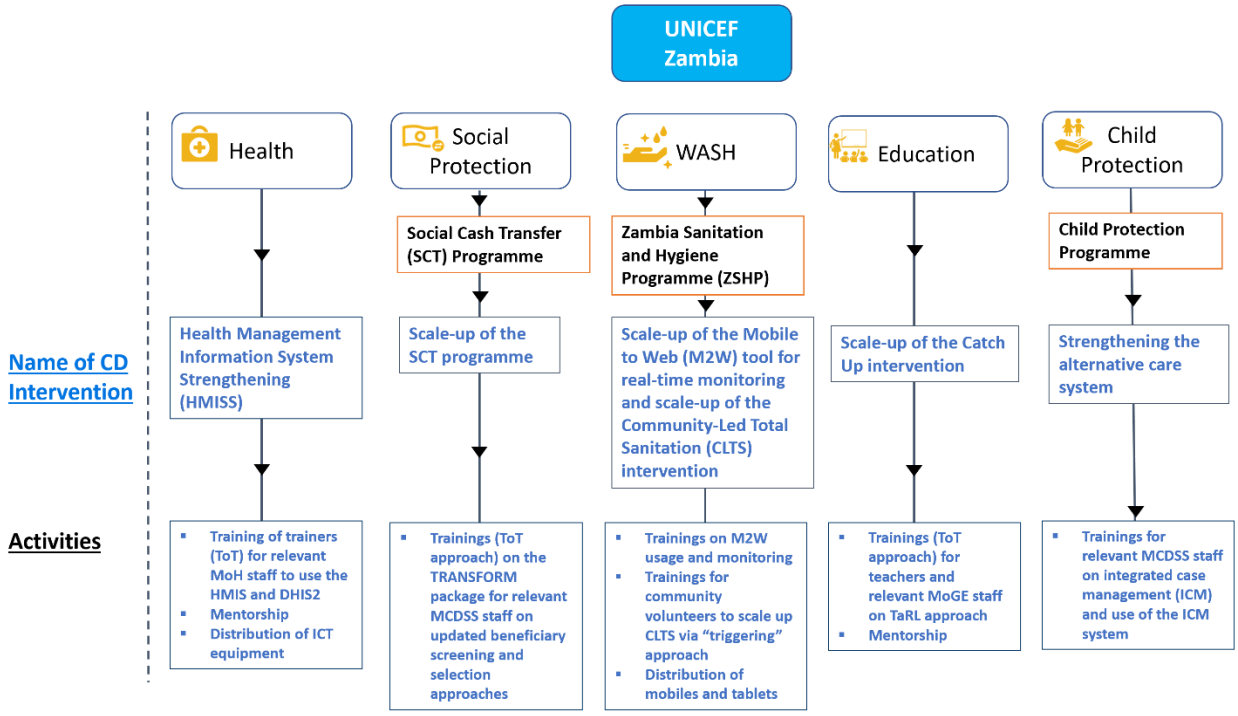
Within the last several years, UNICEF Zambia has supported numerous capacity development (CD) interventions across different programmes, in the form of trainings, professional development and community outreach activities. These CD interventions aimed to improve the capacities of government officials, relevant province/district-level officers, and community-level professionals and staff to use technology and software in a decentralized manner; to enter, clean and utilize data management systems in their decision-making; and to better serve the needs of their beneficiaries. Despite the overall positive feedback from stakeholders and participants, there is currently scarce empirical evidence on what works and whether CD interventions have led to the desired improvements in the skills and knowledge of local government officials, professionals and communities (UNICEF, 2018). Moreover, there is little evidence about the uptake and sustainability of activities.

UNICEF Zambia has contracted the American Institutes for Research (AIR) to examine the ***relevance, effectiveness, perceived impacts*** and ***sustainability*** of five CD interventions. Figure 1 provides a visual overview of the CD interventions and their components. Following the inception meeting in Lusaka with UNICEF Zambia's stakeholders (which took place on February 27, 2019), AIR and UNICEF have come to an agreement to evaluate five different CD interventions in this study. These interventions were implemented within the 2016–18 period across five sectors: ***health; social protection; water, sanitation and hygiene (WASH); education; and child protection***. UNICEF supported these interventions, reflecting a shift in focus from increasing aid to increasing investment in the capacities of local governments, national institutions and members of civil society.

AIR's research team aims to examine shared understandings of the goals and purposes of CD activities, as well as the reach and uptake of the knowledge and skills that were enhanced through those activities. Drawing on our conceptual framework, we will collect data at three levels. At the ***institutional/system level,*** we will explore how trainings delivered to officers and employees of relevant ministries have contributed to improved capacities in allocating and managing resources, using new technology/software and coordinating systematic adoption of new skills by other stakeholders in the lower chains of command. At the ***province/district level***, we will examine how trainings may have led to improvements in the capacities of relevant employees and staff to manage information systems, enter and clean data, and use improved data management systems. Finally, at the ***community level***, we will explore whether training participants (e.g., health committee members, members of the Community Welfare Assistance Committee [CWAC]) have a shared understanding of the goals of the trainings, and whether those

trainings improved theircapacities to perform their tasks and deliver services to the end beneficiaries.

Figure 1: Overview of CD Interventions Included in the Study



The study will collect and use data from a desk review, 51 key informant interviews (KIIs) and nine focus group discussions (FGDs). We will be collecting data within three provinces: Copperbelt, Eastern and Southern.

