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COLLABORATING, LEARNING, AND
ADAPTING FOR IMPROVED HEALTH ACTIVITY

Final Report

Remote and Hybrid Monitoring and Evaluation
Activities of the USAID Health Project in the
Philippines

February 28, 2022

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The views expressed in this report do not necessarily reflect the views of the U.S. Agency for International Development or of the U.S Government.

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ACRONYMS

ADAO	Anti-Drug Abuse Office
AMELP	activity, monitoring, evaluation, and learning plan
BARMM	Bangsamoro Autonomous Region in Muslim Mindanao
BARMMHealth	Bangsamoro Autonomous Region in Muslim Mindanao for Health
CBDR	community-based drug rehabilitation
CFIR	Consolidated Framework for Implementation Research
CiTEC	Cebu City-Wide TB Elimination Campaign
CLA	collaborating, learning, and adapting
CLAimHealth	Collaborating, Learning, and Adapting for Improved Health
COVID-19	Coronavirus disease 2019
DDB	Dangerous Drugs Board
DHIS 2	District Health Information System 2
DMO	Development Management Officer
DOH	Department of Health
DOH-PMIS	Department of Health - Pharmaceutical Management Information System
DOTS	directly observed treatment, short-course
DQA	data quality assessment
DQC	data quality check
FAST	Finding cases Actively, Separating safely, and ensuring effective Treatment
FB	Facebook
FGD	focus group discussion
FHSIS	Field Health Service Information System
FIO	Field Implementation Officer
FP	family planning
FTF	face-to-face
FY	fiscal year
GPPI	good practices and promising interventions
HCW	health care worker
HCWM	health care waste management
HP	health project
HIS	health information systems
HSS	health systems strengthening

IMS	information management system
IP	implementing partner
IPC	infection, prevention, and control
IR	implementation research
ITIS	Integrated TB Information System
KII	key informant interview
KMITS	Knowledge Management and Information Technology Service, DOH
LGU	local government unit
LMICs	low- and middle-income countries
M&E	monitoring & evaluation
MDR-TB	multidrug-resistant TB
MEL	monitoring, evaluation, and learning
MOH	Ministry of Health
MOV	means of verification
MTaPS	Medicines, Technologies, and Pharmaceutical Services Program
NAP	NTP Adaptive Plan
NCR	National Capital Region
NTP	National TB Control Program
P&R	pause and reflect
PBSP	Philippine Business for Social Progress
PD	Pharmaceutical Division, DOH
PHO	provincial health office
PIRS	performance indicator reference sheet
PMDT	Programmatic Management of Drug-Resistant TB
PSAT	Program Sustainability Assessment Tool
RHU	rural health unit
SCM	supply chain management
SI	strategic information
SMS	short messaging service
SOP	standard operating procedure
STC	satellite treatment center
TA	technical assistance
TB	tuberculosis
TBCC	TB Contact Center

TB IHSS	TB Innovations and Health Systems Strengthening
TB LON	TB Local Organizations Network
TB Platforms	TB Platforms for Sustainable Detection, Care, and Treatment
TOC	theory of change
TPM	third-party monitoring
TPT	TB preventive treatment
UNODC	United Nations Office of Drugs and Crime
USAID	United States Agency for International Development
WHO	World Health Organization

DEFINITION OF TERMS

Health Project	USAID/Philippines Health Project implemented from 2019 to 2024
Activities	These refer to the HP's nine implementing partners. Specifically of interest to the study are the following seven activities: ReachHealth, BARMMHealth, TB Platforms, TB IHSS, ProtectHealth, MTaPS, and RenewHealth
Remote	Online/virtual; non-face-to-face
Hybrid	Combination of in-person and remote
M&E activities	Involves planning, data collection, analysis, validation, consolidation, interpretation, use, and dissemination
Practice	Interventions relating to the application of technology to support an M&E activity or enhance its systems even before the COVID-19 pandemic; any process or activity meant to build systems for M&E. "Practice" may include the following activities: data collection, management, analysis, validation, consolidation, interpretation, reporting or dissemination, and utilization.
Effectiveness of an M&E activity	An M&E activity is considered effective when it has facilitated the use of quality M&E data to inform decisions or actions, such as program adaptations or adjustments to more effectively achieve Health Project and implementing partners' outcomes. Other factors such as the practice design and implementation, as well as its integration within the general M&E system, are also considered.
Fidelity	Degree to which a practice was implemented as it was prescribed in the original protocol or as it was intended by the program developers ¹
Adaptations	Deviations that are corrective actions and produce results toward overall objective ^{2,3,4}
Mandate	An official order or commissioning for the practice, whether it was formally written or informally declared by authority.
Feasibility	Extent to which a newly implemented practice can be successfully used or carried out within a given agency or setting ⁵
Sustainability	Extent to which a newly implemented practice is maintained or institutionalized within a service setting's ongoing, stable operations ⁶
Penetration	Integration of a practice within a service setting and its subsystems ⁷

¹ Proctor, Enola et al., 2011.

² Allen, Jennifer et al., 2012.

³ Pérez, Dennis et al, 2016.

⁴ Brownson, Ross et al., 2017.

⁵ Proctor, Enola et al., 2011.

⁶ Proctor, Enola et al., 2011.

⁷ *ibid.*

EXECUTIVE SUMMARY

Monitoring and evaluation (M&E) activities have been a core component of the U.S. Agency for International Development (USAID) Philippines Health Project (HP) (2019-2024) in implementing its activities and assessing progress toward its goals. With the persistence of the Coronavirus disease 2019 (COVID-19) pandemic, the HP had to adjust its usual M&E activities considerably, shifting to largely remote and hybrid approaches. The impact of this shift on the performance of M&E and attainment of goals is largely unknown.

This assessment, implemented by the Alliance for Improving Health Outcomes (AIHO) with support from the USAID Collaborating, Learning, and Adapting for Improved Health (CLAimHealth) project, aims to document and assess the effectiveness of these remote and hybrid M&E practices and, based on findings, propose recommendations for the HP and the country. The practices were evaluated based on the implementation outcomes of fidelity, feasibility, and sustainability. The study developed a weighted evaluation framework (with scoring from 0-3) which allowed for the identification of “good practices” that can be sustained within the project’s contexts. Only practices classified as Level 3 were considered as a good practice and promising intervention (GPPI).

The study explored the general M&E system of seven USAID HP implementing partners (IPs), ReachHealth, BARMMHealth, MTaPS, ProtectHealth, RenewHealth, TB Platforms, and TB Innovations and Health Systems Strengthening (TB IHSS), including their adaptations during the COVID-19 pandemic. All IPs adjusted their M&E activities to allow continuation despite lockdowns and other community safety measures during the pandemic. A total of 17 remote and hybrid M&E practices were identified across the seven IPs. The M&E practices can be classified into six categories: phone-based, web-based, videoconferencing, information management system (IMS), remote access software, and hybrid practices. A weighted evaluation of this assessment’s findings placed two practices at Level 0, three at Level 1, five at Level 2a, three at Level 2b, and three at Level 3. The study only evaluated 16 out of the 17 identified practices due to misconstructions in the definition of one practice.

The following themes characterize the implementation of remote and hybrid monitoring across the IPs: 1) remote and hybrid monitoring generally use digital technologies, 2) implementation is designed based on the need of the IPs, 3) the adapted M&E approaches heavily rely on external partners, and 4) implementation of remote and hybrid monitoring during the pandemic is dynamic.

Weighted Evaluation of Each Identified Practice in Selected USAID IPs		
IP	Remote and Hybrid M&E Practice	Weighted Evaluation
ReachHealth	District Health Information System 2 (DHIS 2)	Level 2a
	Remote phone monitoring	Level 1
	Hybrid rapid feedback mechanism	Level 2a
BARMMHealth	Hybrid monitoring of family planning (FP) program through site visits, phone calls, and Facebook (FB) messenger	Level 2a
	Blended pause and reflect (P&R) sessions	Level 2a
	KoboToolBox	Level 2b
MTaPS	Remote access to information systems (Department of Health - Pharmaceutical Management Information System [DOH-PMIS] and Integrated TB Information System [ITIS])	Level 1
	COVID-19 Special Response Project- hybrid monitoring of facilities (onsite and virtual)	Level 2b
ProtectHealth	Cebu City-Wide TB Elimination Campaign (CiTEC) project regular online conference calls	Level 3
RenewHealth	Community-based drug rehabilitation (CBDR) IMS	Level 0
TB Platforms	Hybrid monitoring of TB Contact Center using regularly scheduled phone calls and onsite monitoring/mentoring visits	Level 2b
	Hybrid monitoring/mentoring for Finding cases Actively, Separating safely, and ensuring effective Treatment (FAST) implementing facilities	Level 1
	Assessment of infection, prevention, and control (IPC) using Google Survey	Level 0
	Remote monitoring and mentoring of Programmatic Management of Drug-Resistant TB (PMDT)	Level 2a
TB IHSS	Remote P&R sessions	Level 3
	Remote rapid assessment survey	Level 3

In general, the remote and hybrid monitoring across the IPs have maintained fidelity to M&E plans and achievement of project goals. Remote and hybrid monitoring substituted and/or complemented face-to-

face (FTF) M&E activities and were viewed as opportunities to expand and modify original plans. Digital technologies used in remote and hybrid monitoring also improved the efficacy of integrating data and generating knowledge.⁸

Most of the remote and hybrid monitoring practices in the IPs were feasible to scale up due to existing perceptions or beliefs about the relative advantages of the practices when FTF is not viable. The technologies adopted were low cost, widely used, and available. The presence of leadership support and policies also clarified roles and expectations. However, the IPs faced challenges when adopted digital technologies had limited uptake or were inappropriate for the particular situation. The study further assessed the potential sustainability of each practice within and beyond the life of the IPs. Practices with limited sustainability had persisting implementation issues in funding stability, organizational capacity, and environmental support.

This assessment of remote and hybrid M&E practices within the HP found that digital technologies play a vital part in responding to the need for remote M&E solutions. Hybrid practices consistently showed an optimal level of M&E effectiveness and acceptability. It is then expected that post-pandemic ways of working in M&E should employ more hybrid practices where remote methods will complement FTF activities, rather than fully replacing them.

Strengthening M&E systems for increased remote and hybrid application would require digital training, commensurate investments, use of multiple tools and methods to improve data validity, understanding of context, and end-user perspective studies. Implementation, in particular, can be strengthened by reducing complexity and generating user confidence in the collected data. Additional studies are recommended to objectively and extensively assess the data quality from remote practices compared to FTF methods, particularly in low- and middle-income countries.

⁸ For instance, information management systems, such as KoboToolbox, improved knowledge generation by allowing for deeper or more efficient analysis and visualization of data.

I. INTRODUCTION

I.1. Background and Rationale

The USAID Philippines Health Project (HP) (2019-2024) has a nationwide outreach through nine activities⁹ to achieve its goals of strengthening healthy behaviors, fortifying quality services, and bolstering health systems. M&E activities have been a core component of the HP to generate, use, and assess the integrity and quality of family planning (FP), tuberculosis (TB), and community-based drug rehabilitation (CBDR) activities.

Efforts to assess the validity, reliability, timeliness, precision, and relevance of HP performance data have taken different forms including data quality assessments (DQAs), data validation activities, and third-party monitoring (TPM). These assessments have generated critical insights that have informed program management, service delivery, and policy and decision making.

For example, a recent data validation of FP performance data helped the HP identify issues on FP stock management, FP data reporting and recording, and lack of training on standard information systems procedures, such as the 2018 Field Health Services Information System (FHSIS) Manual of Procedures. Additionally, TPM and continuous evaluation methods have supported TB and FP program implementation in the complex post-conflict environment of Marawi City and other areas of the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM).

With the persistence of the COVID-19 pandemic, the HP has had to make considerable changes to its usual M&E activities, shifting to largely remote approaches (e.g., by telephone, e-mail, online collaborative workspaces, and/or Internet communications) and sometimes hybrid approaches (blended use of remote communications and in-person/site visits).

The effectiveness of these various innovations in enhancing the performance of M&E and attainment of goals is still largely unestablished. Culling important and scalable processes, as well as identifying factors that affect the way M&E systems are able to function, are worthwhile measures to learn what is and is not working well in this new environment. Because implementation will vary significantly based on context, factors such as monitoring perspectives, stage of implementation, and local settings must also be understood.

This assessment, implemented by the Alliance for Improving Health Outcomes (AIHO) with support from the USAID Collaborating, Learning, and Adapting for Improved Health (CLAimHealth) project, is focusing on the efficacy in the shift from the standard, in-person, to remote (and hybrid) approaches for M&E in the Philippines. This assessment's findings, together with current understanding around the broader developing science and practice on M&E and IR, can help define strategic recommendations for the HP and the country.

⁹ The nine activities: ReachHealth, BARMMHealth, TB Innovations, TB Platforms, TB LON, ProtectHealth, MTaPS, RenewHealth, and CLAimHealth

I.2. Statement of the Problem

1. In the context of COVID-19 community quarantine rules and limited mobility, are remote or hybrid M&E activities effective in achieving the M&E and adaptive management goals of the HP in the Philippines?
2. As remote approaches are expected to increasingly become part of the standard mode of conducting M&E, how can remote and hybrid M&E activities be enhanced in the HP?

I.3. Objectives

1. Document the processes involved, facilitators, and hindrances in remote and hybrid M&E activities, including quantitative and qualitative approaches used to monitor and assess the quality of interventions.
2. Assess the effectiveness of remote and hybrid M&E activities in terms of ability to accurately answer HP performance questions and achieve adaptive management goals, taking into consideration data validity, reliability, timeliness, precision, and integrity.
3. Assess the potential feasibility and sustainability (including during and post-COVID-19) of remote and hybrid M&E activities in terms of time and resources spent and ease of operations.
4. Provide recommendations for quality improvement of M&E activities moving forward, including during and post-COVID-19.

2. BACKGROUND

2.1. USAID Philippines HP Background

USAID/Philippines HP (2019-2024) seeks “to improve the health of underserved Filipinos.” This goal is consistent with objectives set in the Sustainable Development Goals, Philippine Development Plan, and National Objectives for Health. To achieve this, HP’s strategy is to institutionalize and strengthen the Philippine health system to enable: 1) healthy behaviors, 2) quality health services, and 3) agile health system functions. The goal and sub-purposes of the HP are outlined in the results framework ([Figure 1](#)).

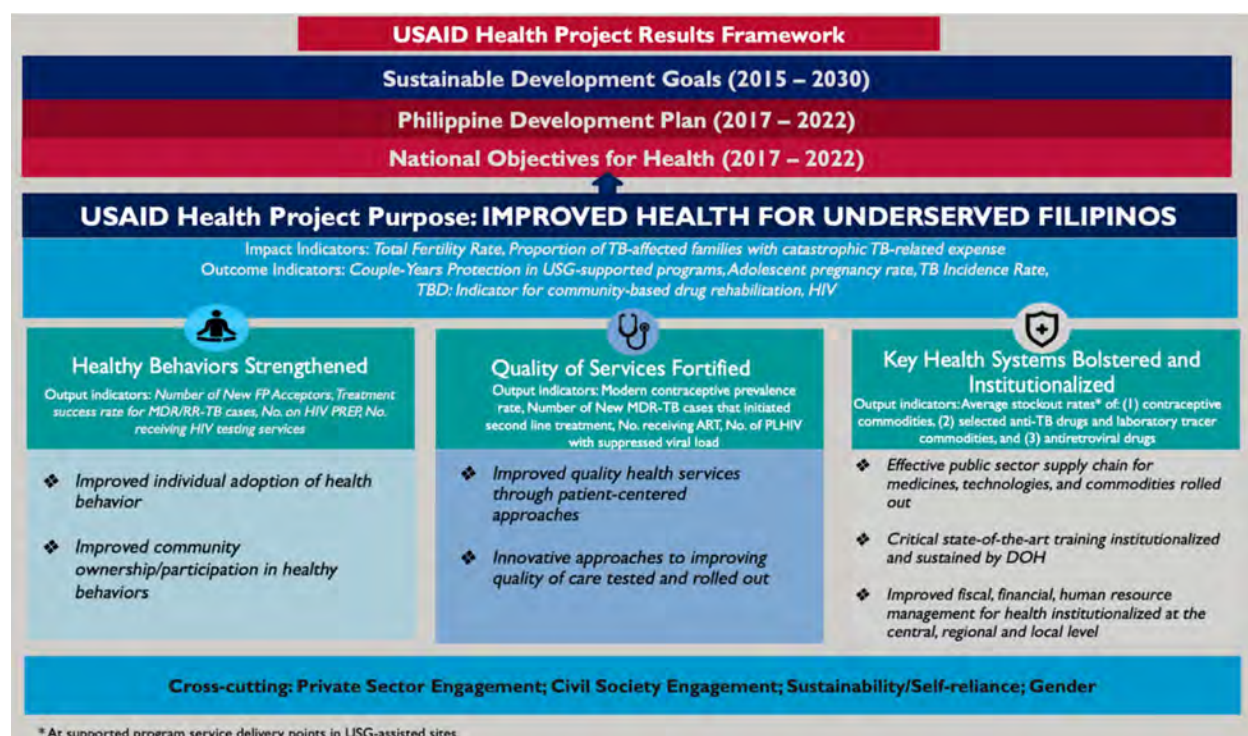


Figure 1. USAID HP Results Framework

HP’s activities focus on TB, FP (including maternal, neonatal, and child health and nutrition), health systems strengthening (HSS), and drug demand reduction (see [Table I](#)). The project sites for these activities are selected based on greatest need, prioritizing underserved populations. Specifically, the main geographic focus areas are where the TB burden, unmet need for modern FP methods, and teenage pregnancy rates are the highest.¹⁰ This assessment focuses on the M&E systems of seven of these activities.

Table I. USAID/Philippines HP activities, 2019-2024¹¹

¹⁰ USAID/Philippines, 2019.

¹¹ USAID/Philippines, 2021.

Thematic Areas/Portfolio	USAID HP Activity*	Estimated Timeline	Status in Fiscal Year (FY) 2020
TB and multidrug-resistant TB (MDR-TB)	Treat TB: Supporting MDR-TB Activities in the Philippines	September 2016 – March 2019	Ended
	TB Innovations and Health Systems Strengthening (TB IHSS)	February 2018 – February 2023	Current
	TB Platforms for Sustainable Detection, Care and Treatment (TB Platforms)	April 2018 – April 2023	Current
	TB Local Organizations Network (TB LON)	October 2020 – September 2023	Current
FP/Maternal, Neonatal, Child Health and Nutrition/Adolescent Reproductive Health	Community Maternal, Neonatal, Child Health & Nutrition Scale-up	August 2016 – December 2019	Ended (Q1 FY 2020)
	FP/Maternal and Neonatal Health Innovations and Capacity Building Platforms (ReachHealth)	December 2018 – November 2023	Current
	Bangsamoro Autonomous Region in Muslim Mindanao Health Capacity Building (BARMHealth)	February 2019 – February 2024	Current
HSS	Institutionalization of the Health Leadership and Governance Program	July 2017 – September 2020	Ended (Q4 FY 2020)
	Health Equity and Financial Protection Platform (ProtectHealth)	March 2019 – March 2024	Current
	Medicines, Technologies, and Pharmaceutical Services Program (MTaPS)	September 2018 – September 2023	Current
	Human Resources for Health 2030/Philippines	October 2017 – June 2020	Ended (Q3 FY 2020)
Drug Demand Reduction	Expanding Access to CDR Program in the Philippines (RenewHealth)	May 2019 – May 2024	Current
Monitoring, Evaluation, and	Collaborating, Learning and Adapting for Improved Health (CLAIMHealth)	March 2018 – March 2022	Current

Learning (MEL)			
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*The study will only focus on M&E systems of the seven activities in bold font.

Robust MEL underpins the broad range of all of HP’s activities. Each implementing partner (IP) uses an Activity MEL Plan to help manage the process of assessing and reporting progress toward achieving project outputs and outcomes and to identify what questions will be addressed during evaluation.¹² Results from the implementation of these activities are measured through a set of indicators at outcome and output levels for HP’s three sub-purposes. Each activity’s specific theory of change (TOC) is aligned with the HP goal and results framework. These TOCs organize the indicators into a frame to show how objectives will be met at both the activity and project level.

The activities also have performance indicators for cross-cutting areas (i.e., sustainability, gender equality and women’s empowerment, supply chain management [SCM], informed choice and voluntarism, private sector and civil society organization engagement, and climate risk management) important to USAID policies and strategies.¹³ Evaluation activities are conducted to provide information on implementation challenges and successes, as well as an overall understanding of performance. USAID activities conduct internal evaluation routinely but may also collaborate with external evaluators commissioned by the agency. Learning is collaborative throughout the program cycle to strengthen existing practices and processes. HP has a specific activity, CLAIHealth, that provides technical assistance (TA), advisory services, and relevant logistical support for MEL of the other activities.¹⁴

One of the major challenges for USAID is assessing these different project frames within a singular M&E frame. Tracking of HP’s progress overall needs to account for the activities’ being at varying stages of implementation, which means that data available to monitor their performance at any given time will vary. Monitoring is affected their performance frameworks that evolve over time, as new indicators and highly contextual issues emerge in the implementation of the individual activities and the HP as a whole.¹⁵

2.2. USAID Approach to MEL

An M&E system is a set of interconnected processes, tools, and policies for systematic collection, analysis, and use of information. A strong M&E system facilitates effective project implementation by using the collected M&E data to support evidence-based decision making, promote accountability, and generate learnings to inform adaptations and improvements of programs and interventions.¹⁶

Monitoring

Monitoring plays a critical role throughout the program cycle of USAID. Monitoring data are used to: 1) assess whether programming is achieving expected results, 2) adapt existing activities, projects, and

¹² USAID, n.d.

¹³ USAID/Philippines, 2019.

¹⁴ USAID/Philippines, 2017.

¹⁵ USAID/Philippines, 2019.

¹⁶ USAID, n.d.

strategies as necessary, and 3) apply USAID learning to the design of future strategies and programming. There are three approaches to monitoring: performance, context, and complementary monitoring. Only the first approach is required by USAID's Automated Directives System. However, a well-rounded monitoring plan may employ all three approaches, provided that they fit into the programming needs and culture.¹⁷

Performance monitoring is the ongoing and systematic collection of performance indicator data and other quantitative and qualitative information to reveal whether implementation is on track and expected results are being achieved. This includes monitoring the quantity, quality, and timeliness of activity outputs within the control of USAID and its implementers, as well as the monitoring of project and strategic outcomes that are expected to result from the combination of these outputs and other factors.¹⁸ USAID has identified five pathways in performance monitoring: 1) establishing performance indicators, 2) performance baselines and targets, 3) monitoring assumptions, 4) collecting, reporting, and sharing performance data, and 5) DQAs.¹⁹

USAID has identified five data quality standards that all performance monitoring indicators must meet:²⁰

1. *Validity*- Data clearly and adequately represent the intended result
2. *Integrity*- Data have safeguards to minimize the risk of transcription error or data manipulation
3. *Precision*- Data have sufficient level of detail to permit management decision making
4. *Reliability*- Data reflect consistent collection processes and analysis methods over time
5. *Timeliness*- Data are available at useful frequency, are current, and timely enough to influence management decision making

Evaluation

Evaluation is the systematic collection and analysis of data and information about the characteristics and outcomes of the project to understand and improve effectiveness and efficiency as well as to inform decisions about current and future programming.²¹ Along with monitoring, evaluation contributes evidence to improve strategic planning, project design, and resource design and is part of a greater body of knowledge and learning.²² USAID has identified five pathways in evaluation: 1) planning for evaluation during design, 2) managing the evaluation process, 3) high quality performance evaluations, 4) rigorous impact evaluations, and 5) following up on evaluations.