*To ensure systematic evaluation, we propose gathering data at the **institution/system** level and at the **province/district** and **community** levels.*

*Our methodological toolkit will include a desk review; **51 key informant interviews** (KIIs) with UNICEF programme officers, CD intervention implementers and relevant participants at the province/district and community levels; and **nine focus group discussions (FGDs)** with community-level stakeholders, including the beneficiaries who are at the receiving end of services.*

In this inception report, we: 1) discuss existing literature on best practices in evaluating capacity-building activities; 2) describe the five selected CD interventions and the context for this evaluation; 3) present our conceptual framework; 4) discuss the research design, including research questions, methodology, data collection methods and sampling approach; 5) discuss how we will ensure the protection of human subjects; and 6) provide a work plan for the study.

Literature Review and Background

Existing Approaches to Studying Capacity Development

Capacity can be defined as "the ability to carry out stated objectives" (LaFond and Brown 2003, p. 3; Goodman et al., 1998). LaFond and Brown (2003) define ***capacity development*** or capacity building as a "process that improves the ability of a person, group, organization or system to meet objectives or to perform better" (p. 5). They explain that ***evaluating capacity development*** is "normally more complex than monitoring and is conducted to gain understanding of the relationship between capacity-building interventions and capacity outcomes, or the links between capacity and performance variables" (LaFond & Brown, 2003, p. 5).

In the last two decades, actors in the international development sector have increasingly recognized that delivering foreign aid without investing in the capacities of local governments, policymakers, national institutions and civil society organizations, as well as communities and individuals, is less likely to lead to sustainable and effective outcomes (World Bank, 2006). The United Nations General Assembly (UNGA) has also emphasized that capacity development is one of the key strategies to achieve broader Millennium Development Goals. UNGA has called upon United Nations organizations to "provide further support to the efforts of developing countries to establish and/or maintain effective national institutions and to support the implementation and, as necessary, the devising of national strategies for capacity building" (UNICEF, 2010, p.2).

Despite the enthusiasm around CD interventions, scholars and international development researchers caution that not all capacity development leads to the desired outcomes and sustainable results. First, if CD interventions only focus on formal policies and legislation, they may not lead to effective enforcement and significant changes for the end beneficiaries (Mittler, 2005; Peters, 2007). Second, programming to build up staff capabilities may not lead to uptake and scale-up (Akerberg, 2001; Organisation for Economic Co-operation and Development [OECD], 1991). Third, not all existing CD interventions account for local culture and local interests as much as they should (Kalyanpur, 1996; Chaudhry & Owen, 2005). Finally, some CD interventions have not proven sustainable and have dissipated with the loss of international consultants and turnover of local staff (Kisanji, 1998).

). Ideally, monitoring and evaluation (M&E) is incorporated within CD interventions (when there are sufficient resources), so that researchers can help donors and stakeholders to explore: 1) ***the process***, or how CD interventions have been implemented; 2) ***the missing parts***, or what else needs to happen to ensure better performance; and 3) ***the outcomes,*** or whether various interventions have led to the desired outcomes and improved capabilities.

Ensuring that CD interventions can be properly monitored and evaluated ideally begins at the planning stage and includes input from stakeholders who are involved in the CD intervention. As researchers and stakeholders embark on an evaluation, it is necessary to clarify who needs to use the M&E data, recognizing that different sets of actors will use the findings for different purposes. In the case of evaluating UNICEF CD interventions across several programmes, evaluation findings are important for UNICEF and other donors, non-governmental organizations, ministries and sub-national government agencies.

Selecting CD Interventions for the Evaluation

The Learning Network on Capacity Development advises that the starting point for any evaluation of capacity-building activities is to clarify the purpose of CD interventions (Pearson, 2011). Clearly defining the purpose of interventions helps researchers to identify the key questions that need to be answered. During our inception visit, we discussed the broader scope of CD interventions within UNICEF and the goals UNICEF wanted to accomplish at the outset through these interventions. After the inception visit, we received a document that mapped various interventions that took place in Zambia during the 2014–18 period.

Drawing from the literature review and UNICEF Zambia's original terms of reference, our team communicated a set of criteria for selecting the CD interventions for the evaluation:

- Interventions that involved stakeholders at different levels, ranging from national stakeholders to province/district stakeholders and community members
- Interventions that were implemented within the 2016–18 period
- Mature interventions
- Interventions that incorporated more than one activity, such as trainings and a technology dimension

Based on these criteria, AIR and UNICEF Zambia agreed to evaluate CD interventions across the following five programmes: 1) ***health*** – the Health Management Information System Strengthening (HMISS) intervention; 2) ***social protection*** – scale-up of the Social Cash Transfer (SCT) programme; 3) ***WASH*** – scale-up of the Mobile to Web (M2W) tool for real-time monitoring, and scale-up of the Community-Led Total Sanitation (CLTS) intervention; 4) ***education*** – scale-up of the Catch Up intervention; and 5) ***child protection*** – strengthening the alternative care system through improved case management of vulnerable children and adolescents.

Background Information on the Five CD Interventions

Health: Capacity development in use of the Health Management Information System and the District Health Information System

The health sector in Zambia previously lacked a decentralized, accessible and well-coordinated Health Management Information System (HMIS) that would allow stakeholders at different levels to use up-to-date information from end users in their decision-making. Furthermore, the existing District Health Information System (DHIS2) was under-utilized: data were missing for most districts and facilities; central health officers could not access the system and make use of it; and province- and district-level health information officers faced challenges entering and using information from the HMIS, instead spending most of their time on data entry and visualization (Akros, 2016). Additionally, facility-level and community-level health workers and environmental health technicians (EHTs) lacked access to computers and the necessary skills to digitally enter data and then use the information to facilitate their work (Akros, 2016).