Collaborating, Learning, and Adapting

Collaborating, learning, and adapting (CLA) is a set of practices that helps USAID improve its development effectiveness. Integrating CLA into USAID's work helps ensure that programs are coordinated with others, grounded on a strong evidence base, and iteratively adapted to remain relevant

¹⁷ USAID, 2016.

¹⁸ *ibid.*

¹⁹ USAID, 2019.

²⁰ USAID, 2016.

²¹ USAID Learning Lab, 2015.

²² USAID, 2021.

throughout implementation. The systematic application of CLA approaches largely springboards from the effective conduct of an M&E activities. CLA is led by people who have the knowledge and resources to carry this out and enables the agency to be an effective learning and development organization.²³

2.3. Remote and Hybrid M&E during COVID-19

The COVID-19 pandemic has dramatically changed the general ways of working in the development and humanitarian sector. The limited fact-to-face (FTF) contact brought by social distancing, community lockdowns, and travel restrictions to control the spread of the virus has disrupted the “normal” way of doing programming and M&E globally. Specifically, this has had an impact on M&E activities from planning, data collection, data analysis, data validation, reporting, and providing feedback, up to dissemination, which all had to be done via phones, tablets, or other virtual platforms. Remote data collection activities include phone-based or online interviews and focus group discussions (FGDs), audio-diary methods, photovoice, video documenting, social media analysis, and auto-ethnography for qualitative data; and phone-based surveys using short messaging service (SMS), interactive voice response, computer-assisted telephone interviews, self-administered postal questionnaires, and web-based survey questionnaires for quantitative data.^{24,25} A case study in Zimbabwe found an increased use of remote data collection methods and secondary data, data collection reduction only to crucial information, simplification of data collection methods and tools, and rethinking of sampling designs in organizations.²⁶ In non-permissive environments, USAID activities have relied on TPM systems to supplement monitoring data and/or verify IP reports. TPM refers to the systematic and intentional collection of performance monitoring and/or contextual data by a partner that is not USAID or an IP directly involved in the work.²⁷ These trends can be observed for the M&E practice globally.²⁸

Although some M&E activities have been conducted remotely in the past, especially in conflict/crisis-affected settings, the COVID-19 pandemic magnified the need for such approaches in an unprecedented way worldwide. Remote M&E activities ensure the safety of staff and project participants, have wider coverage, reduce costs and time in data collection, and encourage more participation and honesty from anonymous respondents. However, switching to remote also poses some challenges including significant time needed to set up trainings, investments, and roll out; more easily compromised data quality and potential breaching of data security; and the need to invest in data collection devices.²⁹ Moreover, not all M&E practitioners have experience or skills in conducting online activities and using virtual platforms; and the impact of the shift to online, technology-based activities on the income and gender digital divide and the social isolation of people with disabilities is unknown.^{30,31} More studies are needed to establish the quality, reliability, and accuracy of remote data collection methods in low- and middle-income

²³ Jessica Z. 2017.

²⁴ Hensen, Bernadette et al., 2021.

²⁵ Greenleaf, Abigail et al., 2017.

²⁶ Groupe URD & CartONG, n.d.

²⁷ USAID, 2021.

²⁸ Dube, Thulane et al., 2021.

²⁹ Women's Refugee Commission, 2020.

³⁰ Dube, Thulane et al., 2021.

³¹ Ukaid, n.d.

countries (LMICs).³²

Some international organizations like the USAID and War Child Canada and Women's Refugee Commission developed guidance documents for their staff and IPs on how to conduct remote M&E activities in their programming during the pandemic. The guidance documents provided key points to consider before implementing remote monitoring methods, which include understanding the information to collect, conducting an internal and external environmental analysis, selection of potential methods, identification of tools (phones, Internet, survey tools) to use, availability of geospatial remote monitoring tools, integration of community-based approaches, and finding additional public resources.^{33,34} USAID's guidance highlights the fact that the appropriate use of remote M&E methods varies considerably in the context where these methods will be implemented.

In this current operating environment, USAID and its IPs face new challenges in implementing activities, monitoring progress, collecting data, and tracking indicators.³⁵ The current context moves development actors to consider adopting remote monitoring and management strategies not only for security or disease outbreak reasons, but also as a permanent measure with the broader aim of building local capacities and strengthening accountability among its partners.³⁶

Ensuring data quality in remote monitoring

Ensuring the quality of data collected through remote and digital channels may also pose a methodological challenge. Thorough yet remote supervision of the fidelity and quality of the data collected may be ensured through the following strategies: 1) using automated systems for quantitative data collection to ensure that human error is kept to a minimum, 2) using a smartphone application to record calls as quality assurance method, 3) duplicating spot-checking of interviews by making three-way phone call with a supervisor, and 4) avoiding questions with long lists of answer choices and instead using a modular questionnaire design to lower the chance of high non-response rates.³⁷ Prior to investing in equipment and human resources, the sustainability of remote data collection over the course of a project should be evaluated. Factors such as capacity, culture and acceptance, and resources within restrictive and remote environments may be taken into consideration.³⁸

2.4. The Implementation Research Approach

Implementation research (IR) is the scientific inquiry into questions concerning any aspect of implementation. IR seeks to understand how an intervention works within real world conditions, taking into great consideration the context in which implementation occurs and factors exerting influence on

³² Greenleaf, Abigail et al., 2017.

³³ Women's Refugee Commission, 2020.

³⁴ USAID, 2020.

³⁵ *ibid.*

³⁶ Women's Refugee Commission, 2020.

³⁷ JSI, 2020.

³⁸ Women's Refugee Commission, 2020.

it.^{39, 40} In the case of the HP, an analysis of desired implementation outcomes may help assess the M&E practices with respect to how they have adapted to changes in the operational environment, whether as a result of COVID-19 or other contextual needs (such as insurgency). Implementation outcome variables (e.g., fidelity, feasibility, sustainability) describe the intentional actions to deliver services and serve as indicators of the success implementation.⁴¹

Fidelity is the degree to which programs are implemented as intended. Implementation fidelity is typically measured by comparing the original evidence-based intervention and the implemented (or adapted) intervention in terms of adherence to the program plan, dose or amount of program delivered, and quality of program delivery.⁴² Feasibility is defined as the extent to which an innovation can be successfully carried out within a given agency or setting.⁴³ Typically used in retrospect, the concept is used to arrive at a potential explanation for an initiative's success or failure. Sustainability refers to the extent to which an intervention is maintained or institutionalized within a service setting's ongoing, stable operations.⁴⁴

Health service researchers make use of an IR approach to perform formative evaluations to assess the extent to which implementation is effective⁴⁵ in a specific context, prolongs sustainability of an intervention in that setting, and promotes dissemination into other contexts.⁴⁶ In formative evaluations, a progress-focused evaluation is appropriate for assessing concurrent implementation progress (as in the case of the HP). This type of evaluation is intended to optimize interventions and/or reinforce progress via positive feedback to key players through an analysis of impacts and indicators of progress toward goals.⁴⁷ Formative evaluations may be guided by the Consolidated Framework for Implementation Research (CFIR), which is a framework for assessing context in terms of existing or potential barriers and facilitators to successful implementation.⁴⁸ The CFIR provides a comprehensive taxonomy of operationally defined constructs that may exert influence on the implementation of complex programs.⁴⁹ The CFIR organizes these constructs into five domains (*i.e.*, intervention characteristics, outer setting, inner setting, characteristics of individuals, and process) and provides a repository of standardized factors that influence implementation effectiveness.^{50,51} The list and brief description of the domains may be found in Annex I.

³⁹ Peters, David et al., 2013.

⁴⁰ USAID, n.d.

⁴¹ Proctor, Enola et al., 2011.

⁴² *ibid.*

⁴³ Karsh, B., 2004.

⁴⁴ Proctor Enola et al., 2011.

⁴⁵ "Effective" in the case of IR looks into the success of achieving implementation outcomes. This differs from the definition of an "effective M&E" which pertains more to success in guiding performance or goal attainment.

⁴⁶ Damschroder, Laura et al., 2009.

⁴⁷ Stetler, Cheryl et al., 2006.

⁴⁸ CFIR Research Team, 2021.

⁴⁹ Damschroder, Laura et al., 2009.

⁵⁰ B Karsh, 2004.

⁵¹ Means, Arianna Rubin et al., 2020.

3. METHODOLOGY

The assessment adopted a progress-focused implementation evaluation under the assumption that remote and hybrid M&E practices are concurrently being implemented across the various activities. The assessment analyzed the effectiveness of these adapted practices in achieving the M&E and adaptive management goals of HP and its activities. In particular, it closely investigated their fidelity to standard operations, M&E plans, and adaptive management goals, as well as their ability to achieve data quality standards (validity, reliability, timeliness, precision, and integrity). The assessment also evaluated the M&E practices based on the implementation outcomes of fidelity, feasibility, and sustainability. This was carried out through the following systematic steps:

3.1. Initial Desk Review

We conducted an initial desk review of selected activity MEL plans, work or implementation plans, progress reports (annual and quarterly), and performance indicator references sheets (PIRS) to gain a fundamental understanding of HP’s current overall M&E system and how this relates to the variable activity-specific M&E systems as well as to aid in framing the questions for the data collection.

We also reviewed relevant literature to underpin the study’s methods and frameworks for analysis. This included a scoping of global evidence on remote and hybrid M&E practices. The online publications reviewed were systematically selected through an expert-guided literature search, which focused on suggested key subject headings and research-related inquiries. The terms “monitoring and evaluation” and “implementation research,” appended with the subject headings outlined in [Table 2](#), were searched in the following databases: USAID, Google Scholar, and Google.

Table 2. Subject headings used for the literature search	
Monitoring and Evaluation	Implementation Research
<ul style="list-style-type: none"> • Remote monitoring • Effectiveness of • USAID (+ names of various activities) • Performance report • Philippines • COVID-19 • Data quality • Data integrity • M&E system • Online 	<ul style="list-style-type: none"> • Progress-focused • Fidelity evaluation framework • Feasibility evaluation framework • Sustainability evaluation framework

3.2. Modeling the Approach to Data Collection and Analysis

We developed a consolidated assessment protocol combining separate assessments on M&E

effectiveness and analysis of desired implementation outcomes to respond to the main research inquiry: *Are remote or hybrid M&E activities effective in achieving the M&E and adaptive management goals of the USAID/Philippines HP?*

We collected qualitative information that allowed comparison and selection of good practices for remote and hybrid M&E, looking into process flow, data validity, reliability, timeliness, precision, integrity of data, and achievement of the M&E and adaptive management goals. Specifically, we organized the M&E questions to inform four general activities namely: 1) monitoring of inputs and activities, 2) monitoring of outputs and outcomes, 3) monitoring of risks and assumptions, and 4) evaluation.

We used an IR approach for the research question to assess the implementation outcomes of fidelity, feasibility, and sustainability. We assessed remote and hybrid M&E practices based on their adherence toward the standard operating procedures (SOPs), plans and objectives, TOCs/logical frameworks, or Mission and Vision in relation to their M&E and their feasibility for scale-up or application in other project settings.

We also built a consolidated tool by combining the approaches or questions delineated by the M&E and IR consultants. For analysis, information that answered the M&E inquiry was culled first, followed by the extraction of information to answer the IR inquiry. Results of these analyses informed recommendations. We then conducted a triangulated analysis and cross-tabulation summarizing analysis of pertinent domains on M&E effectiveness and implementation evaluation to come up with an answer to the main inquiry and identify good practices.

3.3. Development of Data Collection Tools

We developed a tool for documenting the processes of various M&E activities, both as prescribed in the initial activity MEL plan and how they were actually conducted. We also reviewed analytical tools for M&E and IR which allowed the generation of an exhaustive list of questions to be streamlined and used for data collection.

M&E analytical tool

We reviewed the Monitoring and Evaluation Capacity Assessment Toolkit,⁵² specifically the individual and group assessments, to frame questions to suit the needs of the study. We added questions on remote M&E activities as well as the M&E and adaptive management goals based on an identified set of domains (Annex 2), breaking down or specifying items as needed, modifying some item scorings to either a 5-point Likert scale or a binary response (Yes or No) to allow relative comparison of the pre-practice (using recall) and during practice scores. A “practice,” as referred to in the developed tool, pertains to the introduction or strengthening of the remote and/or hybrid M&E activities as a revision from the common practice or an adaptation due to the COVID-19 pandemic.

IR analytical tool

⁵² MEASURE Evaluation PIMA, 2017.

We used the CFIR⁵³ as a general framework for assessing remote and hybrid M&E activities in progress across the various activities. The assessment considered the following for the domains: the “intervention” as being the remote and hybrid M&E practices across the various activities; the “outer settings” as the USAID HP and local partners within the current context of COVID-19; the “inner settings” as the USAID IPs; and the “individuals involved” as the implementers of the M&E systems. The various constructs of the CFIR provided guidance in the formulation of the questions.

Implementation Fidelity: Fidelity is conceptualized as adherence of implementation to the content, frequency, duration, and coverage intended in a practice’s design. [Figure 2](#) shows the process this assessment devised to evaluate fidelity of the practices to the HP’s M&E plans. This first involved identifying core components or key action points in the practice’s design/plan from selected source documents. We checked for presence or absence of actions that deviated from the plans, and deviations that contribute to the overall goal were labeled as “adaptations.” We assessed the key advantages and issues in their adaptations and deviations using the CFIR framework. The strength of this measure is dependent on the presence of a plan or an SOP. In the absence of plans or SOPs, assessments were based on the practice’s designs and plans as stated in written documents or interviews with project staff and by referencing against activity-level goals. Then, we characterized practices as on track, delayed, stalled (temporarily stopped), or aborted. On track and delayed practices with adaptations were considered as having good fidelity. Practices that were stalled and aborted were considered as having poor fidelity.

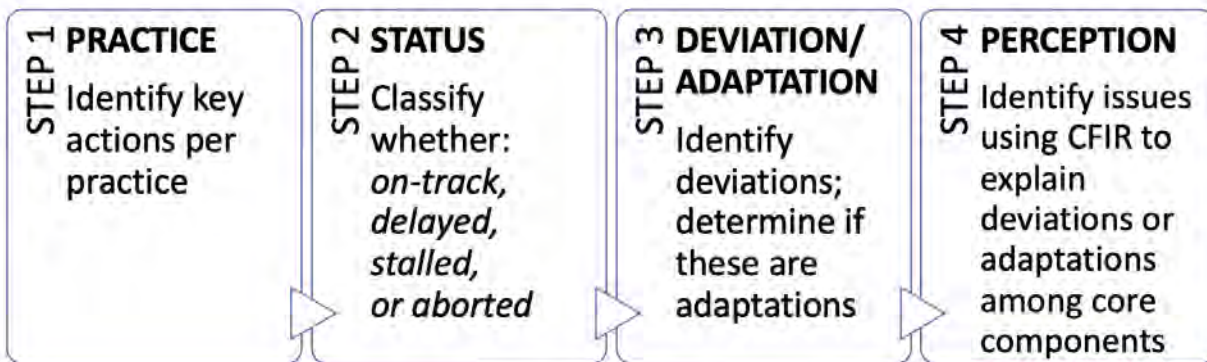


Figure 2. Process of Evaluating Fidelity for Each Practice

Feasibility: Using the CFIR, we identified enablers and challenges in the implementation of each practice and categorized them at the individual (i.e., central office, field project, or field counterpart staff) and organizational level ([Figure 3](#)). All practices with good fidelity and with no major issues at the level of operational individuals are feasible to scale. Unresolved issues pertaining to practice mandates, budget, and training are major issues. Practices with major issues at the level of operational individuals are not feasible to scale at the moment. All practices with only major issues at the organizational level can still be feasible to scale.

⁵³ CFIR Research Team, 2021.

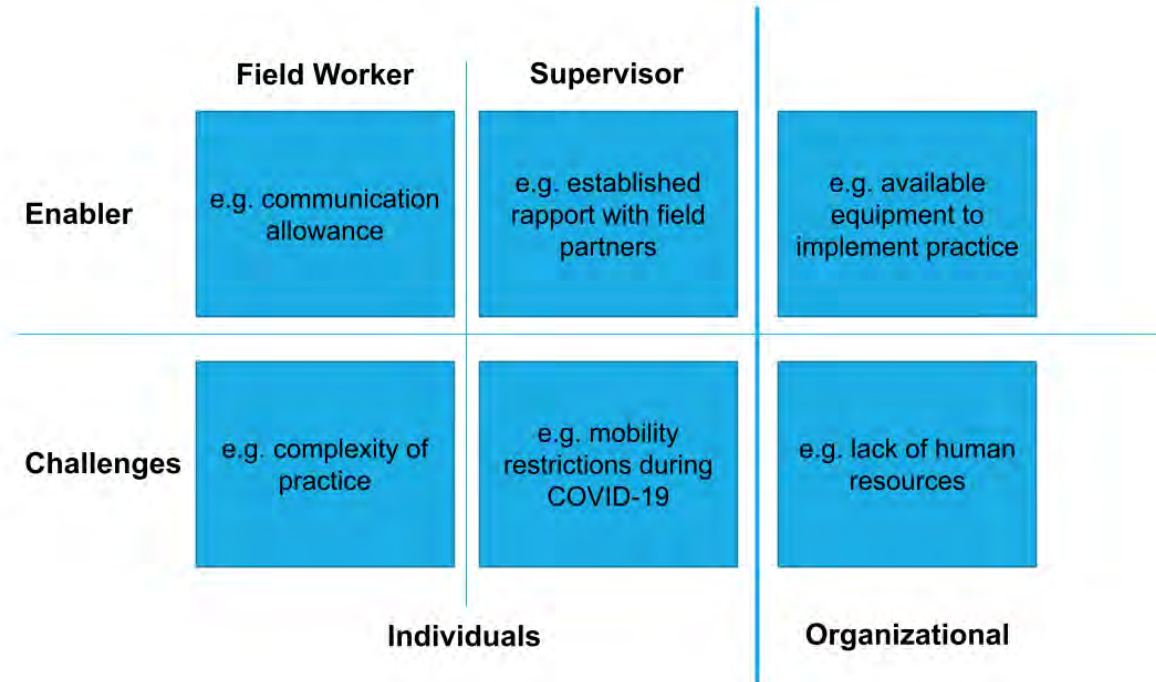


Figure 3. Enablers and Challenges Faced by Operational Individuals and the Organization in the Implementation of Each Practice

Sustainability: The Program Sustainability Assessment Tool (PSAT) is a new and reliable instrument that allows programs to accurately assess their capacity for sustainability across eight domains: environmental support, funding stability, partnerships with stakeholders, organizational capacity, program evaluation, program adaptation, communication with stakeholders, and strategic planning.^{54,55} A description of each sustainability domain is found in [Annex 3](#).⁵⁶ We converted the sustainability domains into a checklist and identified domains present in each practice along with their corresponding source (documents, key informant interview [KII], FGD). All practices with good fidelity and feasibility with no issues on core sustainability domains (environmental support, funding stability, and organizational capacity) had a high chance of being sustainable.

After performing a review of existing analytical tools for M&E and IR, we developed the tools for data collection (online survey, KII, and FGD). Questions in these tools looked closely into the complexity of each practice, and findings fed into the series of evaluative frames. We sought input and feedback on the data collection tools from the CLAIMHealth M&E team and pre-tested the tools with other members of the said team. We then revised and finalized the tools accordingly ([Annex 4](#)).

3.4. Evaluation Framework

We assessed each identified practice using the evaluation frames for M&E and the three implementation outcomes (fidelity, feasibility, and sustainability) for IR. The evaluation frame for M&E tabulated

⁵⁴ Luke, Douglas et al., 2014.

⁵⁵ PSAT, 2019.

⁵⁶ Center for Public Health Systems Science, 2012.

descriptions and identified gaps and challenges against five identified domains. The IR fidelity frame tabulated identified practices against implementation status, adaptations and deviations, and perceptions culled from the KIIs/FGDs. The IR feasibility frame tabulated the enablers and challenges at the personal and organizational level, while the IR sustainability frame tabulated verifications and their sources against the eight PSAT domains. The M&E and IR frames allowed identification of “good practices” that can be sustained within the project’s contexts. The results of the M&E and IR assessment of each practice fed into the consolidated evaluation frame in which each identified practice underwent a weighted and narrative evaluation for a richer depiction. Each practice was classified according to the five levels described in [Table 3](#). These levels were derived from a consensus of the experts within this study. Only practices classified as level 3 by the evaluation will be considered as sufficient for good practice and promising intervention (GPPI) documentation.

Table 3. Remote and/or hybrid M&E practices levels based on the weighted evaluation	
Levels	Description
Level 0	<p>M&E: Practices at the planning stage without allocated resources; several gaps and challenges identified per each domain observed; very little evidence on data use for decision making</p> <p>IR: testing feasibility (practice is halted or aborted or not feasible at the moment)</p>
Level 1	<p>M&E: Practices already being implemented within an activity but with very limited resources; collection, analysis, and reporting of data not well integrated within the general M&E system; evidence of poor data quality; very little evidence on data use for decision making</p> <p>IR: poor fidelity, no adaptation; considerable gaps and challenges identified on the domains observed</p>
Level 2a	<p>M&E: Practices being implemented within an activity with adequate resources; processes in place for analysis and reporting but aligned with the general M&E system; good quality evidence has been generated and used for decision making, but not consistently</p> <p>IR: good fidelity, with adaptation and feasible to scale (acceptable); some gaps and challenges identified on the domains observed but with no major issues with operational individuals</p>
Level 2b	<p>M&E: Practices being implemented within an activity with adequate resources; processes in place for analysis and reporting but aligned with the general M&E system; good quality evidence has been generated and used for decision making, but not consistently</p> <p>IR: high fidelity, with adaptation and feasible to scale (acceptable and appropriate); some gaps and challenges identified on the domains observed but with no major issues with</p>

	operational individuals
Level 3	<p>Identified practice can be considered as a good practice</p> <p>M&E: Collection of data is well resourced and integrated well within the general M&E system; processes in place for analysis and reporting; and high quality evidence has been generated and consistently used for the team’s decision making and improvement of project performance</p> <p>IR: already showing high penetration and is sustainable; fewer gaps and challenges identified on the domains observed; able to improve M&E performance</p>

3.5. Recruitment and Selection of Respondents

We selected participants through scoping discussions with point persons from the activities’ M&E teams to learn more about the contexts in which promising adaptations of remote and hybrid M&E practices were realized. We sought participation of the respondents through the USAID/Philippines CLAIMHealth, concerned local government units (LGUs), and other activity point persons.

3.6. Data Collection

1. Documents gathering: We gathered relevant documents such as activity MEL plans, work or implementation plans, progress reports (annual and quarterly), PIRS, and data collection tools at the HP and activity levels. We extracted the following data from the project documents: Activity objectives, TOCs, logical framework, strategic implementation; M&E and adaptive management goals, principles being followed (results-based, activity-based, or both), information flows, M&E activities before and after the practice, and changes in the M&E plan/activities due to the pandemic.

2. Documentation of good practices: A good practice is defined as a technique or methodology that through experience and research has proven reliably to lead to the desired result. Domains of the World Health Organization (WHO) guide to identifying and documenting best practices in FP programs⁵⁷ closely aligns with the domains assessed by the M&E and IR tools as well as the criteria for GPPI used by USAID/Philippines.⁵⁸ The weighted assessment is then presumed to sufficiently identify a “good practice,” and the information gathered may be used for a full GPPI case report.

3. Online survey: We did an online survey for a preliminary analysis of the HP and IPs as well as their remote and hybrid M&E practices. Survey respondents were relevant M&E staff at various levels of the HP and activities. Some survey respondents also participated in the KIIs or FGDs. The survey sought to

⁵⁷ World Health Organization Regional Office for Africa, *A Guide to Identifying and Documenting Best Practices in Family Planning Programmes* (2017).

⁵⁸ USAID/Philippines Collaborating, Learning, and Adapting for Improved Health (CLAIMHealth) Activity, *Good Practices and Promising Interventions, Technical Series No. 6: Engaging Local Chief Executives to Build Local Capacity and Strengthen Health Systems* (2021).

identify practices being implemented by each activity, the quality of the M&E data collected via these practices, and staff perceptions on their individual and organizational capacity to implement the practices.

4. KIIs/FGDs: We conducted KIIs/FGDs to identify contextual factors that facilitated and hindered the implementation of remote and hybrid M&E and to clarify responses from the online survey. The key informants were M&E focal point persons with an in-depth understanding of the processes of the M&E system and its role in achieving M&E and adaptive management goals of the HP and IPs. FGD participants included M&E coordinators, field coordinators, and other project and counterpart facility staff involved in M&E activities from each of the IP study sites. The goal of both KIIs and FGDs was to gather data on the characteristics and processes related to the practice as well as the inner and outer settings in which the practice is implemented. We also explored pre-practice M&E activities and changes in the M&E plans due to the pandemic during the discussion.

3.7. Data Analysis and Validation

Framework analysis: We reviewed recorded responses from FGDs and KIIs to form abridged transcripts and conducted framework analysis for KIIs and each focus group. We extracted relevant content from transcripts based on domains/themes identified within the developed M&E and IR analytical frames (see modeling approach to analysis). We then generated the narrative responding to the joint M&E and IR inquiry.

Triangulation: We reviewed and analyzed information from FGDs and KIIs to generate the process analyses of the M&E systems from the various IPs. In addition, we did convergence and corroboration of desk review, KII/FGD, and online survey analyses to inform a more in-depth evaluation of identified M&E systems. We also developed an evaluation criteria for remote and hybrid M&E implementation based on expert consensus and assigned weights to identify the GPPIs.

Expert validation: After preliminary analyses, the Project Lead and consultants further reviewed and validated the evaluation matrices and raw data. The CLAIHealth technical team, various IPs, and USAID Office of Health will also be consulted regarding the final assessment. The results of the assessment will be used to generate evidence-based recommendations and identification of GPPI.

3.8. Study Limitations

The study was not able to carry out the quantitative analyses indicated in the inception report. There were limitations in the online survey due to considerable variability of respondents and responses across practices and IPs. Therefore, descriptive analysis of survey results was not done. Results of the survey were included in the qualitative assessments done for the practices.

The study was not able to perform a cross-sectional comparison of selected performance data indicators collected from the baseline (pre-practice) and endline (during practice) because it was not clear which indicators all the M&E practices were related to, and significant changes in the availability of

data collected for tracking the performance indicators were largely contingent on the impact of COVID-19 on the provision of services at the facility level.

The study was also unable to do process documentation during field observations due to difficulties in managing expansion of planned data collection. Moreover, the study opted to collect data remotely to assure the health and safety of staff during the pandemic. The methods generated for the collection of data for weighted analysis were substituted for the documentation of GPPI. Hence, the specific GPPI protocol was not pursued.

4. FINDINGS

4.1. Scoping Results

We conducted scoping discussions with the M&E point persons from various IPs via email and/or zoom calls from June 30 to July 6; and September 7 to 10, 2021. We asked questions on the M&E and adaptive management goals of the USAID HP and Activity as well as their definition of an effective M&E practice to align conceptual understanding. Preliminary interviews, combined with the review of HP documents provided by the USAID IPs, revealed that the goal of M&E activities is mostly centered on tracking the progress of their performance toward achieving a set objectives at both the project and activity level. Other goals include supporting project management and partners as well as developing and finalizing metrics for assessing implementation of programs. The adaptive management goal is an explicit target or outcome, but an overarching discipline for all USAID activities to respond and adjust to changing contexts to continue progress in their work. Definition of an effective M&E practice was different across the respondents.

We also asked the M&E point persons to identify any remote and/or hybrid M&E practices in their activity based on the following criteria/definition:

- Related to the application of technology to support an M&E activity from a distance
- Any process or activity meant to build systems for M&E
- M&E activities supported can be in data collection, management, analysis, validation, consolidation, interpretation, reporting/dissemination, and utilization
- Includes practices even before the COVID-19 pandemic
- Considers practices applied locally or nationally

M&E point persons also recommended potential survey and KII/FGD respondents for each intervention. We narrowed down the initial list of remote and/or hybrid M&E practices based on the criteria/definition and presented it to the CLAIMHealth team for its validation. [Table 4](#) summarizes the 17 identified remote and/or hybrid M&E practices across the seven IPs that were subjected to further analysis.

IP	Remote and/or Hybrid M&E Practices
ReachHealth	District Health Information System 2 (DHIS 2)
	Remote phone monitoring
	Hybrid rapid feedback mechanism
BARMMHealth	Hybrid monitoring of FP program through site visits, phone calls, and Facebook (FB) messenger

	Blended pause and reflect (P&R) sessions
	KoboToolbox
MTaPS	Remote access to information systems (Department of Health [DOH]-Pharmaceutical Management Information System [PMIS] and Integrated TB Information System [ITIS])
	COVID-19 Special Response Project - hybrid monitoring of facilities (onsite and virtual)
ProtectHealth	Cebu City-Wide TB Elimination Campaign (CiTEC project regular online conference calls)
RenewHealth	CBDR information management system (IMS)
TB Platforms	Hybrid monitoring of TB Contact Center (TBCC) using regular scheduled phone calls and onsite monitoring/mentoring visits
	Hybrid monitoring/mentoring for Finding cases, Actively, Separating safely, and ensuring effective Treatment (FAST) implementing facilities
	Assessment of Infection, Prevention, and Control (IPC) using Google Survey
	Remote monitoring and mentoring for Programmatic Management of Drug Resistant TB (PMDT)
TB IHSS	Remote P&R sessions
	Remote rapid assessment survey
	Remote monthly data quality checks (DQCs) using information technology (IT) systems

4.2. Summary of Data Collection Engagement

We conducted online surveys and KIIs/FGDs, which ran for a period of six weeks from September 27 to November 9, 2021. [Table 5](#) summarizes the data collection engagement for this study. We sent invitations to participate in the online surveys and KIIs/FGDs via email and followed up target respondents through email and text. We conducted online surveys first to allow clarifications of some of the responses during the KIIs/FGDs. Some identified respondents were not able to participate due to conflicts and sudden changes in schedule and Internet connectivity issues.

Table 5. Data collection engagement summary				
IP	Online Survey		KIIs/FGDs	
	Number of Target Respondents	Number of Actual Respondents	Number of Target Attendees	Number of Actual Attendees
ReachHealth	7	4 (57.1%)	7	5 (71.4%)
BARMMHealth	13	5 (38.5%)	13	10 (76.9%)
MTaPS	4*	4 (100%)	5	5 (100%)
ProtectHealth	5	4 (80%)	5	4 (80%)
RenewHealth	3	2 (66.7%)	3	2 (66.7%)
TB Platforms	18	10 (55.6%)	18	12 (66.7%)
TB IHSS	7	7 (100%)	7	7 (100%)
Total**	57	36 (63.2%)	58	45 (77.6%)

*One of the respondents was not requested to complete the survey.

**Two respondents served as a representative for two different IPs/practices; thus the actual number of individual respondents in the study is 56.

4.3. Overview of Monitoring and Evaluation of Selected USAID IPs

The USAID HP in the Philippines has nine IPs to help achieve the goals of strengthening healthy behaviors, fortifying quality services, and bolstering health systems in the areas of FP, TB, and CBDR. The study explored the general M&E system of seven IPs, including the adaptations they made during the COVID-19 pandemic ([Table 6](#)).

Pre-COVID/Pre-Adaptation

All IPs except RenewHealth had an established results-based M&E system before the pandemic. They have fully a developed TOC, M&E/Results Framework (indicators and targets), and M&E plan for their activities. They all reported adequacy of resources, especially financial and material. Almost all respondents agreed that there was enough budget and equipment (e.g., laptops) to carry out their M&E activities even before the pandemic. In terms of human resources, all IPs have a dedicated team for M&E across all levels (local, regional, and national) depending on the scale of the project. However, a few of them, like BARMMHealth and MTaPS, lack additional M&E professionals whose responsibilities were being covered by only one M&E staff. For smaller IPs like ProtectHealth, the M&E team receives support from other teams ([Table 6](#)).

Compared to other IPs, RenewHealth was still in the process of establishing its M&E system before the pandemic. The lack of international CBDR benchmarks and standards presented a challenge in drafting their indicators that are needed before initiating any M&E activities. Additionally, the LGUs lack a harmonized CBDR M&E system, making it difficult to integrate RenewHealth's metrics and data collection mechanisms. Respondents from the two IPs working on TB (TB Platforms and TB IHSS) raised issues on the clarity and delineation between their roles and responsibilities, which has led to siloed work and duplication of M&E activities, such as having similar indicators with the same target population and sites. They noted that significant resources could have been saved if collaborations were facilitated early on and if the original roles were followed.

Most IPs had been implementing traditional, paper-based, and FTF M&E practices prior to the pandemic. These included field/facility visits, FTF data collection methods (observation, survey, interview, FGD), secondary data review (either FTF or remote), FTF data validation, FTF feedback activities, and FTF quality assurance activities. Only TB IHSS had used hybrid approaches before COVID-19, conducting half of their M&E activities FTF and half remotely because they could not visit all sites. Their remote practices included the use of phones (call or SMS), emails, and messaging apps (FB Messenger). Regular submission of reports and supporting documents were also done conventionally either through FTF visits, mail, or email.

All IPs had planned to conduct baseline and evaluation activities, including review and learning sessions, in person to ensure high engagement and in-depth collection of information. They also conducted M&E training and capacity building activities, as well as regular stakeholder meetings, in person. All IPs reported that their M&E activities enhance the capacity of their government counterparts in collecting and using relevant data.

In terms of quality assurance activities, the majority of the IPs conducted regular FTF DQAs or DQCs, engaging either internal or external teams. Some IPs with electronic information management systems have been especially careful to ensure that data protection and security measures are in place within their information system. They also have used these systems for validation rules and checks on the data they collected.

Post-COVID/Post-Adaptation

All IPs made adjustments in their M&E system to continue their activities with the lockdowns and social distancing measures during the pandemic. Project and M&E activities were postponed or canceled; M&E staff had to work from home; field visits were halted or limited; and most FTF data collection was moved online. As a response to the changes brought by COVID-19 in their programming, some of them modified their TOCs, implementation assumptions, and M&E/Results Framework by including additional project components, and adding/removing indicators and updating their targets, respectively. Most of them also changed their administrative guidelines to comply with the government health protocols when doing their M&E activities.

Even during the pandemic, most of the IPs' M&E resources remained adequate. In fact, ReachHealth recruited more M&E staff to work on the additional COVID-19 component in their project. However, TB Platforms had limited human resources at the field level who were needed for additional data

collection and encoding for their service delivery work. In terms of costs, a few of the IPs reported that their budget increased due to canceled FTF M&E activities during lockdown. The use of online collaboration platforms such as Zoom and WebEx incurred no expenses. They, however, used this extra budget to cover pandemic-related expenses like testing kits, phone allowance, and additional equipment (for work from home set-up). TB Platforms reported a limited budget at the start of the pandemic because they did not receive additional resources and they were not allowed to use their money for COVID-19, which was later addressed when they were permitted by USAID to do realignment ([Table 6](#)).

Most of the traditional FTF M&E practices of the IPs were replaced by remote methods, especially during the first phase of the pandemic. There has been a notable increase in the use of technology (phones), mobile and web-based tools (Google Forms, KoboToolbox,⁵⁹ SurveyMonkey), video conferencing tools (Zoom, WebEx), and messaging applications (FB Messenger, WhatsApp, Viber, emails). In lieu of on-site visits, the M&E teams were communicated with their partners remotely with phones/smartphones to collect and/or validate both primary and secondary data. Paper-based monitoring forms were converted into an online version (in the form of an online survey) using mobile-based or web-based data collection tools that were then shared to partners for completion. The use of secondary data has been maximized, and MTaPS obtained permission to remotely access government-run databases. All IPs have moved their meetings, training/orientations, and workshops online using videoconferencing platforms, which have reduced logistical issues and expenses. Remote DQAs/DQCs and provision of feedback to partners were conducted usually via phone calls or video conferencing, where partners were asked to scan or send photos of documents (as in the case of ReachHealth and BARMHealth).

IPs used hybrid methods (combination of FTF and remote) in cases where FTF practice (usually facility visits) was necessary, even during the pandemic, due to the type of data being collected, limited connectivity of the facilities, or travel restrictions in the target sites. TB IHSS has generally adapted well to COVID-19 mainly because of their prior use of hybrid practices, which they increased and enhanced during the pandemic. RenewHealth, which had no established M&E system before the pandemic, decided to directly implement remote or hybrid M&E activities during the pandemic.

There were not many changes in the planned FTF evaluation activities of the IPs because most of them are still planned at midterm and at endline. For example, TB Platforms managed to conduct an FTF internal evaluation due to the easing up of restrictions in 2021. On the other hand, MTaPS completed their midterm evaluation remotely.

IPs used similar information management systems to manage their data before and during COVID-19. A few IPs such as RenewHealth tried to hasten the development of a more sophisticated information management system during the pandemic, where partners and/or field workers could directly encode, store, and process a large amount of indicator data. There were no issues reported on data protection and security, as measures were already in place pre-pandemic.

⁵⁹ KoboToolBox: An open-source toolkit for data collection and management.

[Table 6](#) provides a summary of the general M&E system and adaptations by IPs before and after COVID-19.

Table 6. General M&E system and adaptations made by IPs before and after COVID-19

IP	Time	M&E System Principle	M&E resources	Routine Monitoring Activities	Feedbacking activities	Evaluation Activities	Quality Assurance Activities	M&E Database
ReachHealth	<i>Pre-COVID/ Pre-adaptation</i>	Activity-based Results-based	Adequate project staff, money, and equipment	FTF Facility visits	Quarterly FTF P&R sessions	FTF baseline, FTF midterm, FTF endline	Quarterly FTF DQA, system validation rules and checks	Performance Indicator Tracking Table (Microsoft Excel)
	<i>Post-COVID/ Post-adaptation</i>	(No changes)	More field counterpart staff recruited	FTF facility visits, phone interviews, online meetings	FTF and online P&R sessions, hybrid rapid feedback mechanism	(No changes)	Scanning of means of verification (MOVs)	(No changes)
BARMHealth	<i>Pre-COVID/ Pre-adaptation</i>	Activity-based Results-based	Adequate money but limited staff	Secondary data (FHSIS), integrated monitoring and supervisory checklist, FP/maternal and child health exit interview	Monthly feedback sessions	FTF midterm (internal), FTF endline (internal, external)	Regular FTF DQC, phone-based DQA	Microsoft OneDrive
	<i>Post-COVID/ Post-adaptation</i>	(No changes)	(No changes)	Phone/Zoom calls, mobile/web data collection (KoboToolbox)	Blended P&R sessions	(No changes)	Photos of MOVs, Online DQC	KoboToolbox
MTaPS	<i>Pre-COVID/ Pre-adaptation</i>	Activity-based Results-based	Adequate staff, money, and equipment	Secondary data (DOH-PMIS, ITIS, FHSIS, IQVIA, IOR and FP hotline), FTF interviews	FTF P&R, email feedback	FTF baseline, FTF midterm, FTF endline	FTF DQA (as necessary), data protection measures in place	NDrive, Performance Indicator Tracking Table (Microsoft Excel)
	<i>Post-COVID/ Post-adaptation</i>	(No changes)	(No changes)	Remote access to secondary data, online interviews	Learning Thursday	Remote midterm	Intensified data protection measures	Microsoft OneDrive
ProtectHealth	<i>Pre-COVID/ Pre-adaptation</i>	Results-based	Adequate staff, money, and	Secondary data (PhilHealth, DOH)	Client feedback system	FTF IR	FTF visits to PhilHealth	Product Accomplishment

			equipment					Tracking Table (Microsoft Excel) Microsoft OneDrive
	<i>Post-COVID/ Post-adaptation</i>	<i>(No changes)</i>	<i>(No changes)</i>	<i>(No changes)</i>	<i>(No changes)</i>	<i>(No changes)</i>	No FTF visits	<i>(No changes)</i>
RenewHealth	<i>Pre-COVID/ Pre-adaptation</i>	Activity-based Results-based	Adequate project staff, money, and equipment	Secondary data (Anti- Drug Abuse Council/Office [ACAC/ADAO], social welfare, Dangerous Drugs Board [DDB], DOH, United Nations Office of Drugs and Crime [UNODC]), FTF exit interviews, FTF observations, FTF FGD, desk reviews	Partner feedbacking	FTF process (internal), FTF midterm (internal), FTF endline (internal)	Annual FTF DQA	Microsoft Excel
	<i>Post-COVID/ Post-adaptation</i>	<i>(No changes)</i>	Adequate money, but limited field counterpart staff and equipment	Secondary data (ACAC/ADAO, social welfare, DDB, DOH, UNODC)	<i>(No changes)</i>	<i>(No changes)</i>	<i>(No changes)</i>	CBDR IMS
TB Platforms	<i>Pre-COVID/ Pre-adaptation</i>	Activity-based Results-based	Adequate staff, money, and equipment	Secondary data (ITIS), FTF field visits	Weekly updates (national), during and end-of-project implementation (partners)	Annual FTF evaluation (internal), endline (external)	Periodic FTF DQA (internal done at least once a year; external done every 3 years)	Project Management Information System
	<i>Post-COVID/ Post-adaptation</i>	<i>(No changes)</i>	Limited staff, money, and equipment (field level)	Mobile/web data collection (Google Forms, SurveyMonkey), Online meetings, TB Care App, FTF field visits	<i>(No changes)</i>	<i>(No changes)</i>	Reliance on ITIS and systems in place	Microsoft SharePoint, Microsoft Excel
TB IHSS	<i>Pre-COVID/ Pre-adaptation</i>	Activity-based Results-based	Adequate staff, money, and equipment	Secondary data (ITIS, National TB Control Program [NTP],	FTF P&R sessions, FTF meetings and workshops	Midterm, impact (external)	FTF DQA, quarterly FTF DQC, data	Microsoft SharePoint, Performance

				WHO), FTF Field visits, FTF observations, hybrid surveys, hybrid interviews, hybrid FGD, desk reviews			privacy and security policies in place	Monitoring Information System
	<i>Post-COVID/ Post-adaptation</i>	<i>(No changes)</i>	<i>(No changes)</i>	Secondary data (ITIS, NTP, WHO), hybrid surveys, virtual meetings	Online P&R sessions	<i>(No changes)</i>	Quarterly remote DQC (Zoom), data privacy and security policies in place	<i>(No changes)</i>

[Table 7](#) summarizes the 17 remote and hybrid M&E practices identified across the seven IPs. See [Annex 5](#) for detail about data collected on the general M&E systems and the specific M&E practices of the USAID IPs, summarized into the developed M&E and IR analytical frames.

Table 7. Individual characterization of remote & hybrid M&E practices	
Remote & Hybrid M&E Practices	Description
I. ReachHealth	
<i>DHIS 2</i>	<p>DHIS 2 is web-based data management software that can store, manage, analyze, and visualize monitoring data routinely generated by the project through a dashboard. DHIS 2 only serves as ReachHealth’s information system/performance monitoring database and will not substitute FHSIS in any way. Implementation of the system was temporarily halted due to COVID-19, but in June 2021, ReachHealth began partial implementation of DHIS 2 as its project information system, starting with FHSIS data. Full implementation covering all project databases for routinely collected data was completed in the 4th quarter of FY 2021.</p> <p>Prior to implementation and use of DHIS 2, data collected from FHSIS reports and quarterly monitoring tools were re-encoded and analyzed on Microsoft Excel.</p>
<i>Remote Phone Monitoring</i>	<p>Due to mobility restrictions as well as health and safety concerns during the pandemic, collection of quarterly monitoring data shifted from onsite facility visits to remote phone calls during the first two quarters after the emergence of COVID-19. During the call, data collectors from ReachHealth staff administer the standard quarterly monitoring tool to partner facilities at the regional, provincial, and health facility levels. After this period of purely phone-based monitoring, ReachHealth switched to using three modes for quarterly monitoring: phone interviews, facility visits (to a limited extent), and a combination of both.</p>
<i>Hybrid Rapid Feedback Mechanism</i>	<p>The hybrid rapid feedback mechanism is a subset of the regular quarterly M&E activity. It was developed in response to USAID’s recommendation after conducting a DQA in Dec. 2020 to “close the loop” between the identification of problems at the health facilities during quarterly monitoring and actions to address those problems. This feedback mechanism essentially has two phases that can involve hybrid approaches: 1) rapid data collection and 2) rapid feedback dissemination. Data are collected and managed through the rapid assessment tool in the DHIS 2.</p>
II. BARMMHealth	