To tackle these challenges—and to meet the goals of enhancing the functionality and effectiveness of the HMIS in order to provide quality information to improve maternal, newborn, child and adolescent survival, health and nutrition services—UNICEF Zambia and its technical partner, Akros, rolled out the HMISS intervention (Akros, 2018). HMISS included on-the-job training for central health officers and officers from the M&E Unit at the Ministry of Health (MoH) to improve their skills in cleaning HMIS data and to provide system-level support. Province-level senior health information officers and district-level health information officers also received trainings on data entry and ways to scrutinize data, troubleshoot the system and conduct real-time monitoring and data analysis (Akros, 2018). Finally, facility-level staff, community health workers and EHTs received trainings on DHIS2 data entry so that they would be able to enter and use data in their decision-making.

Social protection: Capacity development in beneficiary targeting and selection for scale-up of the SCT programme

UNICEF Zambia has continuously scaled up its flagship SCT programme since 2011 to achieve nationwide coverage. One of the challenges that implementers faced was instituting a beneficiary selection strategy to avoid restrictive coverage and low impact. UNICEF and the government of Zambia recognized that the SCT programme needed to improve beneficiary targeting, moving from a focus on poverty to a focus on rights and an evidence-based approach (Freeland, 2017; UNICEF, 2018). As a result, UNICEF and the Ministry of Community Development and Social Services (MCDSS) implemented a scale-up of the SCT programme in 2017, using a CD intervention that aimed to develop the capabilities of relevant employees and

staff to appropriately screen, select and enrol individuals based on key life-course vulnerabilities (Freeland, 2018).

The intervention included trainings on TRANSFORM for officials from the MCDSS SCT Unit, as well as officers from the MCDSS M&E Unit. TRANSFORM is an innovative learning package on administering national social protection floors in Africa. At the province/district level, this package also included trainings for district officials, district social welfare officers, and members of the District Welfare Assistance Committee (DWAC) and the Area Coordinating Committee (ACC) (UNICEF, 2018). Finally, at the community level, members of the CWAC received trainings to better understand the SCT programme, including payments, the management information system, case management and eligibility criteria for beneficiaries. The trainings were also expected to increase CWAC members' awareness about their role in community validation and information delivery to beneficiary households.

WASH: Capacity development in use of the Mobile to Web tool to improve real-time monitoring, and in community sensitization for scale-up of the Community-Led Total Sanitation intervention

Accurate monitoring of sanitation and hygiene interventions requires precise and timely data. The Zambia Sanitation and Hygiene Programme (ZSHP) initially used a paper-based system, which led to slow data processing and transcription errors and caused significant delays in data transfers from community to central levels. To address these challenges and enable real-time monitoring, UNICEF and its technical partner, Akros, launched an innovative approach through the Ministry of Local Government (MoLG) called the M2W system to digitize monitoring of hygiene and sanitation interventions (UNICEF, 2017b). The M2W system uses mobile phones with simple protocols for reporting and analysis and is coded in the DHIS2. To meet its target of making Zambia open defecation free (ODF) and ensuring that 60% of the population has access to improved sanitation by 2020, the ZSHP also included CLTS activities to mobilize communities to adapt hand-washing practices and eliminate open defecation (UNICEF, 2017b).

The CD intervention included trainings on using the M2W tool for officials from several ministries, including MoLG, MoH, the Ministry of Chiefs and Traditional Affairs (MoCTA) and the Ministry of Water Development, Sanitation and Environment (MWDSEP) (UNICEF, 2017b). At the province/district level, relevant government officials and members of the health promotion team from the District Community Medical Office, among others, received trainings on real-time monitoring and managing the information system. At the community level, chiefs, village headmen and headwomen, community champions (volunteers) and members of Sanitation Action Groups received trainings on M2W data entry and on community triggering (sensitizing and monitoring communities on their sanitation and hygiene practices).

Education: Capacity development in the Teaching at the Right Level approach for scale-up of the Catch Up intervention

UNICEF and the Ministry of General Education (MoGE) have collaborated over the years to tackle low numeracy and literacy rates in the country. To contribute to these efforts, the Catch Up intervention—one of the latest CD interventions supported by UNICEF—uses the Teaching at the Right Level (TaRL) approach. The goal of this intervention is to improve teachers' skills in teaching students at their individual level, grouping children by their ability rather than by age and grade, thereby gradually improving children's learning outcomes (Innovations for Poverty Action [IPA], 2016, TaRL, 2019).

In 2018, MoGE used the Catch Up intervention to provide trainings and mentorship activities for teachers (head teachers, deputy head teachers, senior teachers) and to build the capacity of MoGE staff at the national, provincial, district and school level (IPA,2016). As this intervention is ongoing, MoGE's zonal in-service coordinators are being trained as mentors and MoGE district-level staff are being trained as master trainers.

Child protection: Capacity development to improve integrated case management to strengthen the alternative care system

UNICEF's child protection programme supports the government of Zambia in developing a strong child protection system to provide prevention services and adequate responses to vulnerable children and adolescents (UNICEF, 2019). One of the programme's key areas is strengthening integrated case management (ICM) for child and family welfare and strengthening the alternative care system (UNICEF, 2017a). Stakeholders conceived ICM as a tool for providing services to vulnerable communities, in order to avoid inadequate and intrusive approaches that do not holistically meet the needs of vulnerable families (UNICEF, 2017a, SOS Children's Villages International, 2013). The ICM model recognizes that the rights and needs of children who face multiple risks are best addressed within a coordinated and integrated approach (UNICEF Zambia, 2019).

The intervention that aimed to strengthen the alternative care system was facilitated by UNICEF. The goal was to support MCDSS to implement the alternative care regulatory framework at the national level, through a strengthened ICM, for vulnerable children and adolescents who have been and are at risk of being separated from their families.

Table 1: Summary of CD Interventions

CD Interventions	Activities by Level	Target Audience	Geographic Scope
Health: ***Health Management Information System Strengthening***	**Institutional/system:** On-the-job training on cleaning HIMS data, and system support	• Central health officers, MoH • Officers from the M&E Unit	Two provinces: Lusaka and Copperbelt 11 districts
	Province/district level: Training of trainers (ToT) on data entry and ways to scrutinize data, troubleshoot the system and conduct real-time monitoring and data analysis	• Province-level senior health information officers • District health information officers	
	Community level: Trainings on DHIS2 data entry and using data for decision-making	• Facility-level staff • Community-level health workers • EHTs	
Social protection: ***Technical support to develop and expand the government's cash transfer system (beneficiary selection)***	**Institutional/system:** Training on the TRANSFORM package's modules, including selection and identification of beneficiaries, and on the SCT MIS	• Officials from the MCDSS SCT Unit • MCDSS M&E Unit officers	Across all provinces; 115 districts
	Province/district level: ToTs on data selection and enrolment	• Master trainers, district government officials • District social welfare officers • Members of DWAC • Members of ACC, assistant district officers	
	Community level: Trainings on DHIS2 data entry and using data for decision-making	• Members of CWAC • Chair of CWAC • Secretary of CWAC, beneficiaries of the SCT programme • Enumerators	
WASH: ***Scale-up of the M2W tool for real-time***	**Institutional/system:** Trainings and technology updates at the ministry level	• Officials from MoLG, MoH, MoCTA and MWDSEP	Nine provinces, 72 districts

CD Interventions	Activities by Level	Target Audience	Geographic Scope
monitoring of WASH interventions, and scale-up of the CLTS intervention	**Province/district level:** Trainings conducted by MoLG to build local-level WASH capacity in real-time monitoring and MIS management MoCTA staff support the CD intervention through mass ODF verification and chiefdom triggering Chiefs empowered to view reports, charts and maps	• Province-level officials from the above four ministries • Rural Water Supply and Sanitation (RWSS) focal person • Members of the health promotion team from the District Community Medical Office	
	Community level: Trainings on M2W data entry, DHIS2 data entry and community triggering Training on sensitizing and monitoring villages	• EHTs • Chiefs, village headmen or headwomen • Community champions/community volunteers, Sanitation Action Groups	
Education: ***Scale-up of the Catch Up intervention using the TaRL approach***	**Institutional/system:** Trainings on the TaRL methodology through the teacher-led model of the Catch Up intervention	• MoGE staff at the national level	Two provinces, 22 districts
	Province/district level: Trainings on the TaRL methodology through the teacher-led model of the Catch Up intervention	• Zonal in-service coordinators trained as mentors • District staff trained as master trainers	
	Community level: Trainings on the TaRL methodology through the teacher-led model of the Catch Up intervention	• Deputy head teachers • Head teachers • Senior teachers trained as mentors • Teachers	
Child protection: ***Strengthening the alternative care system***	**Institutional/system:** Support and trainings on improving use of the ICM system	• National-level MCDSS staff and UNICEF child protection officers	Lusaka city

Conceptual Framework

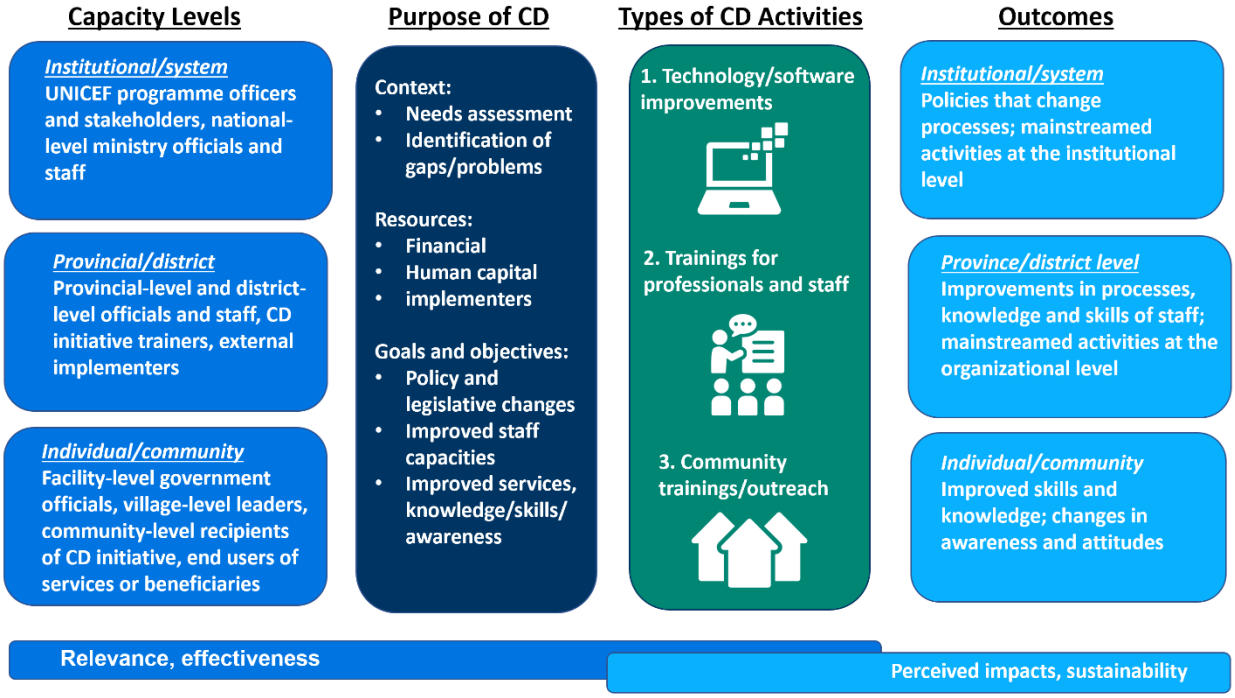
Drawing on the literature and a review of the initial materials provided by UNICEF Zambia programme officers, we developed a conceptual framework that will guide this study. The conceptual framework broadly maps out different moving parts of the CD interventions, but also specifies what kind of information we will gather in the data collection stage. Figure 2 shows the broader conceptual framework for the evaluation, incorporating our understanding of the different levels of CD that UNICEF Zambia programmes sought to build, how and why CD interventions were designed, activities that were incorporated into CD interventions across programmes of interest, and whether outcomes at different levels have materialized. We provide more detailed descriptions of the conceptual framework below.