<p><i>Hybrid monitoring of FP program through site visits, phone calls, and FB messenger</i></p>	<p>This is a special case because the monitoring practice is primarily performed by provincial health office (PHO) staff from the BARMM provinces. Prior to the pandemic, they were already employing hybrid monitoring approaches for FP programs through site visits, phone calls/texts, and FB messenger. During the pandemic, site visits were conducted more frequently than phone calls in areas with few COVID-19 cases or poor mobile and Internet connectivity. In areas with higher COVID-19 cases and decent signal, phone calls were used. FB Messenger group chats were used for updates, clarification, and document sharing.</p> <p>While BARMMHealth utilizes data collected by the BARMM PHOs, they also dovetail their monitoring for project-specific indicators. They also facilitate BARMM PHO monitoring by providing additional transportation for PHO staff as well as representation and transportation allowances to participants when they conduct joint monitoring activities.</p>
<p><i>Blended P&R Sessions</i></p>	<p>The project aims to conduct monthly feedback sessions to discuss BARMMHealth activities and how they can be adapted to improve performance. P&R sessions are used in M&E for planning, data collection, data validation, data consolidation, and data reporting/dissemination.</p> <p>Pre-pandemic, P&R sessions were conducted FTF each month with stakeholders from the municipal/city and provincial level in one venue. Due to pandemic restrictions, P&R sessions have shifted into a blended format. Online P&R sessions operate in a blended manner in the sense that technical staff from the region attend individually while provincial staff gather in areas with good Internet connectivity. Zoom is used for videoconferencing.</p>
<p><i>KoboToolbox</i></p>	<p>The BARMMHealth provincial team uses KoboToolBox, an open-source platform suitable for mobile phones and tablets, to upload data that will help health managers visualize and analyze their data. KoboToolBox was adopted mid-2020 because of the challenges of submitting physical forms due to quarantine restrictions during the COVID-19 pandemic. The toolbox is used for data collection, analysis, interpretation, and reporting/dissemination. Each performance indicator has a corresponding form in KoboToolBox, which is based on the original paper-based forms.</p> <p>During the third-party monitoring activity in selected BARMM areas carried out in 2021, CLAIMHealth noted that this system is only used for activity-level recording of client satisfaction, institutional capacity assessment, informed consent and voluntarism, and data on Muslim religious leaders. Moreover, in BARMM areas that have poor internet access, it may be more practical for BARMMHealth to simply provide pre-programmed Excel sheets for data recording to barangay health stations. BARMMHealth is also exploring the use of DHIS2, another open-source</p>

	platform already being used by ReachHealth.
III. MTaPS	
<i>Remote Access to information systems (DOH-PMIS and ITIS)</i>	<p>MTaPS was given access to the recently upgraded DOH-PMIS in late 2020/early 2021 to support the DOH Pharmaceutical Division (PD) in its monitoring and analysis of supply and consumption data for TB and FP medical commodities. MTaPS was also given “viewer’s privilege” by DOH NTP and Knowledge Management and Information Technology Service (KMITS) in early to mid-2021 to access ITIS and assess the inventory data reported.</p> <p>Prior to this remote access, by MTaPS requested needed data or reports from DOH PD and KMITS, and these were sent via email.</p>
<i>COVID-19 Special Response Project - hybrid monitoring of facilities (onsite and virtual)</i>	<p>The Special COVID-19 Response Project ran from March to September 2020. In response to the pandemic, USAID tasked MTaPS to support DOH to strengthen IPC, health care waste management (HCWM), and SCM practices in facilities. MTaPS delivered a series of virtual training sessions in the three areas.</p> <p>After conducting the remote trainings, MTaPS conducted onsite facility and virtual visits to 42 hospitals between July and Sept 2020 to: 1) determine the status of the hospitals’ IPC, HCWM, and emergency SCM practices during COVID-19, 2) discuss key pointers pertinent to these practice areas with the hospital staff in their daily operations, and 3) to provide onsite support to supplement the virtual training received by health care workers (HCWs).</p> <p>This COVID-19 response project developed its own M&E system which is distinct from that used more broadly for MTaPS.</p>
IV. ProtectHealth	
<i>CiTEC Project Regular Online Conference Calls</i>	<p>Regular conference calls with TB IHSS, the Cebu City LGU, and other stakeholders (e.g., Central Visayas Center for Health Development and barangay officials) started in April 2020 during the planning stage for the CiTEC demonstration study in Cebu City.</p> <p>Initially, there was no regular schedule for the meetings, but eventually a regular time was set, Wednesdays from 2-4PM. In the current implementation phase, the scheduled meetings are less frequent but still held regularly. Because the project is jointly implemented with TB IHSS, both central office and field staff members from ProtectHealth and TB IHSS are involved in the meetings.</p>
V. RenewHealth	

<p>CBDR IMS</p>	<p>CBDR IMS is one of the subdomains of the CBDR portal (cbdr.org.ph), a one-stop website to aid LGUs in their CBDR implementation. This will serve as the backbone for LGU Anti-Drug Abuse Council operations as it helps LGUs monitor CBDR services and better manage information on people who use drugs. The system gathers data from multiple sources, analyzes the information, and reports data to aid in organizational decision making.</p> <p>The primary purposes of the IMS are to support data gathering and retention of involved offices in the LGUs, and to be used to safely keep data that is easily accessible for reporting to Philippine government partner offices. This will not replace reporting systems established by the Philippine government but rather will aid in the submission of reports.</p>
<p>VI. TB Platforms</p>	
<p><i>Hybrid monitoring of TBCC using regular scheduled phone calls and onsite monitoring/mentoring visits</i></p>	<p>From its introduction in Marawi in mid-2019, TB Platforms expanded the implementation of the TBCC in facilities in Region 4-A in May 2020 (later to Region 3 and National Capital Region [NCR]) following the NTP TB Adaptive Management Plan’s recommendation to explore telephone based means to follow up patients during COVID-19. TBCC is a remote (phone call-based) means for TB screening and contact investigation, monitoring of treatment, and addressing patient concerns related to treatment (e.g., adverse drug reactions).</p> <p>TB Platforms monitors implementation of the TBCC using regularly scheduled phone calls and onsite monitoring and mentoring visits to TBCC. During phone calls, call log sheets are validated, and any issues with the implementation of TBCC are raised. During facility visits, the team checks records of incoming and outgoing phone calls, as well as whether all patients' inquiries and concerns were adequately addressed. Stocks of TB preventive treatment (TPT) drugs, TPT implementation, TPT records, and percentage of patients screened are also monitored.</p>
<p><i>Hybrid monitoring/mentoring for FAST implementing facilities</i></p>	<p>In FY 2019, TB Platforms introduced FAST as an infection control strategy for nosocomial TB, especially among HCWs. FAST prioritizes rapidly diagnosing patients and starting treatment to prevent further transmission. FAST also doubled as an intensified case finding strategy within health care settings.</p> <p>Prior to the pandemic, FAST implementing hospitals and health facilities were monitored every month once the system was in place. This included process checks, random patient record checks, and accomplishment of a data collection tool with the FAST point person and other partners and facility representatives. At the end of each monitoring visit, mentoring was conducted by providing feedback on the status of FAST implementation including issues, concerns, and suggestions to improve implementation.</p>

	<p>Onsite monitoring was halted at the onset of the pandemic due to mobility restrictions with the lockdown and strict protocols set by hospitals in the following months. During these times, monitoring of FAST implementing facilities continued through remote approaches such as Google Sheets, FB Messenger, phone calls, and email. Onsite monitoring resumed in late 2020/early 2021. Remote monitoring approaches may still be used but are not employed as often anymore.</p>
<p><i>Assessment of IPC using Google Survey</i></p>	<p>In Q2 2020, TB Platforms provided TA to improve IPC by conducting eMentoring (webinars) to facilities focused on reiteration of IPC protocols as well as integrating systematic screening for both TB and COVID-19 using the FAST strategy. Following these webinars, TB Platforms conducted a baseline assessment among Level 1 and 2 hospitals from Region 3, 4A, and NCR in July 2020 using Google Surveys to assess implementation of IPC in facilities and identify technical support areas for strengthening.</p>
<p><i>PMDT remote monitoring and mentoring</i></p>	<p>TB Platforms conducted remote monitoring and mentoring sessions in PMDT treatment facilities and its catchment rapid TB diagnostic laboratories. Google Meet, Zoom, and Microsoft Teams are the commonly used meeting platforms. Before the scheduled monitoring session, TB Platforms forwards the assessment tool and remote PMDT mentoring tool for completion of the facilities. The remote PMDT monitoring tool was created to simplify data collection and was based on the original PMDT monitoring tool.</p> <p>Representatives from TB Platforms/FHI 360, Philippine Business for Social Progress (PBSP) program officers, satellite treatment center (STC) nurses, and physicians attend the monitoring session. FGDs with facility staff are also conducted where accomplishments of the facilities are discussed. Facilities apply the recommendations that they receive from TB Platforms during the mentoring session to improve PMDT implementation.</p>
<p>VII. TB IHSS</p>	
<p><i>Remote P&R sessions</i></p>	<p>TB IHSS utilizes P&R sessions to determine adaptive management actions undertaken with key stakeholders which drew on evidence-based insights or lessons learned. At the national level, monthly project-level P&R sessions are held to reflect on key learnings and discuss progress, challenges, and hold strategic conversations to inform the overall direction of the project. Internally, this is held annually for HP performance evaluation (includes other IPs). Due to the pandemic, P&R sessions shifted from hybrid to fully remote, with investments to procure licenses for Zoom or online polling tools.</p> <p>Key staff including from the Strategic Information (SI) Unit, top management, and</p>

	<p>sometimes gender focal person and technical advisors attend P&R sessions. Technical advisors and the SI Unit helps facilitate. Needs assessment and planning for the next quarter is discussed. The collected data from P&R sessions provide a “proxy” assessment on the operating environment for TB IHSS activities. Strategies are adjusted based on these findings. Results can inform decision making at the management level as well as advocacy material with relevant government officials.</p>
<p><i>Remote rapid assessment survey</i></p>	<p>DOH NTP, in coordination with USAID TBIHSS, conducted a rapid assessment of TB services using online data collection (Google Surveys in April 2020. These surveys intended to determine the quantitative and qualitative impact of COVID-19 on ongoing TB elimination efforts in Level 3 hospitals in Region 3, Region 4, and NCR implementing ENHANCE (Enhancing Hospital Networks and Communities to End TB), with findings to inform mitigating measures, advisories, and approaches for front-liners involved in TB care. Follow up assessments were conducted a month and six months later. Information and insights gathered have even informed the latest NTP Adaptive Plan (NAP).</p>
<p><i>Remote monthly DQCs using information technology systems</i></p>	<p>Further analysis of this practice was dropped. Suggested respondents to be interviewed weren't aware of this practice. Upon clarification with the TB IHSS M&E Specialist, TB IHSS was not conducting remote monthly DQCs using information technology systems (e.g. web-based ITIS, ITIS Lite mobile tools, data warehouse, and dashboards). Rather, DOH NTP requested TA from TB IHSS to streamline DQCs for the mandatory TB notification with their normal DQC process. The TA will not be limited to FASTPlus facilities but will be adaptable across all regions. So far, DOH NTP has an established process for DQC conducted by the regional, provincial, and city-level coordinators for ITIS, but none for the DQCs of the recently introduced mandatory TB notification in ITIS Lite. This TA is not yet formalized, and only a concept note has been drafted since DOH NTP changed their priority for TA in mid-July 2021. TB IHSS is also awaiting feedback from TB Platforms, who is spearheading DQCs of rural health units (RHUs) for FASTPlus.</p>

4.4. Effectiveness of Remote and Hybrid M&E Practices in Achieving M&E and Adaptive Management Goals

An M&E practice is considered effective mainly when it has facilitated the use of quality⁶⁰ M&E data to make informed decisions or actions, such as solutions which address gaps, adaptations, or adjustments to program implementation and activities toward the achievement of the HP and the IPs’ outcomes. This assessment also considered factors such as the practice design and implementation, as well as its integration within the general M&E system.

⁶⁰ Data quality criteria: Timeliness, Reliability, Validity, Precision, and Integrity

We assessed each remote practice identified per IP based on the following descriptors: implementation status, resources, process of data collection, analysis and reporting, how the data collected are being used, and quality of the collected data. Level 3 practices were considered as a candidate for “good practice” ([Table 3](#)).

The identified remote M&E practices were classified into the following six categories:

- Phone-based practices - one-on-one interview surveys or open-ended interviews conducted by phone, WhatsApp calls, or other online calling platforms
- Web-based practices - online surveys conducted using web-based data collection tools such as Google Forms and KoboToolbox
- Videoconferencing practices - activities with a group using videoconferencing tools such as Zoom, Microsoft Teams, WebEx
- Information management system practices - activities focused on the development or strengthening of the IP's data management system
- Remote access software practices - activities using remote access software
- Hybrid practices - activities that combine FTF and remote methods

Phone-based Practices

ReachHealth implemented remote phone monitoring as an alternative and, later on, as a complement to in-person facility visits. The practice is well resourced, more cost-effective than FTF visits, and is integrated well within ReachHealth's general M&E system following the same data flow, using the same standard facility monitoring tool, and being stored and managed in the same database ([Annex 6](#)).

However, some challenges were identified, particularly on staff acceptability and data quality. Field staff felt “embarrassed” when making long phone calls with high-level officials. This could be addressed by shortening and simplifying the tool, which is currently 22 pages. Also, the reliability of data collected has been compromised in a few indicators, specifically the FP stockout rate, for which actual inventory inspection was the only acceptable practice for monitoring prior to COVID-19. There were low responses and delayed/incomplete submission of secondary data from field staff, especially during the peak of COVID-19, as they were involved in the response. Project and field staff conveyed their preference for FTF data collection methods rather than phone interviews once COVID-19 restrictions are loosened. Overall, remote phone monitoring can be considered as an efficient complement in cases where in-person facility visits are not possible. It is recommended that data collection be adapted as a hybrid practice to maximize the effectiveness of the appropriate method (whether FTF or phone-based) and ensure data quality.

Web-Based Practices

TB IHSS implemented a web-based practice using remote rapid assessment surveys, mainly through Google Forms. Paper and soft copies of the questionnaires were also provided to address the workload and Internet connectivity issue of the respondents (HCWs). The short yet comprehensive online survey tools developed by TB IHSS were validated (content and face validity) and pre-tested before they were rolled out to partners. The team also adjusted the tools during the implementation as necessary. Field staff received orientations, informal training, materials, concept note (with methodology), coding manuals, and operational definitions before the pre-testing and actual roll out. TB IHSS have provided a communications allowance to the target respondents to answer the survey and to follow up with patients during the community quarantine ([Annex 6](#)).

This practice helps TB IHSS see the external factors that hindered efficiency and effectiveness of their activities being implemented in different sites. The DOH NTP team, regional NTP teams, and hospitals are using these findings to identify mitigation measures and recommendations to improve TB care in the facilities. They were also used as one of the points for the NAP during the pandemic. For example, TB IHSS supported the launch of the ITIS Lite mobile app⁶¹ to make it easier for doctors to notify their TB cases using their smartphone while ensuring patient confidentiality and data security.

TB IHSS encountered minor challenges with the remote rapid assessment surveys, including the low sample size, difficulty ascertaining reliability of responses, and the tight window in which they had to develop the questionnaire, orient enumerators, pre-test the forms, and collect and analyze data. The HCWs were busy directly responding to needs pertaining to COVID-19, which contributed to the difficulty of obtaining responses from them. This was addressed by having enumerators constantly follow up with the facilities. This challenge could also be mitigated by calling them when they are likely to be free (before or after their shift or on off days), or making additional calls when previous attempts were unsuccessful.⁶² Though the central team conducts regular data checks, data reliability was a concern because not all data could be validated and data collection was rushed. Respondents should be given an adequate amount of time to complete the surveys, with consideration for their busy schedules.

TB Platforms also used Google Forms to do a baseline assessment of IPC implementation. The survey questionnaire was based on draft questions developed prior to the pandemic, and no information is available on whether the new tool was validated and/or pilot tested. Field staff were given orientations on the questionnaire, references used in developing the tool, technical design (components of IPC), and IPC process ([Annex 6](#)).

In contrast to TB IHSS' successful use of Google Forms in their remote rapid assessment survey, TB Platforms experienced significant challenges in implementing this intervention. Though it was integrated well within the general M&E system, the following major challenges were encountered: poor data quality characterized by numerous duplicates, incomplete/missing data, low response rates, aversion of respondents to open-ended questions, and limited probing of responses (which is expected from online surveys).⁶³ This could be due to the design of the questionnaire which warrants reviewing to be sure that it is short (not more than 30 minutes) and easy (predefined choices) for the respondents to answer.

⁶¹ ITIS Lite: The official application of the DOH Philippines for the TB mandatory notifications by all public and private providers.

⁶² Hensen, Bernadette et al., 2021.

⁶³ Hensen, Bernadette et al., 2021.

Similar to the remote rapid assessment survey of TB IHSS, pre-testing of new tools is recommended and multiple modes (paper and soft copies) of the tool could be provided to the target sites to address Internet connectivity issues.

Another limitation was the discomfort of the team in using Google Sheets and the need for them to use the information to analyze infrastructural aspects of IPC. TB Platforms tried to address this by hiring an external engineer consultant, but they have not yet found a consultant with the necessary expertise. There was also confusion among the facility HCWs when the results were presented because they did not realize that there were multiple respondents per facility. Intensive training is necessary to build technical capacity of staff not just for data collection/analysis but also in building rapport with the respondents.

TB Platforms' baseline assessment achieved its intention to assess the implementation of IPC in the facilities and to identify technical support areas for strengthening; however, provision of feedback regarding these results was limited. Survey results were only fed back to the regions and DOH NTP, but not to most of the facilities because of significant hesitancy among field staff. This was due to their lack of technical capacity in giving feedback coupled with their negative experiences in previous feedback processes when facilities became defensive after scoring low. There was no official SOP or policy in the use of Google Forms, limiting the use of the findings to strengthen the IPC program at the facility level. Nonetheless, regions used the data to strengthen their health worker surveillance programs and supportive supervision systems, and TB Platforms used the data to develop a comprehensive TA package for IPC.

BARMMHealth used KoboToolBox to help provincial staff and data managers accelerate data collection (no encoding needed), reporting (automatic upload), and data generation/analysis during the pandemic. Provincial staff were oriented on how to use the online survey forms, which were based on the original paper-based forms. BARMMHealth intends to transition from KoboToolBox to its own information management system in the future and is in discussions with ReachHealth to consider use of DHIS2, another open-source platform that ReachHealth already uses ([Annex 6](#)).

Results generated from this practice have informed BARMMHealth on certain project decisions such as service delivery as well as identifying areas for improvement. One respondent said that the practice made it easier to see how implementation can be provided and to provide feedback on client satisfaction with services. The generated information can be used for FP service targeting and coverage and identifying areas for improvement. However, BARMMHealth should address the non-reporting of some RHUs to ensure completeness of data.

Video Conferencing Practices

Various practices in the HP used video conferencing tools such as Zoom, Microsoft Teams, or WebEx for their M&E activities. These include the P&R sessions of BARMMHealth and TB IHSS, the regular conference calls of ProtectHealth, and the remote monitoring and mentoring of TB Platforms for its PMDT program ([Annex 6](#)).

IPs use P&R sessions to reflect on key learnings and achievements, as well as to provide feedback to LGU counterparts and beneficiaries for the overall direction of the project. During the pandemic, both BARMMHealth and TB IHSS moved these sessions online (through Zoom), and they were well resourced and integrated within their general M&E systems. BARMMHealth and TB IHSS' remote and blended P&R sessions have provided an avenue for the teams to strategize and learn from well-performing areas. However, BARMMHealth still has limited reach with the blended approach because some areas, especially island provinces, cannot participate in online sessions. It was not guaranteed that BARMMHealth staff could conduct in-person P&R due to travel restrictions. The blended approach is not sufficient to inform project activities by utilizing inputs from all involved partners, thus limiting its effectiveness.

TB IHSS, on the other hand, had been implementing hybrid P&R sessions prior to the pandemic, which eased their transition to being fully remote during the pandemic. It was still challenging, however, for the participants to suddenly shift from hybrid to remote, but they were able to adapt over time. The team uses the information in the P&R to provide a "proxy" assessment on the operating environment for TB IHSS activities. Strategies were changed in accordance to these findings. Results can inform the decision making at the management level as well as advocacy materials with relevant government officials.

The regular online conference calls (through Microsoft Teams) for the CiTEC joint project of ProtectHealth and TB IHSS is well resourced and well integrated within the M&E system of the joint project, which is aligned with the general M&E system of ProtectHealth. The online calls were done weekly at the start of the project but have become less frequent. ProtectHealth uses the information from these calls to track progress of implementation and decisions on operational issues, and to discuss draft protocols and guidelines. For example, one of the meetings discussed revisions in the forms to be used by field implementers, which has led to significant changes in implementation in the field. No major challenges with data reporting, use and quality related to the conference calls were reported. But other aspects of the implementation could further be improved, such as having a consensus agenda on urgent needs to address, downloading app extensions for added features, and creation of a protocol. Another challenge is that added security measures in Microsoft Teams limit the free entry of internal and external participants during the call. Overall, though, the practice is effective in ensuring coordination between the two IPs, which have two different sets of project participants across geographically separated units (central and field level), with ProtectHealth staff receiving financial support for communications. Perhaps most importantly, the online calls enabled the project team members to continue collaborative teamwork to make timely informed decisions and take actions on activities toward the achievement of the outcomes of both ProtectHealth and TB IHSS ([Annex 6](#)).

TB Platforms' remote monitoring and mentoring for PMDT has adequate resources in place, and it is aligned with their general M&E system. Through this, facilities were made aware of the directives to resume TB services during the pandemic. However, the quality of the data collected was questioned. Central office staff participants may have been biased because the questions were sent to them beforehand. Central office and field staff agreed that the limited data validation undermines data quality. Because of these factors, effectiveness of the remote monitoring and mentoring is difficult to assess, although respondents have indicated that the practice was helpful in improving PMDT implementation. Respondents have recommended transforming this remote practice to a hybrid practice to allow FTF facility visits and data validation ([Annex 6](#)).

Information Management System Practices

ReachHealth moved from Microsoft Excel to DHIS 2, a web-based software, to accommodate the massive amount of data that they have to manage, especially during COVID-19 times. DHIS 2 has adequate financial and human resources in place, and it is aligned with the general M&E system. DHIS 2 has improved data management functionality and hastened ReachHealth's reporting and visualization, as it has automatic features and is less prone to human errors compared to Microsoft Excel. However, ReachHealth's use of DHIS 2 was still in the pilot-testing phase at the time of this assessment, and more time will be needed to assess its performance ([Annex 6](#)).

The CBDR IMS of RenewHealth is currently under development. It has adequate resources to maintain and further revise the system, wherein the data collection, analysis, and reporting processes are aligned with RenewHealth's general M&E system. Once operational, the intervention is expected to accelerate RenewHealth's data collection and analysis by facilitating remote data collection and solving the burden of data encoding as well as automating the process of summarizing and generating disaggregated data for the project's performance monitoring ([Annex 6](#)).

The current planning stages face some theoretical bottlenecks; for example, CBDR indicators are still being developed. Given its current stage, the effectiveness of the IMS in aiding RenewHealth's M&E and attending to the partners' needs cannot be fully assessed at this point. The system has not yet generated high quality evidence for the team's decision making and improvement of project performance, but it does have the potential to accelerate data processing and improve data quality of CBDR information of RenewHealth, LGUs, and partner government agencies.

Remote Access Software Practices

The provision of remote access to DOH-PMIS and ITIS was free, and it was well-integrated with the general M&E system of MTaPS. However, the lack of sustainable funding support from DOH PD, NTP, and KMITS for the day-to-day operations of the information systems presents a challenge. Moreover, issues with human resources, equipment, and Internet connectivity posed challenges to encoding data into DOH-PMIS and ITIS at the facility level ([Annex 6](#)).

MTaPS was analyzing secondary data from DOH-PMIS and It is pre-pandemic, but the full remote access during the pandemic has improved data analysis and use due to ease of and fuller access to the data. This has facilitated MTaPS' deeper analysis of information such as stock and consumption of TB medicines, FP consumption and stock-on-hand reporting, etc. However, there were some data quality concerns in DOH-PMIS and ITIS databases including the constant changing of data and the uncertainty about veracity and completeness of data entered. MTaPS is currently working with relevant partners so both information systems can improve the reporting and data challenges for TB medical products.

Hybrid Practices

A hybrid practice is a combination of FTF and remote methods. This has been the most common type of practice across the IPs, usually involving on-site facility visits coupled with phone calls ([Annex 6](#)).

ReachHealth's hybrid rapid feedback mechanism is a well-resourced practice that is aligned with the general M&E system. Implementation of the mechanism has allowed for immediate feedback to partners in some facilities but it is challenged by some perceived data quality issues stemming from remote data collection, and the lack of human resources and time (during the pandemic) at the field counterpart level. However, because ReachHealth's use of the rapid feedback mechanism was still in the pilot-testing phase at the time of this assessment, a performance assessment would be premature. Major aspects of the mechanism are still currently being finalized. For instance, low compliance to targets for data encoding is currently being mitigated through a "pahiyaan" (humiliation/shaming or guilting) system wherein status of encoding per area is tracked and made transparent to all encoders. Developing more sustainable and reliable accountability systems to facilitate data encoding is recommended. Additionally, a remote qualitative measure should be incorporated in the triangulation of quantitative information collected from the remote rapid data collection.