Capacity levels: The first column illustrates the three levels at which CD interventions are typically implemented (Brown, LaFond, & Macintyre, 2001):

1. *The institutional or system level:* Desired outcomes may include changing the policies that guide delivery of services, coordinating different types of agencies (public and private) and improving capacities in allocating and managing resources.
2. *Organizational capacities:* This study looks at provincial and district-level organizational capacities because these organizations link central organizations (such as national ministries) with organizations at the community level (such as community health facilities). Desired outcomes may include changing planning strategies and improving financial management, information management, logistics systems, communication networks and human resource management.
3. *The individual or community level:* Desired outcomes may include changes in behaviour—for example, early recognition of illness and choosing to go through an examination to detect illness; improved capacity of health centre management committees; or improved capabilities to lobby decision-makers and mobilize around advocacy.

Materials submitted by UNICEF Zambia programme officers showed that all of the CD interventions included in this study targeted these three levels.

Figure 2: Conceptual Framework



Why CD? The second column in the framework relates to how and why CD interventions came about, and who and what motivated and enabled CD implementation (Milstein & Cotton, 2000; Preskill & Boyle, 2008). Organizations may decide to implement capacity building either because of internal consensus among employees and stakeholders about existing needs, or because of external factors such as requirements by funders. Preskill and Boyle (2008) highlight that at the evaluation stage, it is important to consider the following:

1. Content that determined the needs and motivation for CD interventions. This includes looking at the assumptions and expectations of different stakeholders.
2. Resources that were dedicated to CD interventions (including financial resources and human resources), and who designed and implemented CD activities.
3. Goals and objectives for each CD intervention at the outset. Goals may include different stakeholders' understandings of what they wanted to achieve or get out of participating in CD activities.

CD activities: The third column is based on our review of the existing materials for relevant CD interventions. Across all five programmes, the most common activities included:

1. Trainings for staff employees and other stakeholders to better use technology/software
2. Trainings for professionals and staff
3. Community-level trainings/outreach activities

To understand these activities, we will look at how these CD activities took place, including: a) the ***strategies*** for capacity development (e.g., management skills, analytical skills, knowledge of a new technology or software); b) the ***substance and content*** of CD activities (e.g., materials that were used, sources); c) the ***delivery methods*** used for various activities (e.g., training of trainers [ToT], participatory methods); and d) the ***regularity*** **and** ***length*** of activities. All of these factors are important both for descriptive purposes and because they mediate effects on outcomes (Durlak & DuPre, 2008; Rapkin & Trickett, 2005).

Outcomes: The fourth column describes how outcomes may differ across different levels. At the institutional/system level, outcomes may include changes in policy and mainstreaming of the broader processes (Boyle, Lemaire, & Rist, 1999; Preskill & Boyle, 2008). At the province/district organizational level, outcomes may include changes in work procedures and how everything is arranged, and improved knowledge and skills of professionals and staff. Finally, at the community/individual level, outcomes may include improved attitudes, knowledge and skills, as evidenced by behaviours such as engaging in certain activities, facilitating a smoother delivery of services to end users, and improved communication with end users (Duffy & Wandersman, 2007; Owen, 2003; Preskill & Boyle, 2008).

Development Assistance Committee (DAC) criteria: The framework also illustrates how we will assess the relevance, effectiveness, perceived impacts and sustainability of the CD interventions in our study (final row, Figure 2). While relevance and effectiveness research questions are important for examining how and why CD interventions came about and which levels they targeted, perceived impact and sustainability research questions are important when looking at specific interventions and their outcomes.

Research Design

Research Questions

The study will be guided by the following research questions.

1. *Relevance:*
   a. To what extent were capacity development activities aligned with the broader UNICEF global and regional priorities?
   b. What were the desired outcomes that CD interventions aimed to achieve?
   c. How did the implementing partners adapt interventions to the local socio-cultural, political and economic context within Zambia?
   d. Were the CD interventions and methods appropriate given the needs of staff and community members who participated in the trainings?
   e. How did CD interventions target individuals and organizations?

2. *Effectiveness:*
    a. To what extent have intended outcomes been achieved through selected CD interventions?
    b. Were there practices or approaches within CD interventions that proved to work consistently?
    c. What factors facilitated or inhibited CD interventions attaining their desired outcomes?
3. *Perceived impacts:*
    a. How do participating individuals, organizations and institutions perceive the impact on their knowledge/skills and capabilities to use technology/software?
    b. How do participating individuals, organizations and institutions perceive the impact on their knowledge/skills and capabilities to carry out their short-term tasks and long-term strategies?
    c. Did CD interventions lead to perceived changes in individual behaviour or practices?
    d. Did CD interventions result in perceptions that individuals, organizations and institutions improved delivery of specific services to end users?
4. *Sustainability:*
    a. Have other organizations allocated resources or made efforts to continue or begin implementing similar CD interventions?
    b. What measures are in place to ensure that the skills, knowledge, and technology built through the CD intervention(s) are retained and passed on?
    c. Have individuals, organizations and institutions continued using the skills, knowledge and technology they received through CD interventions?