Performance monitoring by BARMM PHOs, supported by BARMMHealth, had used hybrid approaches (FTF site visits plus phone calls and FB Messenger) even before the pandemic. Although additional resources were needed for hybrid performance monitoring at the RHU level, there were adequate resources reported at the provincial level. With several data validation measures in place, data generated are of good quality. Despite specific challenges identified, hybrid monitoring was seen as more effective than pure FTF or pure remote monitoring, as it allows adaptation to the geographical context, access to decent Internet and mobile connectivity, and can flex with the constantly changing situation of the pandemic. Implementation of this hybrid approach to monitoring is envisioned to continue during and even beyond the pandemic. BARMMHealth should develop formal guidelines for conducting hybrid monitoring of the local health offices.

The COVID-19 project of MTaPS aims to expand the absorptive capacity of facilities, improve IPCs, HCWM, and SCM practices, and mitigate COVID-19 impacts. MTaPS used hybrid activities to monitor facilities and, though it has adequate resources to implement the practice, this monitoring does not align with the general M&E system. The indicators of the COVID-19 project were somewhat related to the overall HP indicators. Therefore, it is difficult to assess whether it was effective in terms of the project's exclusive intentions. Some challenges encountered relate to human resources such as resignation of team members, COVID-19 infection with the team, and the dual responsibilities of staff between COVID-19 and regular MTaPS work. A few concerns were raised about data quality issues though these were mostly addressed. Data generated will be used by MTaPS and DOH to develop capacity building materials for training of trainers and guidelines that can address gaps at the facility level.

TB Platforms has implemented hybrid monitoring activities (FTF facility visits and phone calls/FB Messenger/email/Google Sheets) for both its TBCC and FAST implementing facilities. Both practices were well integrated within the M&E system. Resources for monitoring TBCC were adequate at all levels, while the hybrid monitoring and mentoring of FAST facilities had limited human resources at the field and facility levels.

TB Platforms conducts regular phone calls and FTF visits with the facilities for TBCC. In cases where HCWs are unavailable to submit reports or do phone monitoring, facilities are visited in person. Monitoring tools are available for facility visits but not for the phone calls, although facility focal points received instructions for filling out the patient contact forms and summary call log sheets. Results from the hybrid monitoring are used to improve TBCC implementation and for advocacy to adopt TBCC to other facilities/LGUs. Any issues identified in the call log sheets or facility visits are discussed with the HCWs, and feedback is provided by the end of the calls/visits. It is recommended that TBCC incorporate any FB Messenger communications in the summary call log sheet to ensure inclusion of all data and maximize accuracy of reports.

For FAST monitoring, the facility focal point answers the form through Google Forms or submits a soft copy of records via FB Messenger or email, which are then discussed through a virtual meeting with TB Platforms staff. Analysis and use of the data from the FAST monitoring showed data quality issues in the TB cascade, prompting TB Platforms to work with the facilities to optimize patient flows, data recording and reporting, and to improve sputum collection and transportation mechanisms as well as patient follow up mechanisms. Challenges identified included the limited availability of facility staff for monitoring (during the pandemic) and some issues with the forms. This practice relies on the availability of human resources at the facility to document data; this should be addressed to ensure the availability and completeness of monitoring data.

Respondents prefer the current hybrid set up of TBCC monitoring due to the current pandemic. However, added COVID-19 responsibilities of the HCWs resulted in challenges in monitoring FAST facilities in collecting and validating information remotely, scheduling FTF visits, and facilitating the monitoring.

For all hybrid practices, guidelines are needed on how to conduct M&E activities. Recommendations for future monitoring efforts by DOH should include building capacity of HCWs to conduct hybrid monitoring activities, and to use technology, monitoring processes, and data to be reported in both FTF and virtual methods.

5. DISCUSSION

5.1. Implementation Contexts, Opportunities, and Challenges

The pandemic has changed our ways of working in conducting M&E. It has been particularly challenging for those working in public health and managing public health programs, given the need for FTF interaction in providing a health service, supervision, and engagement of multiple local community stakeholders. The current situation forces us to innovate, either by using technologies to create a new product/process, or by repurposing old technologies. Digital technologies are being used more frequently now in M&E to allow remote and hybrid monitoring, augmenting FTF M&E activities to minimize physical contact. To improve the implementation of these new ways of working, we need to investigate how they are implemented and what enables or hinders the implementation, and then as needed recalibrate, adapt, and further innovate to optimize their effectiveness.

Implementation is always contextual and heavily affected by the environment, the characteristics of those who are implementing the practice, and the properties of the practice itself. The CFIR captures the key domains in investigating implementation (Figure 4). In our case, we slightly modified the framework to depict the relationships of these components to reflect the practice in question, which is remote and hybrid monitoring.

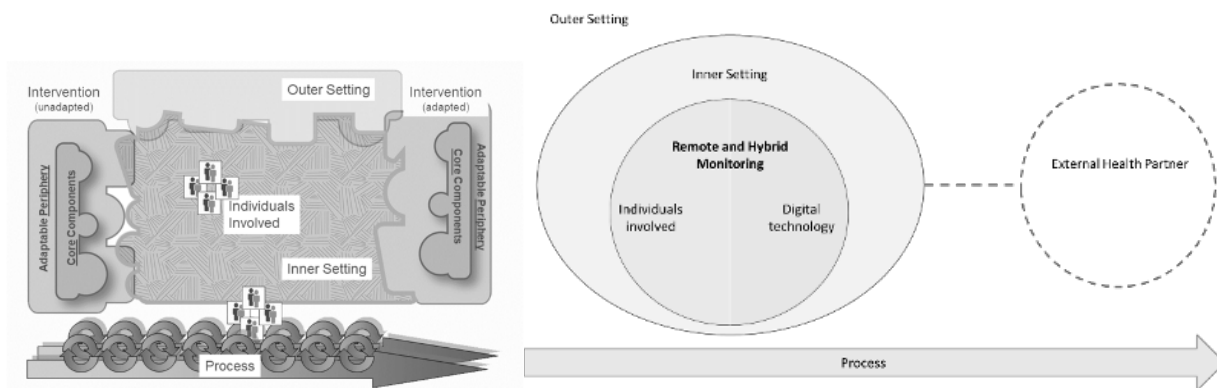


Figure 4. The CFIR (Left) and the Modified (Right) Framework to Capture the Relationships of the Key Domains in the Implementation of Remote and Hybrid Monitoring

We identified the following key themes in the implementation of remote and hybrid monitoring across the IPs in this assessment:

1. Remote and hybrid monitoring generally use digital technologies. Most practices implemented by the IPs include one or more of the following: use or development of information systems such as the DHIS 2, video conferencing such as Zoom for weekly meetings, phone calls for data collection, social media applications such as FB Messenger for communication, and web-based tools such as Google Forms for reporting. Aside from DHIS 2, these technologies are widely available, have been used even prior to the pandemic, and the IPs have the necessary equipment

to use them. Therefore, investment needs are low and implementation is fast. However, the level of success in implementing the same digital technology in the IPs differs. Some practices, even when proven to be efficacious, widely available and low cost, can fail when user acceptability is low or users lack needed capacity to implement them.

2. Implementation is designed based on the needs of the IPs. M&E assesses performance of programs or projects, involves field data collectors and managers, and is inherently dependent on the movement of data and information and their eventual use. Remote and hybrid monitoring is mostly substituting for an activity in the M&E process. The practice consists of two integral core components: 1) the digital technology that allows remote activity and (2) the individuals that implement the technology. The complexity of the digital technology used and the data collected depends on the IPs' needs. Reducing the practice complexity, simplifying processes, and ensuring the matching of capacities of the implementers and target partners are among the main challenges.
3. Reliance on an external partner. M&E of nongovernmental organizations heavily relies on data from government health program partners. These may be LGUs or regional or national offices. They are considered within the "outer" setting because the IPs do not directly control and supervise them; rather they can only be influenced and persuaded.
4. The implementation of the remote and hybrid monitoring during the pandemic is dynamic. The country's general lockdown has led to field movement restrictions. Once the restrictions are lifted, pre-pandemic activities may resume. However, global and local uncertainty remain, and the practices may still evolve with the situation.

5.2. Adaptiveness of Practices

In general, the remote and hybrid monitoring across the IPs have been adaptive. Most such activities were based on M&E plans, had good fidelity, and were on track with achieving project goals ([Annex 7](#)). Common adaptive management practices implemented by the IPs are described further below.

1. Remote and hybrid monitoring used digital technologies to substitute or complement FTF M&E activities such as data collection, capacity building activities, team meetings, and engagements with health partners in their pre-pandemic plans. Video conferencing tools (WebEx) were used for virtual visits. Counterpart staff on the field clearly illustrated the continuous presence of TB Platforms despite the pandemic through their remote phone monitoring,

"They're really here. If they cannot come to the hospital, they will still call. They really maintained it even during the pandemic." (FGD, Field Counterpart Staff 2, TB Platforms)

2. Remote and hybrid monitoring are viewed as opportunities to expand and modify original plans. An example of this is the remote rapid assessment survey of TB IHSS, where they modified their survey tool to evaluate their practice on the field.

"Originally, we didn't plan to have the follow-up survey after six months...it's good to have one to evaluate what has happened or what is the effect of the intervention done if ever, coming from the results of the baseline and one month assessment." (KII, Central Office Staff 4, TB IHSS)

3. Use of digital technologies in remote and hybrid monitoring improved the efficacy of integrating data and knowledge generation. For instance, the use of KoboToolBox in BARMMHealth has facilitated data consolidation and its communication.

“It is easier to generate summary reports (tables, charts) with Kobo, and deeper analysis can be done using customized charts...” (FGD, Central Office Staff 2, BARMMHealth)

Practices with lower adaptability were observed in those with delays in implementation. Key issues across the IPs that hindered adaptations are summarized in [Table 8](#). Of note, practices that are more complex and larger in scale for planned implementation, such as DHIS 2, are expected to have delays due to multiple components within the practice: conduct of training virtually is difficult; the data the information system collects can be complicated; the security and access to the system are given to everyone; equipment distribution can be delayed; and there may be complex nuances in the actual use of the system.

Table 8. Key Issues That Hindered Adaptability of Implementation of Remote and Hybrid Monitoring	
Issues	Illustrative quotes
Complexity of the practice	<i>"It's difficult to know if participants can understand and grasp the concept, if they are listening or are still on the call or not." (KII, Central Office Staff 3, ReachHealth)</i>
Difficulty in verifying data collected	<i>"Difficulty obtaining MOVs during phone monitoring and preference towards facility visits." (KII, Central Office Staff 2, ReachHealth)</i>
Low participation of target participants	<i>"It is common practice for nurses to answer [the surveys] even if they were sent to the doctors. Compared to doctors, the nurses usually have more knowledge on the operations side." (KII, Central Office Staff 1, TB Platforms)</i>
Development of digital tools takes time	<i>"It took a while to finalize the online training materials... [partners] were requesting if we could perhaps revise some of the materials to reflect this and that, so we adjusted." (KII, Central Office Staff 2, MTaPS)</i>
Difficulty in retrofitting tools for the pandemic	<i>"It was difficult to come up with a tool that approximates pre-COVID levels of data collection." (KII, Central Office Staff 2, TB Platforms)</i>

<p>External partners are decision makers</p>	<p><i>“We have no hold, no access inside [the technical working group] so we are just waiting.” (KII, Central Office Staff 2, RenewHealth)</i></p> <p><i>“Those were delayed a bit due to the development of the materials. Number one, we needed to consult a lot of other development partners, not just DOH...” (KII, Central Office 2, MTaPS)</i></p>
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5.3. Feasibility for Broader Use of the Practices and Their Sustainability

Successful practices need to be replicated, but implementing them could be difficult. Therefore, replication needs to focus on the core components of practices, as practices cannot work without them. Remote and hybrid monitoring as a practice has two core components: the digital technology used and the implementing individuals.

Because practices are contextualized, an understanding is first needed as to whether they are feasible to scale. The interaction between core components provides information on what enables or hinders these components. This assessment targeted end-users of digital technology as among the respondents, evaluating individual acceptability of the technology and the appropriateness of the technology to their work. Acceptability encompasses the user’s cognitive understanding, feelings and beliefs, and their perceived burden and benefits of the practice.⁶⁴ Appropriateness is the matching of the expected task to the level of the implementer’s capacities.⁶⁵

Enablers and challenges encountered by the participating individuals involved in implementation were identified. These end users were not acting independently but rather for the organizations. Therefore, some of their responses pertained to what affects them directly and indirectly on an individual and on an organizational level. These enablers and barriers are classified and summarized in [Figure 5](#).

⁶⁴ Sekhon, Mandeep et al, 2017.

⁶⁵ Proctor, Enola et al., 2021.

	Enabler	Barrier
Individual	<ul style="list-style-type: none"> Belief in the intervention Relative advantage of the intervention Availability of resources for implementation Established relationships with external partners Low cost of implementation Leadership and policy supporting the intervention 	<ul style="list-style-type: none"> External partners resources and capacity Complexity of the intervention Technology failures ie lack of mobile signal Preference for field visits Perceived burden
Organizational	<ul style="list-style-type: none"> COVID 19 generated the push to use the intervention Provision of resources ie finances, technology and knowledge Leadership and policy supporting the intervention 	<ul style="list-style-type: none"> Complexity of the intervention Difficulty verifying collected data External partners' capacity and preferences External policies

Figure 5. Enablers and Barriers at the Individual and Organizational Level with Remote and Hybrid Monitoring

When starting implementation of the practices, IPs emphasized 1) training of implementers to ensure the practice is rolled out correctly, 2) defined roles and expectations for each of the implementers, and 3) a budget to accommodate the costs of implementation. When feasibility to scale was assessed, these three components were checked particularly at the individual level because issues on the field level with these components will most probably lead to failure in implementation. In these cases, the practice should not be scaled up.

In general, most of the remote and hybrid monitoring practices in the IPs were feasible to scale due to perceptions or beliefs on the relative advantages of the practices, which were associated with the project staff's confidence to implement the M&E practices correctly. The technologies were low cost, widely used, and available. There was leadership support and policies that clarified the roles and expectations. However, there were challenges when the digital technology being used failed or was inappropriate for the particular situation.

We then assessed the potential sustainability of these practices within and beyond the life of the IPs. For this, we focused on the organizational enablers and barriers in [Figure 5](#) and were guided by the Program Sustainability Framework⁶⁶ ([Annex 3](#)). Funding stability, organizational capacity, and environmental support reflects the three components in the assessment of feasibility to scale. Issues in scaling will

⁶⁶ Luke, Douglas et al., 2014.

persist when not addressed. Likewise, issues in adaptation to shifting and changing contexts as noted and listed in [Table 8](#) affect sustainability as well. Partnerships are also important because M&E in the IPs is heavily dependent on collecting data from external health partners in the government. The general capacity, resources, level of authority, and status of working relationships can determine the ease or difficulty of collecting data. Therefore, buy-in of the external partners to the practices is critical. The practices have limited sustainability when the current implementation issues in the above-mentioned domains persist.

[Annex 8](#) consolidates the results of the assessment of each practice using the M&E and IR analytical frameworks. Notably, the overall level of assessment of the practices, which considers implementation outcomes, largely differs from the earlier assessment which used only M&E domains.

6. SUMMARY AND RECOMMENDATIONS

6.1. Summary

M&E Practice Types and Levels of Effectiveness

The M&E sections of this report discussed the general M&E systems of seven USAID Philippines HP IPs, along with their adaptations to the pandemic. The 16 identified specific remote and hybrid M&E practices were classified into six categories: phone-based, web-based, videoconferencing, information management system, remote access software, and hybrid practices. Various factors that contributed to the effectiveness level of these practices, particularly in the use of quality M&E data for decision making toward the achievement of their project results, were qualitatively analyzed. In summary, there was one practice (6%) at Level 0, three (19%) at Level 1, nine (56%) at Level 2, and three (19%) at Level 3, the last of which are considered candidate good practices. Almost all hybrid practices fall under Level 2, which indicated a good level of effectiveness as compared to other practices. This summative assessment of the practices is in terms of M&E effectiveness and does not yet consider the fidelity, feasibility, and sustainability of its implementation.

Weighted Evaluation

Considering the results of both M&E and IR framework analyses, the weighted evaluation placed two (12%) practices at Level 0, three (19%) at Level 1, five (31%) at Level 2a, three (19%) at Level 2b, and three (19%) at Level 3, which are considered candidate good practices.

6.2. Recommendations for Strengthening the Remote and Hybrid M&E Systems (For USAID and IPs)

Perform continuous digital training to ensure that staff are prepared to use the new M&E methods.⁶⁷

The respondents generally felt that the remote methods were good alternatives to continue routine monitoring when in-person contact are not possible. Remote approaches ensured the continuity of routine monitoring despite mobility restrictions and safeguarded the health and safety of not only the project staff but also their partners and respondents. Relevant orientations to new methods and tools would be necessary. We recommend a more formal mandate from USAID on remote and hybrid M&E practices to ensure consistency in implementation and institutionalization/full integration of the approaches within project M&E systems.^{68,69}

Keep abreast on the various emerging methodologies for data security and protection. Some IPs have developed or intensified their data protection and security measures by limiting people who can access the data. Data protection could be further enhanced by limiting the collection of sensitive and/or

⁶⁷ Dube, Thulane et al. 2021.

⁶⁸ Hensen, Bernadette et al., 2021.

⁶⁹ Raftree, L, n.d.

personal information, conducting risk-benefits assessments, establishing a data sharing agreement with relevant partners, and ensuring data security, from data collection (e.g., end-to-end encryption) to data disposal.^{70,71}

Support additional workload and demands with commensurate investments in resources, capacity, training, and support such as personal protective equipment and mental health support. While almost all of the practices were well resourced, a few IPs were initially under-budgeted and had limited staff, particularly at the field level. Most remote methods require an initial upfront investment - but are more time-efficient compared to FTF methods.⁷² One of the facilitating factors identified in the practices was the provision of communications allowance to respondents.

Carefully consider the nature of project indicators when determining the type of remote methods to be used.⁷³ Though remote practices were widely accepted, some respondents felt that these could not always replace the FTF practices, especially when collecting data for indicators such as FP stock out rate, and when conducting data validation or DQAs/DQCs, where checking the physical documents on-site is vital. ReachHealth and BARMHealth have addressed the latter by asking the health facilities to scan or send photos of needed documents; with this adaptation, extra vigilance is needed to ensure confidentiality of these documents.

Account for intrinsic methodological limitations and practicality at the level of implementers when considering remote/hybrid M&E approaches to adopt. The remote approaches were frequently reported to have lesser reliability and integrity due to challenges in physically validating the data. These and other limitations of remote methods should be anticipated and acknowledged as part of the risk assumptions in M&E.⁷⁴ The participants have also expressed the relative advantage of an FTF approach when it comes to ensuring data quality for process checks, data collection, and checking of physical means of verifications. Looking ahead, however, the possible impact on data quality when collecting data remotely instead of in-person needs further assessment. USAID should also consider balancing/reducing data for accountability requirements, easing compliance and/or anti-fraud requirements, and avoiding an extractive process, especially at times of emergencies like the pandemic.

Digital tools or solutions must undergo end-user validation tests and refitting to enhance participation. Participants prefer online surveys that are short (no longer than 30 minutes) and highly structured (predefined answer choices, no open-ended questions), particularly when they use smartphones with small screens as it is hard to enter large quantities of text.^{75,76} Incorporating these features will thus help improve response rates. This assessment found that doing this was one of the reasons that remote rapid assessment surveys of TB IHSS were more effective than the remote phone monitoring of ReachHealth and remote IPC assessment of TB Platforms.

⁷⁰ Hensen, Bernadette et al., 2021.

⁷¹ Raftree, L, n.d

⁷² Hensen, Bernadette et al., 2021.

⁷³ USAID, 2020.

⁷⁴ Groupe URD & CartONG, n.d.

⁷⁵ Dabalen, Andrew et al., n.d.

⁷⁶ Dette, Rahel et al., 2016

Understanding context is vital in bridging the digital divide.^{77,78} Careful examination of internal and external implementation environments would help in making M&E practices more inclusive. According to 2020 World Bank data,⁷⁹ the Philippines has high mobile phone access (155 mobile cellular subscriptions per 100 people, compared to the global average of 107). However, only 114,000 per 1 million people have secure Internet servers and 5 per 100 people have fixed broadband subscriptions. The IPs should take this into consideration by exploring more phone-based practices (SMS, voice messaging, calls) that require zero or minimal Internet use in their routine monitoring. In addition, IPs could explore existing monitoring and communications systems outside USAID with whom they can tap, leverage, and share data. This could help both to obtain data and build shared understanding between development actors.^{80,81}

Finally, USAID could explore innovative, community-based monitoring schemes.^{82,83,84} USAID could consider engaging and training barangay health workers, community volunteers, key informants, local community leaders, and community-based organizations in USAID routine monitoring and validation activities. This could both strengthen the relationship of the IPs with the local community while at the same time addressing the gaps resulting from limited FTF visits, as these community members can access the target sites more easily.

6.3. Recommendations for Strengthening Implementation of Remote and Hybrid M&E Practices

The practices that this assessment investigated are largely distinguished and shaped by the needs of specific IPs. It particularly explored the domains of implementation, arriving on the following themes of action to strengthen implementation:

Reduce complexity of the practice by improving the acceptability and appropriateness of the digital technologies. This is best done by testing and validating the tools with end users and health partners before implementation. Complexity arises from the data that are collected and competency and capability of the external stakeholder expected to use the technology. With respect to the latter, the competency of the external health partner in using the technology was found to be a major barrier, especially considering that video conferencing apps and digital technology could fail in remote areas.

Modification of paper-based data collection tools which are converted for digital use (either by web-based forms or by phone calls) should be considered. The more successful practices have considered redesigning their tools and focusing data collection on their most critical indicators. Flexibility and use of

⁷⁷ USAID, 2020.

⁷⁸ Raftree, L., n.d.

⁷⁹ World Bank, n.d.

⁸⁰ Groupe URD & CartONG, n.d. ,

⁸¹ USAID, 2020.

⁸² Hensen, Bernadette et al., 2021

⁸³ USAID, 2020.

⁸⁴ Raftree L., n.d.

both physical and digital data collection forms should be considered based on what is available in each health partner's context.

Generate confidence in the data collected via remote monitoring. This involves the development of a manual or verification guide for data collected remotely and virtually. Preference for field visits is mostly rooted in mistrust of remotely collected data, with participants citing the lack of data verification activities and questionable data quality. However, the quality of data collected remotely has not been formally tested in this study.

Engage external partners and stakeholders more inclusively and ensure their early buy-in. Ensure their active participation in developing tools and decision making from the start, such as by including them in stakeholder consultation meetings during the planning stage. Their participation and buy-in must be sustained throughout implementation, as external partners play a vital role in sustainability.