Research Methodology

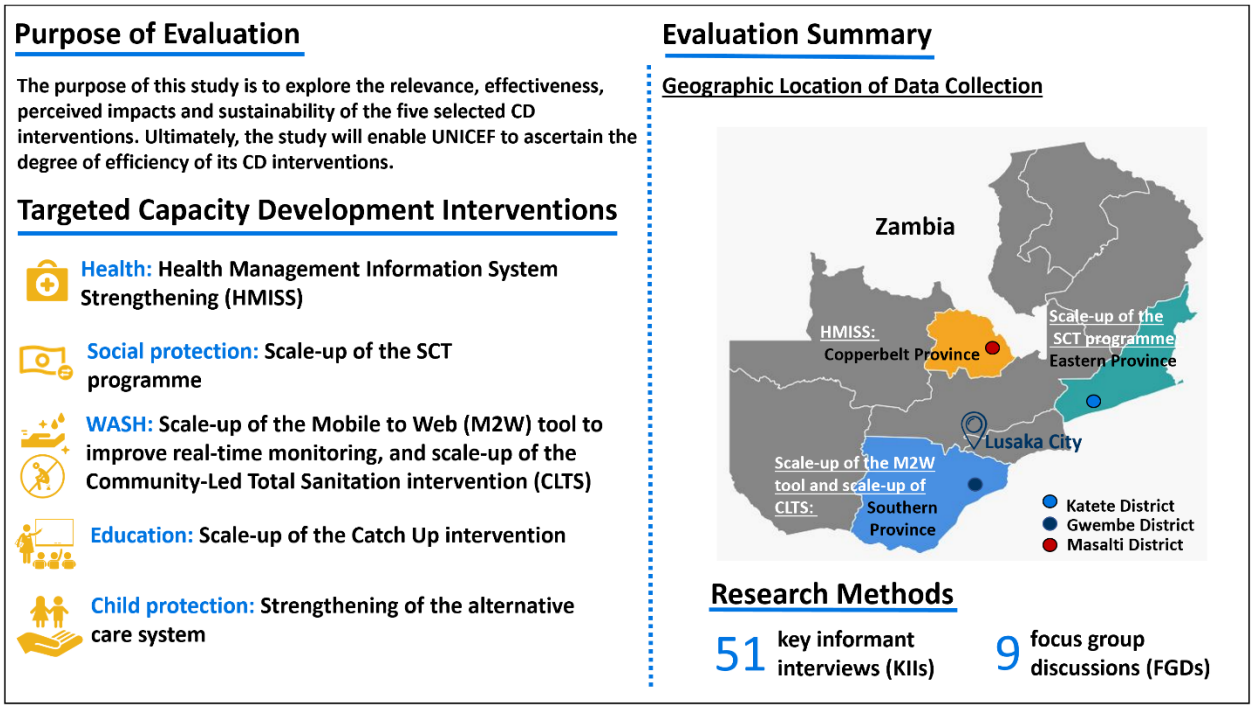
We will use qualitative methods to examine the relevance, effectiveness, perceived impacts and sustainability of five CD interventions. In addition to a desk review of all the relevant materials, we will conduct 51 KIIs and nine FGDs at the institutional/system, province/district and community levels. While the institution/system-level interviews will all happen in Lusaka, other KIIs and FGDs will happen in three provinces: Copperbelt, Eastern and Southern. We discuss our selection of these locations in the "District Selection and Sampling Approach" section of this report.

Given the study's research questions, we are primarily interested in examining how ***the process of designing*** a CD intervention was arranged, ***how those activities were implemented*** and whether they ***led to specific changes***. A qualitative approach is useful for investigating the ***how*** of project implementation because of its exploratory and discursive nature. Qualitative methods are particularly well suited for evaluations of capacity development activities and strategies for the following reasons (Patton, 2012, p. 195):

1. Depicting processes requires detailed descriptions of what happens and how people engage with one another.
2. People's experiences of processes typically vary in important ways, so respondents' experiences and perceptions of their experiences need to be captured in their own words.
3. The process of any project implementation is fluid and dynamic, so it cannot be fairly summarized on a single rating scale at one point in time.

Qualitative data collection is also well suited for studies like ours because it enables researchers to explore formal activities and anticipated outcomes, as well as informal patterns and unanticipated interactions (Patton, 2012). Qualitative data give the researcher flexibility to explore unforeseen areas of interest in order to understand where elements of programme implementation may have affected impacts. The qualitative methods of data collection will help us illuminate strengths and challenges associated with implementing an intervention, as well as how beneficiaries experience the programme and translate lessons learned into practice. Figure 3 provides an overview of the evaluation. Below, we discuss each of the methods and the sampling frame and approaches.

Figure 3: Evaluation and Research Design Overview



Institutional/system level: Interviews with UNICEF programme officers and government stakeholders, including relevant ministry representatives, will provide information on how CD interventions (such as technology/software improvements, trainings of staff and community outreaches) were conceived and designed. These interviews will contribute to our understanding

of how central government stakeholders defined existing needs, and how they partnered with UNICEF and other donors to select priority areas, as well as organizations and individuals to be targeted. These interviews will all be conducted in Lusaka.

Province/district level: Interviews with officials and staff members who participated in trainings, as well as implementers of CD interventions, will inform our understanding of how the CD interventions were rolled out and whether newly acquired knowledge and skills gained through trainings are being used in practice. They will also contribute to our understanding of how ToTs were delivered, what approaches were used in trainings on new technology/software, what specific types of skills and knowledge were expected to be improved and what outcomes were achieved. The interviews will be held in three different provinces. Figure 3 details targeted province and district locations for each of the CD interventions.