6.4. Specific Recommendations per Identified Remote and Hybrid M&E Practice

Table 9. Specific Recommendations per Identified Practice	
Remote and Hybrid M&E Practice	Recommendations
I. ReachHealth	
DHIS 2 <i>Weight: Level 2a</i>	Resolve implementer-level issues (training, technology uptake, and resource).
Remote Phone Monitoring <i>Weight: Level 1</i>	<p>While this may be an appropriate M&E practice during the pandemic, it is difficult to scale given the implementation hurdles at the field level (both project and counterpart staff). Mitigating these challenges may also be difficult as some are beyond ReachHealth's control (i.e., limitations of not being on-site, poor mobile signal, limited availability of field counterpart staff). A hybrid monitoring approach may be needed, giving data collectors discretion in choosing which method is best their specific contexts.</p> <p>Although FTF approaches are also being used when remote data collection is not viable, hybrid monitoring may need to be integrated into official mandates to move toward process excellence and quality data. Additional qualitative remote measures of corroboration can help ensure data quality when using remote approaches. More broadly, sustained programmatic evaluation of the effectiveness of approaches used for M&E—especially new remote approaches—is needed.</p>

<p>Hybrid Rapid Feedback Mechanism</p> <p>Weight: Level 2a</p>	<p>There is a need to finalize major phases (rapid data collection and dissemination) and to fully adopt refinements being made along its development. At this point, risks and assumptions must be adjusted to mitigate external barriers to implementation (i.e., lack of field partners' time and human resources during the pandemic).</p> <p>More is needed to ensure quality of data and accountability in monitoring practices. Strengthening quality of data obtained from remote methods may require additional qualitative remote measures for corroboration. There may also be more sustainable and reliable methods of increasing compliance for data encoding other than a <i>pahiyaan</i> (shaming) system.</p> <p>In general, sustained programmatic evaluations of M&E approaches used by USAID are urgently needed.</p>
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II. BARMMHealth

<p>Hybrid monitoring of FP program through site visits, phone calls, and FB messenger</p> <p>Weight: Level 2a</p>	<p>The assessment for this practice is a special case because identified respondents were all from (non-USAID) regional and provincial counterpart health offices, which was then regarded as the inner setting. Although USAID BARMMHealth utilizes data collected by the BARMM Ministry of Health (MOH) and PHOs, they also conduct independent monitoring adjacent to the monitoring of the local health offices.</p> <p>This assessment considered USAID BARMMhealth as part of the outer setting that supports local monitoring activities. Given their current critical role in providing TA and other external support to the monitoring activities of the local health offices, key recommendations will focus on actions that USAID BARMMHealth can take to further strengthen and sustain the capacity of the local health offices to implement their monitoring activities, especially beyond the life of the project.</p> <p>In general, there is a need to address the persistent challenges inherent in BARMM's unique geographical and digital environment. For example, limitations in securing MOVs or conducting inspection through remote approaches may be addressed by alternative qualitative remote measures for corroboration. Given their technical capacity, BARMMHealth can help develop guidelines for conducting hybrid monitoring activities of the local health offices. This will translate current iterations for hybrid monitoring into official mandates that will help improve both the monitoring process and quality of data.</p> <p>Given the unique set up of BARMM Region's health system, there is an urgent need to strengthen communication and collaboration with MOH-BARMM. The</p>
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	<p>regional health office (RHO) will need to assume current support that BARMMHealth provides to the PHOs’ monitoring activities, as they will sustain these activities beyond the life of the BARMMHealth project; and the RHO will need capacity-building support and TA for auditing and monitoring the provincial level. Human resources and communication allowances will also be needed to facilitate monitoring activities at the RHU level.</p>
<p>Blended P&R Sessions</p> <p><i>Weight: Level 2a</i></p>	<p>There is urgency in addressing poor Internet connectivity in partner areas.</p> <p>Adopting blended P&R will be difficult because FTF is still preferred. Some exploration on how to strengthen blended P&R is needed, focusing on refining and defining the protocol, building incentives, and assessing the quality of information generated.</p>
<p>KoboToolbox</p> <p><i>Weight: Level 2b</i></p>	<p>BARMMHealth needs to determine and address causes of non-reporting among some RHUs to ensure completeness of data. Both paper-based and Kobo forms need updating to preserve data precision. Also, counterpart staff need training to navigate this new technology for data collection.</p> <p>The interoperability of KoboToolBox with DOH data entry forms should also be explored to identify any duplicated processes.</p> <p>There is still limited understanding about the advantages of KoboToolBox versus the project management information system of BARMMHealth. Because the project intends to transition to the latter, the former needs to be designed/developed in a way to ease transition such that it is acceptable to the end users. Good practices to be adapted and maintained during the transfer must be identified.</p>
<p>III. MTaPS</p>	
<p>Remote Access to Information Systems (DOH-PMIS and ITIS)</p> <p><i>Weight: Level 1</i></p>	<p>DOH needs to resolve a number of issues around funding, equipment, server problems, human resources, data quality, and sustainability.</p> <p>USAID, as a more meaningful partner and co-developer, should continue to actively participate in planning for HIS strengthening of DOH-PMIS and ITIS. Collaborative agreements for system development, performance analytics, TA, resource support, as well as TA on DQA activities for DOH should be sustained to ensure that DOH is able to pursue their plans for developing the HIS platforms. Costing of the development and sustainability of DOH-PMIS and ITIS should be done, and data should be used to inform how to run and manage these information systems.</p>
<p>COVID-19 Special</p>	<p>Recommendations for future monitoring efforts by DOH would include</p>

<p>Response Project-hybrid monitoring of facilities (onsite and virtual)</p> <p><i>Weight: Level 2b</i></p>	<p>capacitating HCWs to conduct hybrid monitoring activities (since they are used to being mobilized in the field) as well as educating the people you are monitoring on the use of technology, monitoring processes, and data to be reported in both FTF and virtual. Issues in Internet connectivity should be resolved as well.</p> <p>If partners such as DOH prefer WebEx as the online video conferencing platform, USAID MTaPS should adapt accordingly to facilitate its use.</p>
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IV. ProtectHealth

<p>CiTEC Project Regular Online Conference Calls with TB IHSS, Cebu City LGU, and other stakeholders (e.g., Central Visayas Center for Health Development and Barangay officials)</p> <p><i>Weight: Level 3</i></p>	<p>A few minor issues need to be addressed to improve the effectiveness and quality of these regular conference calls. As recommended by the participants, the agenda for the calls should focus on concerns that require all-party consensus and issues that need to be urgently addressed to avoid repetitive updates. Software extensions may be downloaded to further improve participant experience in the meetings, such as noise-canceling applications. Additionally, participation in these meetings may be more effectively sustained by provision of incentives (e.g., representation allowance) rather than disciplinary measures (e.g., set quotas on the number of meetings to be attended).</p> <p>Specific guidance with legal or contractual implications (e.g., recording without consent of participants) can help improve the quality and security of the conference calls.</p> <p>While there is not plan to sustain the practice after the CiTEC project, it is worth considering in future work with a similar set-up, particularly if the organization is ready to implement the practice and there are minimal challenges to continue implementation.</p> <p>The development of a protocol may further enhance the implementation of regularly scheduled video conference calls across diverse and distinct units/participants. A set of guidelines covering the essential dimensions of an online conference call can improve the procedures and serve as a baseline to gauge quality improvements. Guidelines could cover provisions on the use of the online conference platform, ethical considerations, agenda-setting, and key roles and responsibilities of regular meeting participants (e.g., implementation leader). A manual may also benefit other IPs or organizations who intend to employ the same practice.</p>
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V. RenewHealth

<p>CBDR IMS</p>	<p>The IMS needs to be finalized based on LGU and partner government agencies' needs, and to fully adopt the refinements being made along its development.</p>
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<p><i>Weight: Level 0</i></p>	<p>Despite having planned measures to mitigate risks in implementation, support to LGUs may need to be adjusted to unforeseen challenges once the system is finalized and implemented on the ground.</p> <p>Ensuring the system is sustained beyond the life of the project requires intensified engagement with partner agencies (DOH, DDB, Department of Interior and Local Government, Department of Social Welfare and Development). RenewHealth must also secure the buy-in of an agency that may continue the legacy of the IMS before the project ends. Establishing <i>plantilla</i> (permanent, full-time) positions for system implementers in the LGU may be needed to mitigate constant staff turnover.</p> <p>Assessments on the effectiveness of the system are also needed, both to support USAID RenewHealth M&E and its ability to improve data management and sharing between the LGU and partner government agencies.</p> <p>Guidelines to be developed for CBDR IMS should be both detailed to be useful to field-level implementers and inclusive to consider the various contexts of LGUs (i.e., differing structures of CBDR service delivery across LGUs) that will be using this system.</p>
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VI. TB Platforms

<p>Hybrid monitoring of TBCC using regularly scheduled phone calls and onsite monitoring/mentoring visits</p> <p><i>Weight: Level 2b</i></p>	<p>Hybrid monitoring of TBCC is still recommended given the ongoing pandemic, as call log sheets can be validated remotely. Current call log sheets should also incorporate transactions/communications which used FB messenger to avoid creating a "false decrease" of calls/communications with the patient (current log sheets only count phone calls). A monitoring tool for use during the scheduled phone calls, as well as an orientation for the use of this tool, should be developed. Provision of forms should be streamlined as well.</p> <p>In implementing the TBCC, official protocols/guidelines should be developed to better elicit needed data from the patients. TB Platforms should also devise a better way to disburse communication allowances for HCWs, preferably in the facilities instead of at the province level).</p> <p>Ensuring the sustainability of TBCC and its monitoring activities beyond the life of the project will entail further investigation of the local context as to where TBCC is being implemented (such as number of RHUs implementing TBCC, restrictions of TBCC in a certain area). There is a need to look at other facilities interested in implementing TBCC and to engage stakeholders such as the RHUs, Municipal Health Offices, Development Management Officers (DMOs), and PHOs at the local level. Sustainability measures should focus more on the district and</p>
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	<p>provincial levels . There must first be evidence for sustainability at the local level before scaling up up at the national level.</p>
<p>Hybrid monitoring/ mentoring for FAST implementing facilities</p> <p><i>Weight: Level 1</i></p>	<p>This is a promising M&E practice, but challenges during implementation would suggest that it is not feasible to scale at the moment. Given its potential adaptability and sustainability, we provide these recommendations.</p> <p>Strengthening the quality of data from the intervention and sustaining its implementation will require addressing inadequate human resources and the current limitations in the remote monitoring approaches used. Field counterpart partners must be able to document and provide data for monitoring to ensure the quality of data. Short-term assistance may not be sufficient to address the lack of human resources on either side of the monitoring activity. Overcoming this hurdle may require additional staff focused on M&E (TB Platforms side), and retraining current point persons and building capacity of other staff members in the FAST implementing facilities (counterpart facilities side).</p> <p>Previous iterations for the use of remote approaches should be institutionalized as official mandates to improve both processes and data quality. Adding hybrid monitoring to the current process guide will improve remote monitoring procedures and quality of data obtained from remote approaches. Strengthening the quality of data obtained from remote methods may also require additional qualitative remote measures for corroboration. In addition, it can be leveraged to ease the burden of onsite monitoring. As stated by one of the participants, “We have proven that there are certain activities we can do, such as the hybrid mechanism, that it can be remotely or virtually done. There are less physical activities since most have been conducted virtually.”</p> <p>Shifting from FTF to remote approaches requires adjusting expectations of what successful implementation looks like given the inherent differences between the two modes. Having set guidelines for a hybrid approach will help to this end. These guidelines can also serve as a baseline process guide to gauge quality improvements when remote approaches are used. Findings may then be integrated with the internal evaluation of the implementation of FAST strategy as whole. The creation of a manual will eventually benefit the organizations which intend to continue monitoring FAST implementation beyond the life of TB platforms, or other organizations seeking to employ similar remote monitoring approaches.</p>
<p>Assessment of IPC using Google Survey</p> <p><i>Weight: Level 0</i></p>	<p>Before considering the use of different platforms such as Open Data Kit or DHIS, the current design must be assessed to mitigate the risk of failure with the use of another digital platform. The questionnaire used in the survey should be shorter (fewer questions), and other platforms can be considered for open-ended</p>

	<p>questions. In any survey, respondent issues such as busy schedules and Internet connectivity should be considered. In addition to using Google Surveys, paper-based hard copy or soft copy Word files may be provided as an alternative option. With the influx of online surveys, respondent burnout is a risk. Thus, it is important to provide feedback to respondents so they understand the value of the data being collected.</p> <p>A clear framework is needed in the pre-implementation phase. There was no clarity regarding baseline acceptability of the survey; consultations on the design; conduct of validation, pre-testing or piloting; looking at actors/players involved; and other important considerations at the pre-implementation stage. Preference for other platforms aside from Google Survey may have affected planning and implementation of this activity.</p> <p>The appropriateness of the people providing feedback to the facilities should be considered. Feedback may be done in tandem with a DMO who may already have regional connections to allow backing. It may have been inappropriate to have someone with a background in engineering engaged for the baseline assessment of IPC.</p> <p>Overall, Google Surveys has great potential due to its innovation, global interoperability, and advantages. However, due to poor planning and implementation, this was not utilized well. A more in-depth investigation is needed to identify for the reasons for failure. An key lesson from this experience is the importance of good planning prior to implementation.</p>
<p>PMDT remote monitoring and mentoring</p> <p><i>Weight: Level 2a</i></p>	<p>Improving the quality of information obtained through remote monitoring will involve several adjustments in implementation. This may require additional qualitative remote measures for corroboration. The remote monitoring tool can also be enhanced to capture more detail for well-informed decision making. Regular orientation or a briefer may also be provided to the participating facilities on how to answer the monitoring tool to avoid misinterpretation of the questions.</p> <p>Remote monitoring and mentoring in PMDT facilities is a good alternative when in-person activities are not possible and may also be used in tandem with FTF monitoring. Where possible, monitoring/mentoring sessions can be conducted in a hybrid manner: some activities such as FGDs and filling out the monitoring tool can be done online, while data validation is better done in-person if feasible.</p> <p>The protocol for PMDT monitoring/mentoring may be revised to include steps to do this remotely or using a hybrid approach. These will guide cases where onsite monitoring is not feasible or if a hybrid setup for monitoring is possible.</p>

	<p>According to a participant, “Hybrid is good because there are remote and FTF activities. Only two representatives per STC are needed. Also since my STC is small, FTF monitoring is not advisable if there are a lot of attendees. But it is also good for them to see the difficulties of the STC nurses.”</p> <p>DQCs can also be done in a hybrid manner, especially for those who are not provided any accommodation since they reside within the same province but live far from the conference venue.</p> <p>The development of guidelines for remote and/or hybrid monitoring of PMDT facilities may improve the quality of monitoring procedures and, by extension, the overall quality of data obtained. Development of said guidelines can also serve as a baseline process guide to gauge quality improvements when remote or hybrid approaches are used. Written guidelines will eventually benefit organizations which seek to use similar remote monitoring approaches.</p>
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VII. TB IHSS

<p>Remote P&R sessions</p> <p><i>Weight: Level 3</i></p>	<p>Regional implementation teams should be trained to conduct and process outputs from P&R to decrease the burden on support staff and the SI unit. Addressing poor Internet connection in partner areas may improve engagement in remote P&R sessions.</p> <p>Other practices which use an online conferencing format may adopt TB IHSS use of online polling, e-games, and other interactive methods to sustain the attention of participants.</p>
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<p>Remote rapid assessment survey</p> <p><i>Weight: Level 3</i></p>	<p>The remote rapid assessment found that remote data collection has been successful in the dynamic COVID-19 situation. Factors contributing to the implementation’s success include: 1) being mindful of HCWs’ busy schedules by designing a short but comprehensive questionnaire, 2) validating and pre-testing the questionnaire, 3) providing paper-based forms (that HCWs can take photos of) to be sent to the Field Implementation Officer [FIOs]) as well as soft copy Word files (can be sent via email), 4) conducting ongoing validation simultaneous with data collection to clarify any missing or conflicting information, and 5) involving upper to lower management. Complementing these practices was a strong commitment of personnel involved,</p> <p>Because this is considered as a good practice, TB IHSS can start formulating steps for quality improvement and process excellence such as having pre-implementation checks for scaling up (same rigor of planning, collection, and analysis), mid-implementation monitoring, and post-implementation M&E. If this is well-designed, scale-up of the practice is easier and investments are not poorly</p>
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placed since there is acceptability and trialability at the pre-implementation phase. USAID should consider the best way to persuade DOH to adopt the practice as it has been conducted by TB IHSS.

If the survey is to be used in the future, the questionnaire will need further modifications to ensure it remains relevant to the current situation and the needs of DOH NTP. Sample size should be increased (if possible, not limited to the big three regions) to thoroughly evaluate reliability of the results and provide better analysis of data. More time should be allotted for implementation, and logistics should be considered (e.g., communication allowance for Internet connectivity). If implemented nationally, NTP should have a department memo/policy on the conduct of the surveys to make it easier for the hospitals because they are informed of its importance.

7. CONCLUSION

The use of remote M&E practices has become the “new normal” in the COVID-19 era. Although remote M&E methods are not new to development and humanitarian work, the pandemic has forced almost all organizations to increase use of such methods to comply with restrictions. This assessment of the remote and hybrid M&E practices within the HP has shown how digital technologies play a vital part in responding to the need for remote M&E solutions. The nature of these technologies and the complexity of the needed information influenced the levels of effectiveness, adoption, and adaptation. Individual and organizational facilitators of implementation include resource allocation, leadership and policy support, external party involvement, trust and commitment of implementers, relevant digital skills, and adequacy of process orientation (e.g., through SOP). Barriers include complexity of the M&E solution, FTF preference or staff resistance, technological failures (e.g. Internet signal), poor data quality generated, low participation, overburdened staff, and low leadership support.

Strengthening M&E systems would require digital training, commensurate investments in associated technology, use of multiple tools and methods to improve data validity, context understanding, and end-user studies to improve the intervention. Implementation can be strengthened by reducing complexity and generating user confidence in the collected data. Additional studies are recommended to objectively and extensively assess the data quality from remote practices when compared to FTF methods, particularly in LMIC settings.

Of the 16 remote and hybrid M&E solutions, three were evaluated as good practices: TB IHSS Remote Rapid Assessment Survey, TB IHSS Remote P&R Sessions, and ProtectHealth’s CiTEC Project Regular Online Conference Calls. All three demonstrated features of an effective M&E practice, had fidelity in the implementation design, were feasible to scale, and had potential for sustainability. Nascent systems such as RenewHealth’s CBDR IMS still warrant further observation. Hybrid practices, in particular, consistently showed an optimal level of M&E effectiveness and acceptability in the study. It is then expected that post-pandemic ways of working in M&E should employ more hybrid practices where remote methods will complement FTF activities rather than fully replacing them.

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ANNEX I: CFIR DOMAINS AND CONSTRUCTS^{85,86}

DOMAIN	SHORT DESCRIPTION
Intervention characteristics	Aspects of an intervention that may affect implementation success, including its perceived internal or external origin, evidence quality and strength, relative advantage, adaptability, trialability, complexity, design quality and presentation, and cost.
Outer setting	External influences on intervention implementation including patient needs and resources, cosmopolitanism or the level at which the implementing organization is networked with other organizations, peer pressure, and external policies and incentives.
Inner setting	Characteristics of the implementing organization such as team culture, compatibility and relative priority of the intervention, structures for goal-setting and feedback, leadership engagement, and the implementation climate.
Characteristics of individuals	Individuals' beliefs, knowledge, self-efficacy, and personal attributes that may affect implementation.
Process of implementation	Stages of implementation such as planning, executing, reflecting and evaluating, and the presence of key intervention stakeholders and influencers including opinion leaders, stakeholder engagement, and project champions

⁸⁵ Safaeinili, Nadia et al., 2020.

⁸⁶ Constructs (n.d.)

ANNEX 2: IDENTIFIED M&E DOMAINS

M&E Domains	Description
Overview of the overall M&E system	This includes planning, capacity building, adaptive management, and the necessary resources for the implementation of the practice or the M&E system (e.g., budget, personnel, equipment).
Monitoring System	This involves the implementation of set activities (e.g., data collection, management, analysis, validation, consolidation, interpretation, reporting or dissemination, utilization) in the MEL plan which involve monitoring performance data.
Evaluation System	This involves plans and processes related to evaluation activities of the IPs.
Information management	This refers to the systems and processes related to the management of collected and stored data.
Monitoring of risks and assumptions	This refers to the processes involved in the identification and monitoring of risks and assumptions of project implementation.
Data quality	Assessing the quality of data involves looking into the criteria below:
<ul style="list-style-type: none"> • Timeliness 	Data are available at useful frequency, are current, and timely enough to influence management decision making
<ul style="list-style-type: none"> • Reliability 	Data reflect consistent collection processes and analysis methods over time
<ul style="list-style-type: none"> • Validity 	Data clearly and adequately represent the intended result
<ul style="list-style-type: none"> • Precision 	Data have sufficient level of detail to permit management decision making
<ul style="list-style-type: none"> • Integrity 	Data have safeguards to minimize the risk of transcription error or data manipulation

ANNEX 3: SUSTAINABILITY DOMAINS OF THE PSAT

Domains	Description
Environmental Support	Having a supportive internal and external climate for your program
Funding Stability	Establishing a consistent financial base for your program
Partnerships	Cultivating connections between your program and its stakeholders
Organizational Capacity	Having the internal support and resources needed to effectively manage your program
Program Evaluation	Assessing your program to inform planning and document results
Program Adaptation	Taking actions that adapt your program to ensure its ongoing effectiveness
Communications	Strategic communication with stakeholders and the public about your program
Strategic Planning	Using processes that guide your program's direction, goals, and strategies

ANNEX 4: DATA COLLECTION TOOLS



Annex 4 - Data
Collection Tools.docx

ANNEX 5: DATA COLLECTION TABLES



Annex 5 - Data
Collection Tables.xlsx

ANNEX 6: SUMMARY OF IDENTIFIED M&E PRACTICES BY CATEGORY

M&E Practice	IP	Level	Facilitating Factors	Hindering Factors
I. Phone-based practices				
Remote phone monitoring	ReachHealth	2	<ul style="list-style-type: none"> Well resourced (staff, money, equipment) Well integrated within the general M&E system Cheaper than FTF 	<ul style="list-style-type: none"> Low acceptability from enumerators Long questionnaire Compromised data quality Not appropriate for specific FP indicators (e.g., FP stockout rate) Low response rate
II. Web-based practices				
Remote rapid assessment survey	TB IHSS	3	<ul style="list-style-type: none"> Well resourced (staff, money, equipment) Well integrated within the general M&E system Multiple modes of data collection Short yet comprehensive questionnaires Conducted pre-testing and validation of tools Training and manuals provided to enumerators Communications allowance provided to respondents Constant follow-up of enumerators Regular validation of data Strong commitment of personnel involved Involvement of upper to lower management 	<ul style="list-style-type: none"> No policy developed, only concept note Low sample size Difficulty ascertaining reliability of responses Tight window period
Assessment of IPC using Google Survey	TB Platforms	1	<ul style="list-style-type: none"> Well resourced (staff, money, equipment) Well integrated within the general M&E system Training provided to field staff 	<ul style="list-style-type: none"> No official SOP or policy Poor data quality especially with open-ended questions Low response rate Discomfort in using Google Sheets Limited field staff technical capacity in analysis and providing feedback Limited field staff technical capacity in providing TA on engineering Negative experiences of staff in giving feedback

KoboToolBox	BARMMHealth	2	<ul style="list-style-type: none"> • Aligned with the general M&E system • Well resourced (staff, money) • Orientations provided to provincial staff • Automatic generation of tables and charts • Bias measures conducted 	<ul style="list-style-type: none"> • Not updating the online and paper-based forms at the same time • Low reporting rates
III. Videoconferencing practices				
Blended P&R sessions	BARMMHealth	2	<ul style="list-style-type: none"> • Well resourced (staff, money, equipment) • Well integrated within the general M&E system 	<ul style="list-style-type: none"> • Limited Internet connectivity in some areas • No SOP/guidelines for P&R sessions
Remote P&R sessions	TB IHSS	3	<ul style="list-style-type: none"> • Well resourced (staff, money, equipment) • Well integrated within the general M&E system • Has a licensed platform account • Had pre-pandemic experience of hybrid P&R sessions, with interactive activities 	<ul style="list-style-type: none"> • No SOP/guidelines for P&R sessions
CiTEC project regular online conference calls	ProtectHealth (and TB IHSS)	3	<ul style="list-style-type: none"> • Well resourced (staff, money, equipment) • Well integrated within the M&E system for the CiTEC project, which is aligned with the general M&E system of ProtectHealth • Capacity to adapt (flexible schedule) • Communications allowance provided • Added security measure (in Microsoft Teams) 	<ul style="list-style-type: none"> • No guidelines on the process • Repetitive updates
PMDT remote monitoring and mentoring	TB Platforms	2	<ul style="list-style-type: none"> • Well resourced (staff, money, equipment) • Well integrated within the general M&E system 	<ul style="list-style-type: none"> • Potential bias from respondents • Limited data validation affecting perceived data quality • No guidelines developed
IV. Information management system practices				
DHIS 2	ReachHealth	2	<ul style="list-style-type: none"> • Aligned with the general M&E system • Well resourced (staff, money, equipment) • Consultant available • Automatic features 	<ul style="list-style-type: none"> • Limited system capacity to manage volume and complexity of information collected
CBDR IMS - <i>still being developed</i>	RenewHealth	0	<ul style="list-style-type: none"> • Aligned with the general M&E system • Well resourced (staff, money, equipment) 	<ul style="list-style-type: none"> • Early stages of the program • Lack of clear CBDR indicators • No guidelines developed

V. Remote access software practices				
Remote access to information systems (DOH-PMIS and ITIS)	MTaPS	1	<ul style="list-style-type: none"> Well resourced (staff, money, equipment) Well integrated within the general M&E system Real-time updates and fuller access to data Presence of data map 	<ul style="list-style-type: none"> Lack of sustainable funding for DOH-PMIS and ITIS (government) Identified data quality issues in DOH-PMIS and ITIS
VI. Hybrid practices in USAID Philippines HP				
Hybrid Rapid Feedback Mechanism - <i>still being developed</i>	ReachHealth	2	<ul style="list-style-type: none"> Well resourced (project staff, money, equipment) at national level Well integrated within the general M&E system Quick turnaround time 	<ul style="list-style-type: none"> Perceived data quality issues Limited field staff in counterpart facilities
Hybrid monitoring of FP program through site visits, phone calls, and FB messenger	BARMMHealth	2	<ul style="list-style-type: none"> Well resourced (staff, money, equipment) at provincial level Communications and transport support provided at provincial level Pre-pandemic experience of hybrid P&R sessions Data validation measures in place 	<ul style="list-style-type: none"> Limited staff and communication allowance at RHU level No guidelines on the process Limited Internet connectivity of some facilities
COVID-19 Special Response Project - hybrid monitoring of facilities (onsite and virtual)	MTaPS	2	<ul style="list-style-type: none"> Well resourced (money, equipment) Few data quality issues which were easily addressed 	<ul style="list-style-type: none"> Not aligned with the general M&E system Challenges with human resources Dual responsibilities of staff (COVID-19 and regular project work)
Hybrid monitoring of TBCC using regular scheduled phone calls and onsite monitoring/mentoring visits	TB Platforms	2	<ul style="list-style-type: none"> Well resourced (staff, money, equipment) Well integrated within the general M&E system Communications allowance provided Guide on filling out the forms (patient contact form and summary log sheet) available Monitoring tool available for the facility visits Follow-up calls made if late submission 	<ul style="list-style-type: none"> Issues with the form Limited availability of facility staff for monitoring No monitoring tool used for the phone calls SMS/FB Messenger calls not logged
Hybrid monitoring and mentoring for FAST facilities	TB Platforms	1	<ul style="list-style-type: none"> Well resourced (money, equipment) at national level Well integrated within the general M&E system Multiple modes of data collection Communications allowance provided Clear instructions for 	<ul style="list-style-type: none"> Limited human resources at field and facility level No guidelines for remote monitoring COVID-19 workload of point persons Difficulty in data validation remotely

			accomplishing the tools • Virtual meetings to validate data	• Difficulty in scheduling FTF visits
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ANNEX 7: IMPLEMENTATION FIDELITY OF EACH IDENTIFIED PRACTICE IN THE SELECTED USAID IPs

IP	Remote and Hybrid M&E Practice	Associated with a plan	Progress
ReachHealth	DHIS 2	✓	Delayed
	Remote Phone Monitoring	✓	On Track
	Hybrid Rapid Feedback Mechanism	✓	Delayed
BARMMHealth	Hybrid monitoring of FP program through site visits, phone calls, and FB messenger	x	On Track
	Blended P&R Sessions	✓	On Track
	KoboToolBox	✓	On Track
MTaPS	Remote access to information systems (DOH-PMIS and ITIS)	✓	On Track
	COVID-19 Special Response Project- hybrid monitoring of facilities (onsite and virtual)	✓	Delayed
ProtectHealth	CiTEC project regular online conference calls	✓	On Track
RenewHealth	CBDR IMS	✓	Delayed
TB Platforms	Hybrid monitoring of TBCC using regular scheduled phone calls and onsite monitoring/mentoring visits	✓	On Track
	Hybrid monitoring/mentoring for FAST implementing facilities	✓	On Track
	Assessment of IPC using Google Survey	✓	Aborted
	Remote monitoring and mentoring of PMDT	✓	Delayed

TB IHSS	Remote P&R sessions	✓	On Track
	Remote rapid assessment survey	✓	On Track

ANNEX 8: CONSOLIDATED EVALUATION FRAMEWORK OF THE IDENTIFIED REMOTE AND/OR HYBRID M&E PRACTICES

Remote and/or Hybrid M&E Practice	M&E Assessment	IR Assessment	Weighted Evaluation
I. ReachHealth			
DHIS 2	DHIS 2 has adequate financial and human resources in place, and it is aligned with the general M&E system. DHIS 2 has improved data management and expedited certain processes in ReachHealth. It has generated good quality data for decision making, but not for a significant amount of time to reliably conclude effectiveness.	Fidelity: Had delayed implementation which led to sequential delays in training, refitting, adoption to revised contexts, unclear status of establishment of validation rules, dashboard development, migration of databases (compounding the effect of delayed establishment). DHIS 2 has good feasibility, deemed a good system with good organizational championship. Issues that can become major considerations included implementer-level training limitations, radicalness (technology mismatch). There is promising sustainability, based on good fidelity in terms of general adherence to the design of implementation despite delays and good feasibility.	Level 2a DHIS 2 being implemented within ReachHealth with adequate resources; processes in place for analysis and reporting but aligned with the general M&E system; generated evidence of good quality has been used for decision making but not consistently; good fidelity, with adaptation and feasible to scale (acceptable); some gaps and challenges identified on the domains observed.
Remote Phone Monitoring	The collection of data using remote phone monitoring is well resourced as evidenced by available data collectors (project staff) and materials (phone with allocated communications allowance). Serving as an alternative to in-person facility monitoring, it is integrated well within the general M&E system: follows the same data flow, using	There is good fidelity because adaptation ensures the implementation of quarterly monitoring data collection despite restrictions under the pandemic. Further adaptations were made to ensure regular monitoring (i.e., FTF options in case remote is not possible). Starting Q2 FY 2020, use of remote phone monitoring	Level I ReachHealth is implementing remote phone monitoring with adequate resources; processes in place for analysis and reporting

	<p>the same standard facility monitoring tool, stored and managed in the same DHIS 2 database. The data generated are analyzed, visualized, and are used by the team particularly in reporting to USAID and during reviews with partners.</p> <p>However, there were a few challenges identified, particularly on staff acceptability and data quality. Field staff are not comfortable making long phone calls with high-level officials by asking them many questions, which could be addressed by shortening the tool. Also, the quality of data collected through remote phone monitoring has been compromised in a few indicators, specifically the FP stockout rate, where prior to COVID-19, actual inspection of inventory was the only acceptable practice for monitoring. When constraints of COVID-19 are removed, FTF data collection rather than phone interview is preferred by both project and field counterpart staff.</p> <p>We are suspending judgment on the effectiveness of the remote approach in comparison to the FTF approach for data collection. Despite specific gains in terms of coverage (1,250 public health facilities in FY 2020 vs. random sampling via FTF prior to Y2Q2) and cost-effectiveness, the remote approach may have less reliability in tracking some indicators (e.g., stockout rates) as well as issues with user acceptability. Unlike for indicators, the standard for monitoring stockout rates requires actual onsite inspection and, according to a key informant, there are studies showing a decline in reliability when remote approaches are used. Moreover, there is limited information in assessing the effectiveness of the approach because some decline in information gathered can be supported by the challenges faced during COVID-19 (i.e., non-responses due to busy schedules of the partners), not necessarily correlated to the ineffectiveness of the phone</p>	<p>was also able to expand the coverage of quarterly monitoring to almost all sites compared to facility visits from randomly sampled sites done in previous quarters.</p> <p>There may be limited feasibility despite no major issues on mandates, budgets, and training specific to implementation of phone monitoring. Project staff and field counterpart staff both expressed preference for FTF data collection. Despite wider coverage in phone monitoring, there are some issues in ensuring data quality (i.e., reliability of stockout rate). Participants also identified several relative advantages of field visits over data collections: rapport, immediate TA, reliability, seamlessness, and appropriateness (especially with high-level interviewees). The main factors that limit feasibility at the implementer level may be a result of the users' lack of familiarity with the remote approaches versus FTF approaches.</p> <p>With good fidelity and limited feasibility, the practice may not be sustainable as regularly maintained activity due to the lack of support from project and field counterpart staff alike. Reliance on this mode of data collection also depends on the situation of the pandemic. However, this may still serve as an important alternative measure to data collection that complements FTF approaches to ensure and enhance monitoring in certain cases.</p> <p>It is worth noting that while the respondents for this practice are central office staff members, they were able to highlight field implementer-level challenges for remote phone monitoring.</p>	<p>but run aligned with the general M&E system; generated evidence of good quality has been used for decision making but not consistently; good fidelity, with adaptation, limited feasibility (acceptability) on the side of ReachHealth; some gaps and challenges identified on the domains observed.</p>
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	<p>monitoring.</p> <p>Overall, this can be considered as an efficient alternative in cases where in-person facility monitoring visits are not possible. This serves to complement FTF data collection rather than replace it.</p>		
Hybrid Rapid Feedback Mechanism	<p>The hybrid rapid feedback mechanism has adequate financial and trained human resources for its implementation. Its data collection, analysis, and reporting processes are aligned with the general M&E system. Implementation of the mechanism has allowed for immediate feedback to partners in some facilities, but it is challenged by some data quality issues due to its remote approach for data collection, and the lack of human resources and time (during the pandemic) on the side of field partners. It has generated good quality data for decision making, but not for a significant amount of time to reliably conclude effectiveness. Major aspects of the mechanism are still currently being finalized.</p>	<p>Despite delayed implementation, there may be good fidelity because adaptations improved data encoding and management and due to the data collection tool's ease of use and accountability systems for encoding; there are only minor deviations due to external factors (i.e., unavailability of field partners during feedback). The range of adaptations presented has increasing integration and acceptance within the system but needs further solidification into the common practice. Considering only USAID ReachHealth's internal capacity to implement the rapid feedback mechanism, there may be limited to moderate feasibility. Despite adequate mandates, budget, and training in place, the practice may not be feasible to scale due to unresolvable issues related to fulfilling mandates on the side of the field partners. Challenges in accomplishing rapid data collection and providing feedback at the required levels (i.e., lack of field partners' time and human resources during the pandemic) are beyond the control of USAID ReachHealth. With good fidelity (based on general adherence to design of the practice) and limited to moderate feasibility (the organization's internal capacity to implement the practice), there may be promising sustainability for this developing practice, especially because it is driven by the recommendation of USAID.</p>	<p>Level 2a</p> <p>Hybrid rapid feedback mechanism is being implemented within ReachHealth with adequate resources; processes in place for analysis and reporting but aligned with the general M&E system; good quality evidence has been used for decision making but not consistently; good fidelity, with adaptation and limited to moderate feasibility to scale (acceptable) on the side of ReachHealth; some gaps and challenges identified on the domains observed.</p>
II. BARMMHealth			
Hybrid	Data collection and validation using the combination of	There is good fidelity as they continued using the	Level 2a

<p>monitoring of performance through site visits and validation through phone call and FB Messenger</p>	<p>hybrid monitoring approaches (site visits, phone calls, and FB messenger) has adequate resources as evidenced by available human resources and communication allowance at the provincial level. BARMMHealth also provides support to the implementation through transportation for the PHO staff and allowances (transportation and representation) for participants of the monitoring activities at the RHU level. However, there may be a need to provide support for human resources and communication allowances at the RHU level in some areas. The hybrid monitoring approaches have been employed even before the pandemic and are well integrated within the general M&E system of the BARMM PHOs. With several data validation measures in place, data generated are of good quality. Despite specific challenges identified for each mode of data collection/validation, hybrid monitoring is seen as more effective than purely onsite or remote monitoring, as it allows adaptation to the geographical context, access to decent Internet and mobile connectivity, and the constantly changing situation of the pandemic. Data collected through hybrid monitoring approaches have been consistently used for monitoring the activities of the FP program. Overall, this can be considered as a good practice as it has ensured the continuity of monitoring despite the various constraints brought about by the pandemic. Implementation of this hybrid approach to monitoring is envisioned to continue during and even beyond the pandemic.</p>	<p>combination of hybrid monitoring approaches, adapting in terms of frequency of mode used, to ensure quarterly monitoring activities under the pandemic. There may be moderate feasibility because there are no major issues on mandates, budgets, and training specific to implementation of hybrid monitoring approaches. No individual challenges were presented by the participants. However, participants at the regional level identified challenges in coordination and collaboration for activities in partnership with BARMMHealth. Given the unique set up of BARMM Region's health system, organizational level support for monitoring activities from the regional level is as important as implementer level support from the provincial level. In addition, some organizational challenges in executing each specific mode of data collection may be difficult to address because they are tied to wider geographical (weather, island areas) and digital limitations (Internet, mobile connectivity) across the BARMM PHOs. Despite good fidelity and moderate feasibility, the hybrid approach to monitoring in these areas may have limited sustainability. Taking into consideration that support from BARMMHealth is temporary (the project will end by 2024), sustainability will be ensured if constant coordination, collaboration, and support from MOH-BARMM is solidified before the project ends.</p>	<p>The hybrid approach to data collection and validation is being implemented within the BARMM PHOs with adequate resources; good quality evidence has been consistently used for decision making; good fidelity, with adaptation and feasible to scale; some gaps and challenges identified on the observed domains.</p>
<p>Blended P&R Sessions</p>	<p>Blended P&R has adequate financial and human resources in place, and it is aligned with the general M&E system. Blended P&R has contributed to the M&E goals of the project as a venue to strategize and learn from well-performing areas. However, this approach still has limited reach because some areas cannot participate in online sessions, and it is not guaranteed that BARMMHealth staff can conduct in-person P&R due to travel restrictions. The blended approach was able to inform project activities but</p>	<p>It is difficult to assess fidelity of blended P&R because there is no tangible protocol to reliably account for its performance. Blended P&R also has limited to moderate feasibility; the hybrid method cannot ensure that if participants cannot join online meetings, in-person sessions can be conducted, and vice versa. No individual challenges were stated by the participants. With good fidelity in terms of adherence to the Activity Monitoring, Evaluation, and Learning Plan (AMELP) and</p>	<p>Level 2a Blended P&R is being implemented within BARMMHealth with adequate resources; good quality evidence has been consistently used for decision making; well-aligned with the general M&E system; good</p>

	was not able to collect inputs from all involved partners, thus having limited effectiveness.	limited to moderate feasibility, blended P&R may not be sustained as a regular activity due to its limited reach. However, it may be useful as an alternative measure while in-person P&R is not yet possible. Decisions are not incumbent upon P&R sessions; thus there is no urgency to conduct them. To address this, organizational incentives must be clarified to ensure the regular conduct of P&R sessions for the improvement of M&E processes.	fidelity, with adaptation and limited to moderate feasibility; some gaps and challenges identified on the observed domains.
KoboToolbox	KoboToolBox has adequate financial and human resources in place, and it is aligned with the general M&E system. KoboToolBox has contributed to the M&E goals of the project by accelerating data collection, reporting, and generation/analysis. It has consistently generated good quality data for decision making. KoboToolBox also has good effectiveness, having successfully informed project decisions such as service delivery as well as identifying areas/themes for improvement in reporting RHUs.	KoboToolBox has good fidelity: BARMHealth was able to establish a reporting system for use while the planned PMIS has not yet been developed. A further adaptation includes the conversion of paper-based data collection tools into an electronic format to accelerate data encoding and validation. KoboToolBox also has good feasibility, being deemed a good system for data consolidation and analysis at the central office and implementer levels. Individual challenges were also well addressed, while some are beyond the control of the project. KoboToolBox also demonstrated adaptability as it can be modified according to project needs, and trialability wherein BARMHealth can easily revert back to the original data consolidation process. With good fidelity in terms of adherence to the AMELP and good feasibility, sustainability is also promising, as no major issues were identified for environmental support, funding stability, and organizational capacity to implement the practice in the long-term, until such time that the intended PMIS has been developed for use.	Level 2b KoboToolBox is being implemented within BARMHealth with adequate resources; good quality evidence has been consistently used for decision making; well-aligned with the general M&E system; good fidelity, with adaptation and feasible to scale; some gaps and challenges identified on the observed domains.
III. MTaPS			
Remote access to information systems (DOH-	Remote access to DOH-PMIS and ITIS is free. MTaPS has adequate financial and human resources in place; however, this is a challenge on the side of DOH PD, NTP, and	There is good fidelity, as the adaptation facilitated better M&E of one of its major indicators. Despite little to no issues on the side of MTaPS in implementing the	Level I Practice is already being

<p>PMIS and ITIS)</p>	<p>KMITS for the day-to-day operations of the information systems. DOH PD lacks funding support for manpower, software, and plug-ins, and is heavily reliant on DOH KMITS for its infrastructure needs. DOH KMITS is heavily dependent on Global Fund for Internet connection, servers, equipment, Apple and Google subscriptions, and human resources to operate ITIS. At the facility level, issues with human resources, equipment, and Internet connectivity pose challenges to encoding data into DOH-PMIS and ITIS.</p> <p>Remote access to DOH-PMIS and ITIS is very well-integrated with the general M&E system of MTaPS, and it has improved data analysis and use due to ease of and fuller access to the data. However, there were some issues with the quality of data in DOH-PMIS and ITIS. MTaPS is working with NTP to improve the reporting rate of its TB Directly Observed Treatment, Short-course (DOTS)-providing facilities to ITIS and to further strengthen NTP's management and analysis of inventory data from ITIS. MTaPS is also working with the DOH's PD to further strengthen their recently upgraded DOH-PMIS. Both information systems will improve the reporting and data challenges for TB medical products.</p>	<p>remote access to the information systems, there is poor feasibility on the side of partners who maintain these systems (DOH PD, NTP, and KMITS). There are major issues in human resources, inadequacy of funding and equipment, server problems, Internet connectivity, and data quality. Sustainability of operating these information systems is not ensured due to major challenges faced by partners in terms of environmental support, funding stability, and organizational capacity.</p> <p>However, MTaPS provides assistance to DOH such as quarterly meetings to review quality of DOH-PMIS stock data, and conducting analysis and providing recommendations on PD's consumption and stock-on-hand reports and on DOH-PMIS' and ITIS' stock and consumption data of TB medicines. Likewise, MTaPS is working with NTP to improve reporting rate of its TB DOTS-providing facilities to ITIS and to further strengthen NTP's management and analysis of inventory data from ITIS. MTaPS is also working with the DOH's PD to further strengthen their recently upgraded DOH-PMIS. Both information systems will improve reporting and data challenges for TB medical products.</p>	<p>implemented within MTaPS with adequate resources, but with very limited resources on the side of DOH to support continued use. Collection, analysis, and reporting of data is well integrated within the general M&E system; with evidence of poor data quality; evidence on data use for decision making; good fidelity, but with considerable gaps and challenges identified on the domains observed.</p>
<p>COVID-19 Special Response Project - hybrid monitoring of facilities (onsite and virtual)</p>	<p>This COVID-19 project of MTaPS is a special activity, with a big effort around COVID-19 was in Feb/March 2020, and a significant level of government intention to expand absorptive capacity of facilities, improve IPC, HCWM, and SCM implementation, and mitigate COVID-19 impacts. The monitoring effort was built as part of the adaptive goals to respond to the pandemic.</p> <p>There are adequate financial resources and equipment to conduct the onsite and virtual facility assessments as well as the online training. Some challenges with human resources included: 1) resignation of one national consultant, 2) delays in hiring of additional field</p>	<p>Despite some delays in the implementation of their activities due to various reasons (e.g. dynamic COVID-19 pandemic, difficulties creating the materials, and rescheduling of facilities for visits), there is good fidelity, as adaptations were made and activities indicated in the work plan were implemented by the end of the project. It also has good feasibility because there is transferability (manual of operations/SOPs), trialability, access to knowledge and information, financial resources, external policies, and leadership engagement, with some issues on human resource and use of technology (WebEx) on MTaPS' side. There was high support and cooperation from DOH due to the</p>	<p>Level 2b</p> <p>Onsite and virtual facility visits were implemented by MTaPS with adequate resources; data collection, storage, and reporting do not align with the general M&E system, but align with an emergent adaptive goal which is COVID-19 mitigation. The indicators that the special COVID-19 response project is working on relate to an indicator</p>

	<p>consultants, 3) COVID-19 infection in the team, and 4) dual responsibilities of MTaPS staff with the COVID project and regular MTaPS work. Despite these issues, the right skills and previous experiences of the team aided in the successful implementation of the activities.</p> <p>Its data collection, storage, and reporting generally do not align with the general M&E system, but align with an emergent adaptive goal of COVID-19 mitigation. The indicators that the Special COVID-19 response project is working on relate to an HP indicator (number of institutions with improved capacity on HCW and emergency SCM to assess or address disaster and climate change risks supported by USG assistance), but it is not really similar. Thus, it is difficult to assess whether the project was effective in terms of its original intentions. Some significant overlaps with the general M&E system included use of Microsoft Excel for data analysis, use of WebEx as their main video conferencing platform, and conduct of P&R sessions. Moreover, this COVID-19 project has a component on HCWM and SCM which supports MTaPS' objective in building health care facilities' resilience on climate risk mitigation.</p> <p>There were a few data quality issues identified, but these were mostly addressed or mitigated. Data gathered from the monitoring activities were immediately shared with the facilities. Likewise, a list of recommendations/areas for improvement in the three areas was shared with DOH, and data generated will be used by MTaPS and DOH to develop capacity building materials for ToT and guidelines that can address gaps at the facility level.</p> <p>Overall, the COVID-19 response project demonstrated successful onsite and virtual facility visits under a dynamic pandemic situation, with adaptations made along the course of the project. While this monitoring activity was</p>	<p>concerted effort to prioritize COVID-19, which aligns with the intentions of the project.</p> <p>There is no need to ascertain whether this activity is sustainable because by intention, it was a short-lived project with a specific purpose. Whether this should be continued will depend upon the COVID-19 situation. But in particular, one critical demonstration that would have been useful was the virtual facility tours, which were unique to this project. Virtual facility tours are complex and are difficult to implement, and few facilities were assessed this way. This experience has shown that virtual tours do have certain requirements such as Internet connectivity, high quality videos, and the ability to capture the right angles and visualization of the particular assessment domain. To date, there is insufficient information with this particular effort to demonstrate that the virtual facility tours were effective and if this is something worth strengthening or investigating.</p>	<p>of the HP but are not particularly similar. However, there were some significant overlaps with the general M&E system. Good quality evidence has been used for decision making; good fidelity, with adaptation and feasible to scale (acceptable and appropriate); some gaps and challenges identified on the domains observed. Sustainability cannot be ascertained because this was a short-lived project with a specific purpose.</p>
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	<p>just added to USAID activities, it does resemble the framework of many COVID-19 emergency response efforts which begin with status assessment, immediate gaps response, and building capacities. Thus, it can also be interpreted based on its effectiveness of averting/controlling COVID-19, but this was not manifested as part of the indicators.</p>		
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IV. ProtectHealth