Community level: FGDs with training participants and end users of services will allow us to explore perceived gains from the CD activities, as well as perceptions about changes in behaviours, skillsets, knowledge, data use and decision-making capacities among local stakeholders. They will also help us explore individual and community experiences with service delivery and mechanisms through which changes have occurred as a result of CD interventions, as well as unanticipated outcomes and consequences associated with the programme. Table 2 reviews the levels that will be targeted for all the CD interventions.

Table 2: CD Interventions and Data Collection Levels

	Health: HMISS	Social Protection: Scale-Up of the SCT Programme	WASH: Scale-Up of the M2W Tool and CLTS Intervention	Education: Scale-Up of the Catch-Up Intervention	Child Protection: Strengthened Alternative Care System
Institution/system level	✓	✓	✓	✓	✓
Province/district level	✓	✓	✓	✓	✓
Community level	✓	✓	✓		

Data Collection Methods

AIR will use a qualitative approach in this study, relying on KIIs and FGDs in particular.

Key informant interviews: For the purposes of this study, a key informant is a person who possesses comprehensive knowledge about the scope and processes of the targeted CD interventions. The team will conduct KIIs with national-level, provincial-level and district-level officials from MoH, MCDSS, MoLG, MoCTA and MWDSEP, as well as members of DWAC, members of ACC, the RWSS focal person, master trainers and external implementers of the HMISS and SCT interventions. These respondents will shed light on the structure, inputs, challenges and implementation of the interventions.

Focus group discussions: FGDs create an environment in which participants feel comfortable and empowered to discuss the study topics with their peers and carefully trained facilitators. We will create a social dynamic that encourages participants to reflect upon their opinions and experiences and express them verbally. Based on past experience, we expect to benefit from synergies in which contributions from participants inspire other participants to think about and discuss their own experiences. FGDs will help to facilitate a deeper understanding of the usefulness and impact of particular CD interventions. The team will conduct FGDs with heads of communities, members of community-based volunteer committees and groups, and beneficiaries.

District Selection and Sampling Approach

The scope of our study does not allow random sampling, so we will instead use a combination of ***purposeful and convenience sampling*** approaches, driven both by theory and the geographic scope of CD interventions. Since each intervention differs in terms of the number of stakeholders involved and the geographic scope, the number of respondents for each intervention varies slightly. However, we believe that the numbers we have allocated for each CD intervention and each data collection method will allow us to reach saturation, obtaining rich information from each category of respondent, and gathering only limited new information from each additional respondent. Using a qualitative approach requires sacrifices in terms of generalizability and comparability, and a small sample size (often non-randomized and ***purposively*** selected to allow researchers to explore and understand the experiences, opinions and perspectives of their informants in greater depth). Anthropologist Russell Bernard (2011) notes that "there is growing evidence that 10–20 knowledgeable people are enough to uncover and understand the core categories in any well-defined cultural domain or study of lived experience" (p. 154). Our selection of provinces and districts is based on ***convenience*** sampling, defined by Etikan, Musa and Rukayya (2016) as "a type of nonprobability or non-random sampling where members of the target population meet certain practical criteria, such as easy accessibility, geographical proximity, availability at a given time or the willingness to participate" (p. 2).

All of *the* ***institution/system-level*** interviews will happen in Lusaka, since all of the ministries and key government offices are based there. Our team will conduct interviews with key actors at the institutional level across all five CD interventions, using purposive sampling. In other words, based on our knowledge of who participated in trainings, we will select participants who are most relevant at the institution/system level—for example, central health officers and M&E Unit officers at MoH. We have also selected three provinces to collect data at the ***province/district level*** and ***community level*** for the three key CD interventions, using a combination of purposive and convenience sample approaches. We have tentatively selected Copperbelt, Eastern and Southern provinces, based on our theoretically informed understanding that provinces and districts that are further away from financial and administrative centres like Lusaka are more likely to face challenges with accountability mechanisms, management of resources and systems, and growing their local staff's capabilities.

In order to avoid collecting data in provinces and districts that are next to the capital city or administrative centres, we suggest the following locations. We will collect data for the HMISS CD intervention in ***Copperbelt province***, and within it ***Masaiti district***. Copperbelt was one of the two provinces where this CD intervention was implemented. We will collect data for the scale-up of the SCT programme in ***Eastern province***, and within it ***Katete district***. We will collect data for the ZSHP programme in ***Southern province***, and within it ***Gwembe district***. As mentioned above, our selection of districts that are some distance away from (but still in the vicinity of) administrative centres is partly based on a convenience sampling approach. This approach will allow the research team to collect data efficiently, in terms of time and money spent on travel. Table 3 summarises our sample for each CD intervention.

Table 3: Sample for Each CD Intervention

Levels/Entry Points	Method and Number of Respondents
Health—Health Management Information System Strengthening	
Institution/system level:	
UNICEF programme officers	1 KII
Central health officers, MoH	2 KII
M&E Unit officers	2 KIIs
Implementers (Akros)	1 KII
Province/district levels:	
Province-level senior health information officers	2 KIIs
District health information officers	2 KIIs
Community level:	
Facility-level staff	2 KII
Community-level health workers	2 KII
EHTs	1 FGD
Beneficiaries receiving services from health workers and EHTs	2 FGDs
Social protection—technical support to develop and expand the government's cash transfer system (beneficiary selection)	
Institutional/system:	
UNICEF programme officers	1 KII
Officials from the SCT Unit, MCDSS	2 KIIs
M&E Unit officers	2 KII
Province/district level:	
Master trainers, district government officials	1 KII
District social welfare officers	2 KII
Members of DWAC	2 KIIs
Members of ACC or assistant district officers	1 KII
Community level:	
Members of CWAC	2 KIIs
Chair of CWAC	1 KII
Secretary of CWAC	1 KII
Enumerators	1 FGD
Beneficiaries receiving SCTs	2 FGDs