<p>CiTEC Project Regular Online Conference Calls</p>	<p>The regular conference calls between ProtectHealth and TB IHSS are well resourced as evidenced by available human (staff time) and financial (communication allowance) resources. The general M&E monitors three indicators related to the CiTEC project: 1) proportion of the resource requirements for the CiTEC activities in Mambaling and Pasil funded by commitment of partners, 2) proportion of TB cases who availed of PhilHealth-provided TB-benefits (Intensive Phase), and 3) proportion of notified TB cases who availed of PhilHealth TB benefits (Intensive Phase). However, the M&E system for the CiTEC implementation project is separate from the general M&E system of ProtectHealth. The regular CiTEC meetings (through conference calls) are well integrated within the M&E system for the CiTEC project because it is part of five main activities (under Data Analysis and Reporting) involved in the database management of the CiTEC project as written in the “Protocols Monitoring the Progress of Implementation of CiTEC.” The data presented during these meetings are used for tracking progress of implementation and decision making and are documented as part of an end of project/demonstration study report. No major challenges with data reporting, use, and quality related to the conference calls were reported. Overall, the practice is effective in ensuring coordination given the unique set-up of the joint project, with participants from two different IPs and across</p>	<p>There is good fidelity, with a range of adaptations made to the meetings (whether in mode, scope, or regularity) to ensure adequate and efficient coordination between the partner projects. The practice's inner characteristic of trialability allowed for the reversal of certain adaptations (i.e., frequency) to ensure the continuing achievement of the project's needs and goals. Although there is a decrease in call frequency, the practice itself is increasingly being adopted and improved to maximize efficiency. There is also good feasibility, with no major issues on mandates, budgets, and training. The conference calls are well-scheduled (calendar-blocked) yet flexible, and are conducted on a reliable platform, Microsoft Teams. Participants did not have any problems using the platforms despite the lack of orientation for these conference calls. This may be attributed to their basic technology skills or familiarity with modern communication technologies. Participants were able to balance the relative advantages between remote and FTF modes of meeting by having nuanced expectations of the purpose of these conference calls, viewing them as venues for coordination and data sharing between units from distinct projects and varying levels, as opposed to other activities that would be benefit more in a FTF set-up (i.e., data collection, first-time engagement with potential partners). The relative advantages of these scheduled conference calls are the</p>	<p>Level 3</p> <p>Practice can be considered as a good practice; already showing high penetration and is sustainable; fewer gaps and challenges identified on the domains observed; able to improve M&E performance. There are processes in place for analysis and reporting; and high quality evidence has been consistently used for the team’s decision making and improvement of project performance.</p>
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	<p>geographically separate units (central and field level). The M&E practice's effectiveness is also evidenced by its capacity to adapt (i.e., in terms of frequency) to continue facilitating timely informed decisions/actions on activities in the achievement of set outcomes of the HP and IP (both ProtectHealth and TB IHSS).</p>	<p>following: time-saving, logistical convenience, ease of set up, and commitment of higher-ups. The only downside is the lack of regular representation allowances for food during meetings. These are only allowed under specific circumstances such as events involving external stakeholders or for meetings longer than two hours. With no major issues in environmental support, funding stability, and organizational capacity, the practice has promising sustainability. While there are no concrete plans yet for changes when the project reverts to an office setup, these online conference calls between the two projects and across central and field staff may continue and be adapted until the end of the CiTEC project.</p>	
<p>V. RenewHealth</p>			
<p>CBDR IMS</p>	<p>The CBDR IMS is well resourced as evidenced by available human resources and budget to maintain and further revise the system. RenewHealth staff also have adequate equipment to use the system, which only requires a computer/mobile device with access to Internet connection. Data collection, analysis, and reporting processes are aligned with the general M&E system. Once operational, the CBDR IMS will expedite data collection and analysis for RenewHealth M&E staff by removing the burden of data encoding of LGU forms and automating the process of summarizing and generating disaggregated data for the project's performance monitoring. The CBDR IMS is intended to address gaps in the current data collection, management, and sharing of CBDR information from LGUs to government agencies. LGUs who will be using these have staff who are familiar with information systems. They will also receive equipment (e.g., devices and Internet connection). Orientation and a manual for the CBDR IMS will be provided. Partner agencies will also have access to disaggregated data generated by the IMS.</p>	<p>The development, implementation, and capacity-building activities for the CBDR IMS are delayed. Despite having adequate budget, the mandates for implementation and training are still being resolved and are dependent on factors beyond the control of RenewHealth (i.e., technical working group matrix of essential data components influencing system design and orientation materials as well as approval of USAID and partner government agencies). However, the practice is still in its pre-implementation phase and there may still be good fidelity, as further adaptations were already made and will still be made to the system to address the needs of the LGU and government agency partners, which is the main intention behind the IMS. There may be limited to moderate feasibility in implementing the CBDR IMS, as foreseeable issues in important domains have mitigation measures in place. Once CBDR IMS is approved for implementation, RenewHealth has adequate internal mandates and budget to operationalize the system. There are enough human</p>	<p>Level 0 Practice is still in pre-implementation stage but has adequate resources allocated for it; processes in place for analysis and reporting will be aligned with the general M&E system; will have capacity to generate evidence of good quality for decision making; may have good fidelity, with adaptation and may be feasible to scale (acceptable and appropriate); some foreseeable gaps and challenges identified on the domains observed.</p>

	<p>As an early stage practice, CBDR IMS is challenged by planning hurdles. Setting up the system is hindered by theoretical bottlenecks such as the need to finalize performance measures for CBDR services. At this stage, the system is still under the review of USAID and partner government agencies, which will mean further refinements to the latest version of the system. Having yet to graduate into the stage of implementation, the effectiveness of the IMS in aiding RenewHealth's M&E as well as in attending to the LGU and partner government agencies' needs cannot be fully assessed at this point. The system has not yet generated high quality evidence which has been consistently used for the team's decision making and improvement of project performance. However, as a comprehensive yet complementary information system envisioned to manage data across the cascade of CBDR services, there is great potential to accelerate processing and improve data quality of CBDR information on the side of RenewHealth, LGUs, and partner government agencies.</p>	<p>resources to maintain the system. Additional consultants can be hired to support the one staff member who can provide system orientation to users, and online materials will be made available in the CBDR Resources domain of the CBDR portal. LGU users are willing to implement the IMS. Technical and technological barriers in using the system will be mitigated by provision of FTF and online orientation, manual for the IMS, and necessary equipment (e.g., devices and Internet connection). Despite potentially good fidelity and limited to moderate feasibility in implementing the CBDR IMS during the life of the project, there may be a challenge in sustaining the system beyond the project given issues in the three major domains (environmental support, funding stability, and organizational capacity). The system will have limited sustainability if key partner agencies do not obtain increased support for the IMS, and if no agency is identified as the recipient of the system by the end of the project. Funding stability may become a problem once the system is turned over and will definitely become a problem if it fails to be turned over. Sustained use in LGUs will also be challenged by constant staff turnover.</p>	
VI. TB Platforms			
<p>Hybrid monitoring of TBCC using regularly scheduled phone calls and onsite monitoring/mentoring visits</p>	<p>Hybrid monitoring of TBCC using phone calls and facility visits is well-resourced as evidenced by available staff and materials (mobile unit, SIM cards, and communication allowances) on the side of TB Platforms and the counterpart facilities. It is also well-integrated within the general M&E system of TB Platforms.</p> <p>This can be considered as an effective M&E practice because it is simple enough while at the same time, monitoring activities generate the necessary information</p>	<p>Fidelity is high, as all activities are on track, with several adaptations made: provision of mobile unit and use of FB messenger (instead of phone calls) to improve implementation of TBCC, adjusted frequency of phone calls based on the needs of the facilities, revision of forms, and creation of a data analysis tool to facilitate monitoring of TBCC.</p> <p>Feasibility is good with minor issues with: 1) the lack of mandate/policy on the implementation and monitoring</p>	<p>Level 2b</p> <p>Practice is being implemented with adequate resources; processes in place for analysis and reporting but aligned with the general M&E system; good quality evidence has been used for decision making; high fidelity, with adaptation and feasible to</p>

	<p>to identify challenges and improve implementation of TBCC. Data gathered from the monitoring activities were also used to advocate for the adoption of TBCC to other facilities/LGUs. However, there were a few challenges identified, particularly the availability of staff in facilities for monitoring (during the pandemic), and some issues with the forms. Respondents prefer the current hybrid set up of monitoring TBCC due to the current COVID-19 pandemic. Overall, hybrid monitoring using phone calls and facility visits is a good practice, having ensured monitoring of TBCC during the pandemic generating good quality data for decision making. Type of information gathered fits well with the platform being used. However, small improvements and changes are needed.</p>	<p>of TBCC, 2) human resource strains of the counterpart facilities (dual responsibilities, quarantine) causing delays in submission and validation of reports and unavailability for monitoring, and 3) with the forms/monitoring tool (delayed provision of forms, confusion, and non-inclusion of transactions which used FB messenger, lack of monitoring forms for the scheduled phone calls).</p> <p>Another contributor to good feasibility is baseline acceptability of the TBCC practice. Before facilities were engaged, sites were first identified based on their status of TB contact screening and investigation, receptivity to the practice, support of LGU, and availability of manpower and logistics. Online meetings were held to advocate the establishment of TBCC, and facilities were informed beforehand of the required monitoring and completion of forms. Furthermore, implementation of TBCC maximized existing structures that allowed for easy uptake, contributing to organizational feasibility. There is no overreaching of TB Platforms due to respect on control with the management level. There is seamless integration in how the RHUs work, with TB Platforms supporting what the RHU needs.</p> <p>Sustainability is also good, with no major issues on environmental support, funding stability, or organizational capacity. Monitoring of TBCC will continue so long as the TBCC is implemented. Sustainability of the implementation of TBCC at the local level should continue as long as there are partners willing to carry it out.</p>	<p>scale (acceptable and appropriate); some gaps and challenges identified on the domains observed.</p>
<p>Hybrid monitoring/mentoring for FAST implementing facilities</p>	<p>The hybrid monitoring and mentoring of FAST implementing facilities has available resources in terms of budget, equipment and orientation. However, there is a lack of adequate time and human resources on both TB Platforms field project and facility counterpart sides to</p>	<p>There is good fidelity: adaptations were made to ensure the continuity of the monitoring and mentoring activities in FAST implementing facilities throughout the pandemic. The adaptability and trialability of the practice is shown in the shift from depending on</p>	<p>Level I</p> <p>Practices being implemented within an activity with adequate resources; processes in place for</p>

	<p>adequately implement this. The remote approaches to monitoring and mentoring are integrated within the general M&E system, following the same data flow and monitoring tool used in onsite monitoring/mentoring visits. The team analyzes, visualizes, and uses data from these monthly data collections in much the same way as before. Data are useful for feedback and mentoring to improve implementation in FAST facilities. However, a few challenges were identified with both remote and onsite monitoring approaches during the pandemic. While remote monitoring approaches allow for data collection during some periods in pandemic, TB platforms project staff had difficulty not only in obtaining all data needed remotely, but also in validating data that were provided to them. Scheduling of onsite remote monitoring was also more difficult due to changing circumstances related to COVID-19. Across both approaches, FAST point persons had difficulties facilitating the monitoring due to added COVID-19 responsibilities. It is difficult to fully assess the effectiveness of a hybrid monitoring approach versus a purely FTF approach because several limitations in conducting the hybrid approach are attributed to the circumstances brought about by the pandemic. There are specific advantages in using remote approaches, such as ensuring the continuity of monitoring despite mobility restrictions. However, the remote approach may be less reliable given the challenges in validating data. The participants have expressed the relative advantage of an FTF approach when it comes ensuring quality for process checks and data collection. Currently, they are doing more FTF than remote methods of monitoring. However, they are open to sustaining hybrid practices for monitoring, as remote approaches may not only be useful in contingencies but also in complementing onsite monitoring (i.e., online platforms used for additional qualitative validation).</p>	<p>remote approaches during the earlier parts of the pandemic to returning to FTF approaches once restrictions eased, and other adjustments to the pandemic have been made. There is limited feasibility in implementing the hybrid setup for monitoring and mentoring in FAST implementing facilities. Despite no major issues on mandates and budgets, implementation hurdles stem from the lack of human resources and capacity-building practices on both the provincial project and facility counterpart staff levels. The complexity of the tool and the process also contributes to limited uptake. Even prior to the pandemic, TB platforms staff would often fill out the data collection tools, which ideally should be accomplished by point persons in FAST implementing facilities. Given the added burden of COVID-19 responsibilities, facility counterpart staff find it even more difficult to remotely accomplish data collection tools themselves or provide all necessary data to the provincial project staff. This is the case even with additional support from short-term data collectors and encoders from TB platforms. Onsite monitoring is also dependent on the changing circumstances related to COVID-19, such as mobility restrictions or positive cases in the facility. Despite these limiting factors beyond the control of TB platforms, external mandates (i.e., the need to report to USAID or regional policies supporting FAST implementation) drive the continuous implementation of the monitoring activities. There is sustainable environmental support and funding stability for FAST implementation, especially in areas where TB platforms was able to establish regional and local policy support. However, there is limited sustainability for the practice of hybrid monitoring and mentoring in FAST facilities due to insufficient human resource capacity at TB Platforms and the partner facilities. This also impacts the quality of data generated, especially when remote</p>	<p>analysis and reporting and aligned with the general M&E system; good quality evidence has been used for decision making but not consistently; high fidelity, with adaptation and feasible to scale (acceptable); some gaps and challenges identified on the domains observed.</p>
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		<p>monitoring approaches are employed. There may be potential sustainability when these challenges are addressed. The assessment is on the hybrid monitoring and mentoring approach for FAST facilities and not the implementation of the FAST strategy itself, which showed good uptake and promising sustainability. Respondents for this practice were primarily field project and counterpart staff, which may skew the analysis toward a focus on field-level implementer challenges. In addition, there is no objective evidence that data collected and validated through remote approaches were poorer than data collected from FTF approaches. The perception of lower data quality using remote approaches and the preference for FTF approaches must be understood in context. Factors such as familiarity with FTF approaches as well as perceived limitations and uneven expectations for remote approaches may have hindered adoption of remote approaches.</p>	
<p>Assessment of IPC using Google Survey</p>	<p>There were adequate financial resources and equipment to implement the Google Survey. Despite adequacy of personnel, technical capacity of the field staff to perform analysis as well as to provide TA and feedback were a challenge. There were plans to hire an external consultant (engineer) to provide short-term TA to develop simple guidelines for IPC, but they have not found one yet. The use of Google Survey is well-integrated within the general M&E system of TB Platforms. However, several data quality issues were identified with the use of Google Survey forms: 1) need to clean the data due to numerous duplicates, 2) incomplete responses even for required fields, 3) missing results even if respondents accomplished the survey, and 4) inability to further probe responses.</p> <p>Results of the survey were fed back to the regions and to DOH NTP, but not to the majority of the facilities because of hesitancy among field staff to provide feedback</p>	<p>Although adaptations were made along the way, there is low fidelity because some activities were delayed and aborted. Despite having an adequate budget, there is low feasibility due to major issues with human resources (gap in technical capacity of field staff and unavailability of an external consultant). Likewise, there are major issues with the quality of data collected using Google Surveys as well as with issues due to the preference of using other platforms. There is low sustainability given major issues in organizational capacity. Future assessments on IPC will use IPConnect instead.</p>	<p>Level 0</p> <p>Practices already being implemented within an activity with adequate equipment and financial resources but with issues on human resources; it is well integrated within the general M&E system; with evidence of poor data quality; some evidence on data use for decision making; low fidelity, with some adaptations; considerable gaps and challenges identified on the domains observed.</p>

	<p>due to a lack of technical expertise and negative experiences in previous feedback (i.e., facilities were defensive after scoring low). This then limited the use of the baseline findings at the facility level, but nonetheless were used by the regions in strengthening health worker surveillance programs and supportive supervision systems and by TB Platforms in developing a comprehensive TA package for IPC. Overall, it was difficult to assess the effectiveness of Google Surveys from the M&E standpoint due to implementation issues.</p>		
<p>PMDT remote monitoring and mentoring</p>	<p>Remote monitoring/mentoring has adequate financial and human resources in place, and it is aligned with the general M&E system. Remote monitoring/mentoring has contributed to the M&E goals of PBSP in the sense that facilities were made aware of the directive to resume TB services during the pandemic. However, respondents expressed mistrust of the quality of the data. For the central office staff, there is a possibility of bias from the monitoring/mentoring participants because questions are sent to them beforehand. Central office staff and field counterpart staff agree that limited data validation undermines data quality. Because of these factors, effectiveness of remote/monitoring is difficult to assess, although respondents have indicated that the practice was helpful in improving the implementation of PMDT.</p>	<p>Despite delayed implementation of remote monitoring/mentoring in terms of the AMELP, there is still promising fidelity because adaptations (i.e., shift to remote approaches) were made to ensure continuity and improve monitoring (enhancements in remote monitoring tool) despite mobility restrictions during the pandemic. In addition, only poor-performing facilities will require constant follow up. Remote monitoring/mentoring has limited to moderate feasibility; there are significant individual challenges at both the central project and field counterpart staff levels, mostly regarding the perceived quality of data collected. While participants highlighted the relative advantage of in-person monitoring in ensuring data quality, they also acknowledged the benefits of remote approaches to monitoring: less preparation needed, less intimidating, and appropriate for smaller facilities that cannot accommodate facility visits with numerous staff members. Field staff are also having difficulty balancing remote monitoring/mentoring with other duties. With promising fidelity and limited to moderate feasibility, sustainability is questionable given the limited acceptability of purely remote monitoring/mentoring among central and field staff; however, this may be sustainable when used in tandem with FTF monitoring activities.</p>	<p>Level 2a</p> <p>Remote monitoring/mentoring is being implemented with adequate resources; with limited evidence of good quality data used for decision making; well-aligned with the general M&E system; promising fidelity, with adaptation and limited to moderate feasibility; considerable gaps and challenges identified on the observed domains.</p>

VII. TB IHSS

<p>Remote P&R sessions</p>	<p>Remote P&R has adequate financial and human resources in place, and it is well integrated within the general M&E system. Remote P&R has contributed to the M&E goals of the project as a venue to strategize and learn from well-performing areas. It has consistently generated good quality data for decision making.</p>	<p>Remote P&R has good fidelity: TB IHSS was able to ensure the continuity of conducting P&R sessions by adapting a previous hybrid activity into a fully remote. Remote P&R also has good feasibility: it demonstrates adaptability by addressing challenges with adaptive measures such as utilizing online tools for learning and engagement. Remote P&R also demonstrated trialability because data collection tools were piloted within the team and revised as needed. Remote P&R participants also indicated that the practice had impact. With good fidelity in terms of adherence to the AMELP and good feasibility, sustainability is also promising given no major issues in environmental support and funding capacity and only minor issues in organizational capacity. Currently, the SI team can conduct and process outputs from P&R; it will be beneficial if the regional teams are also capacitated to do so. Additionally, there are already plans of integrating this process in the toolkits of the innovations that will be turned over to the project's counterparts.</p>	<p>Level 3</p> <p>Remote P&R is being implemented within TB IHSS with adequate resources; good quality evidence has been consistently used for decision making; well-aligned with general M&E system; good fidelity, with adaptation and feasible to scale; some gaps and challenges identified on the observed domains that have been well addressed.</p>
<p>Remote rapid assessment survey</p>	<p>Remote rapid assessments were well-resourced as evidenced by available budget, staff (Chief of Party, technical teams, Operation Research Specialist, Regional Implementation Managers, and FIOs), and equipment (laptop and communication allowance). It is well-integrated within the general M&E system of TB IHSS. A concept note was developed for the implementation of the three surveys, but there was no policy or mandate provided by DOH NTP.</p> <p>The team ensured that the questionnaire was short but comprehensive, and it was validated and pre-tested before deployment. Data were collected through online Google Survey Forms, paper-based hard copies, or soft copy</p>	<p>There is high fidelity. All planned activities were implemented, and necessary adaptations were made such as: 1) having the option of responding to the survey with paper-based forms or through soft copy (Word file), in consideration of HCWs busy schedules and Internet connectivity, 2) extending the data collection period to give HCWs more time to respond to the survey, 3) providing HCWs a communication allowance after the first survey, (4) conducting a follow up survey after six months to evaluate practice, and 5) expanding coverage to regions beyond the planned scope.</p> <p>Feasibility is high with no major issues on budget,</p>	<p>Level 3</p> <p>Remote rapid assessment surveys can be considered as a good practice; already showing high penetration and is sustainable; fewer gaps and challenges identified on the domains observed; able to improve M&E performance. Collection of data is well resourced, and practice is integrated well within the general M&E system; processes in place for analysis and reporting; and</p>

	<p>Word Files, in consideration of HCWs' busy schedules and Internet connectivity. However, there were difficulties with obtaining responses from HCWs in the hospitals due to the COVID-19 response work. Responses were validated simultaneously with the data collection; any missing or conflicting information identified by the central staff was relayed to the FIOs for validation with the hospitals. Data were analyzed through STATA. There was no official plan for specific data analysis because analysis depended on partner and technical team needs. There were minor issues with data quality such as the low sample size, reliability of responses, and tight window period.</p> <p>Results of the assessments were presented to DOH NTP, regional NTP, and hospitals and helped to identify mitigation measures and recommendations to improve TB care during the pandemic. Results of the assessments were also used as one of the decision points for the NAP, while results of the third assessment helped in the implementation of FASTPlus. Overall, the remote rapid assessment is effective and has demonstrated the successful conduct of remote data collection under a dynamic COVID-19 situation, with adaptations made along the way. Experience from this activity paved the way for TB IHSS' subsequent survey development and data collection on the ground.</p>	<p>training, and mandates. Although DOH NTP did not provide memos on the conduct of all three surveys, high-level agreements between USAID and DOH as well as established partnership and rapport between TB IHSS and the hospitals aided in the rollout of the surveys. Other minor issues include: 1) difficulty of data collection during the pandemic because HCWs in the hospitals were busy with COVID response, 2) Internet connectivity, 3) low response rate and reliability of data, and 4) tight timeline for development of questionnaire, orientation, pre-testing, data collection, and data analysis. Nonetheless, strong commitment and technical capacity of TB IHSS personnel, involvement of the upper to lower management, willingness of facilities to answer the survey, and provision of STATA and communication allowances by TB IHSS were enablers in the implementation of the remote rapid assessment surveys.</p> <p>Sustainability is high, with no major issues in environmental support, funding stability, or organizational capacity on the side of USAID. The remote rapid assessments are already being scaled up, with interest of an external partner (DOH NTP) to adopt it. Though there are no plans to conduct follow up surveys, experience from this activity paved the way to develop subsequent surveys and data collection activities.</p>	<p>good quality data have been consistently used for TB IHSS' decision making and improvement of project performance.</p>
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