Levels/Entry Points	Method and Number of Respondents
WASH—M2W for real-time monitoring of WASH interventions and CLTS	
Institutional/system:	
UNICEF programme officers	1 KII
MoLG	1 KII
MoH	1 KII
MoCTA	1 KII
MWDSEP	1 KII
Implementing partners	1 KII
Province/district level:	
Province-level officials who received training	3 KIIs
RWSS focal person	1 KII
Members of the health promotion team from the district community	
Medical Office	2 KIIs
Community level:	
EHTs	2 KIIs
Chiefs	2 KIIs
Village headmen or headwomen	1 KIIs
Community champions/community volunteers	1 FGD
Beneficiaries who receive CLTS services	2 FGDs
Education—Catch Up using TaRL approach	
UNICEF programme officers	1 KII
MoGE	2 KIIs
Child protection—strengthening the alternative care system	
UNICEF programme officers	1 KII
MCDSS	2 KIIs
Total:	**51 KIIs** **9 FGDs**

Qualitative Analysis

AIR's research team will audio-record all KIIs and FGDs, some of which will be in English (in Lusaka) and some of which will be in the local language. We will then transcribe and translate all the data into English. Transcripts and relevant documents will be uploaded to and analysed using the qualitative data analysis software NVivo. The coding process will begin with the development of a preliminary coding outline, based on the research questions, interview protocols and themes that emerge during data collection. This coding outline will serve as a tool for organizing and

subsequently analysing the information gathered in the qualitative work. A list of definitions for the codes accompanies the outline so that coders categorize data using the same standards.

Using these coded data and themes identified through the desk review and KII and FGD findings, the team will identify and refine themes, categories and theories that emerge from the qualitative data and either confirm or refute the researchers' initial impressions. During this iterative process of data analysis, reduction and synthesis, researchers will characterize the prevalence of responses, examine differences among groups, and identify key findings and themes related to the research questions. Researchers will also create concepts and categories based on the data and refine these concepts as the data analysis progresses to eventually inform the overall findings. Because multiple researchers will be analysing the data, we will periodically conduct interrater reliability testing using NVivo to ensure validity and reliability in our analyses, in addition to qualitative comparisons of coding across coders. Testing validity and reliability is a crucial step to ensure that researchers have a similar understanding of the codes, which allows the coding and analysis process to function similarly across researchers. Following our analysis of the KII and FGD transcripts and official documents, we will create and analyse summaries of our key findings and consider these analyses in light of the findings from other data sources.

Ethical Considerations

AIR conducts rigorous ethical reviews through our Institutional Review Board (IRB) for all of our own internal research activities and provides this service for a variety of subcontractors and collaborators. AIR's IRB has conducted expedited and full board reviews of research involving human subjects for more than 25 years. AIR is registered with the Office of Human Research Protection as a research institution and conducts research under its own Federalwide Assurance. We will obtain approval from the AIR IRB and from the Zambian ethical review board prior to commencing data collection. The following paragraphs outline how we will obtain consent and maintain confidentiality.

Consent

We will inform participants that the information they share is confidential. We will also inform them that their participation is voluntary, and that they can end their participation at any time or skip any questions they do not wish to answer. We will obtain informed verbal consent from each participant after reading the consent form aloud and ensuring that the participant has understood. The informed consent procedures will comply with both the local and AIR's consent requirements.

Assurances of Confidentiality

AIR handles all data in accordance with the procedures and protocols approved by our IRB. Standard practices include digital recording, transcription and translation where necessary, complete anonymization of data and protection of confidentiality.

The study will protect confidentiality using a number of methods. First, all staff members will be trained and certified in ethical conduct of research. Second, we will not identify any individual by name in any report or publication about this study. We will also not share specific information about an individual with anyone outside the research team. We have developed data-handling procedures to safeguard completed forms. Each participant will be assigned a unique identification code which we will use to link participant records across modules. After we transcribe the data, we will assign all transcriptions new names according to the code system to ensure data and informant confidentiality, and we will encrypt and password-protect the data files. The file connecting identification numbers and associated names will be accessible only to AIR key researchers and will be destroyed at the end of the study. All AIR computers are encrypted and password-protected. The team will analyse data collectively so that information from any one participant remains anonymous.

Communication and Dissemination Plan

High-quality research with concrete policy recommendations is a necessary condition for policy impact. Our policy influence strategy has three components: disseminating our results to policymakers and capacity development and programme implementation professionals within Zambia, sharing our findings with the research community, and publicizing the lessons learned from our evaluation in the international policy community. The AIR team will support UNICEF in sharing findings from the study by broadly disseminating the evaluation report and delivering a presentation to key stakeholders in Zambia.

Work Plan

AIR proposes the following timeline for conducting the activities within the study.

Tasks	Month	February		March		April		May		June		July		August		Sept	
	Week	1	3&4	1&2	3&4	1&2	3&4	1&2	3&4	1&2	3&4	1&2	3&4	1&2	3&4	1&2	3&4
Inception trip to discuss overall research scope and design																	
Finalize evaluation work plan																	
Conduct qualitative desk review																	
Develop qualitative collection tools																	
Draft inception report																	
Obtain AIR and Zambia IRB approvals																	
Data collection training																	
Qualitative interviews and FGDs																	
Data transcription																	
Coding and analysis																	
Deliver draft final report																	
Receive feedback from UNICEF																	
Revised final report																	
Evaluation report dissemination (including in-country presentation)																	

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