MINISTRY OF HEALTH

DIVISION OF REPRODUCTIVE HEALTH

Baseline Capacity Assessment Report on M&E Functions
Division of Reproductive Health
Department of Family Health

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ACRONYMS AND ABBREVIATIONS

ASRH	Adolescent Sexual and Reproductive Health
DDU	Data Demand and Use
DHIS	District Health Information System
DHS	Demographic Health Survey
DivHIS	Division of Health Information Systems
DRH	Division of Reproductive Health
HIS	Health Information System
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MEASURE	Monitoring and Evaluation to Assess and Use Results
MECAT	Monitoring and Evaluation Capacity Assessment Tool
MNH	Maternal and Neonatal Health
MOH	Ministry of Health
MSH	Management Sciences for Health
NHSSP I	National Health Sector Strategic Plan I
NHSSP II	National Health Sector Strategic Plan II
STI	Sexually Transmitted Infection
TWG	Technical Working Groups
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nation's Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development

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EXECUTIVE SUMMARY

Major national and international public health initiatives, such as the Safe Motherhood Initiative of 1987, International Conference on Population and Development of 1994, and Millennium Development Goals of 2000, among others, have called for improved reproductive health interventions. Kenya has responded to calls to strengthen reproductive health policies and strategies by formulating and implementing various reproductive health strategies, beginning in 2005 with the establishment of the Division of Reproductive Health (DRH). Since then, Kenya has achieved notable progress in implementing reproductive health programs, especially with the reversal of the once rising infant mortality and a reduction in maternal mortality.

In July 2013, DRH was the subject of a MEASURE Evaluation-PIMA monitoring and evaluation (M&E) capacity-building baseline assessment that entailed use of individual and group assessment tools and key informant interviews with DRH senior management, program managers, program staff, and representatives from strategic partners. The group assessment explored 12 M&E functional capacities.

The goal of this assessment was to understand and document DRH's current organizational and individual capacity to successfully achieve its performance objectives in program-level monitoring and evaluation. The assessment had these specific objectives:

- Understand, document, and clarify performance objectives for Division-level M&E
- Determine the current performance in key M&E functional areas for the Division
- Identify gaps in DRH's national program capacity to meet performance expectations

Results from the July 2013 capacity-building baseline assessment showed that DRH's overall organizational capacity to carry out its M&E mandate is weak (38.23%). DRH scored below average in the four dimensions of M&E capacity: (1) status, (2) quality, (3) technical autonomy, and (4) financial autonomy. The status of DRH M&E is rated at an average of 4.87 out of 10; the quality of DRH's M&E is rated at an average of 3.89 out of 10, the technical autonomy at an average of 3.01 out of 10, and the financial autonomy at an average of 1.22 out of 10. The individual assessment tool also showed that the average performance rating for all DRH staff was below 50% for M&E leadership, data management, evaluation, data analysis and use, and general management.

The July 2013 capacity-building baseline assessment showed that DRH's strongest capacity areas are routine monitoring, partnerships and governance, and advocacy communication and cultural behavior. DRH's weakest areas are the supervision and auditing processes, human capacity for M&E, implementation of surveys and surveillance, and the development of national and subnational databases.

The M&E unit in DRH has been providing data on family planning; maternal, newborn, and children's health; gender; reproductive tract cancer; and adolescent sexual and reproductive health usage coverage and demand. The M&E unit also provides policy formation, regulatory measures, and capacity building for reproductive health at the national level. DRH's M&E unit is considered a stand-alone program that is not fully integrated into other reproductive health programs.

Performance of the M&E unit has been affected by staff attrition, dependence on donors for technical support, and competing priorities among numerous stakeholders who are engaged in the area of reproductive health. The assessment revealed that leadership is also a factor in below-

average M&E performance. DRH has a hierarchical structure that emphasizes management at the program manager level, and consequently, program officers are not directly responsible for policy or program decisions, and they do not have the mandate to streamline plans and strategies that strengthen DRH M&E. Staff also mentioned several challenges in program implementation, including prioritization of work and lack of regular staff meetings, coordination of activities between programs, and implementation of existing policies. A specific skill that is lacking is the ability to use data for policymaking. A lack of key tools, such as an updated M&E workplan, and advocacy, behavioral, and communication tools and a data use plan contributed to the absence of a systematic process to implement activities and channel information to stakeholders.

Governance structures also have affected the role of DRH to support reproductive health activities at a national level. As a result of devolution, DRH is viewed primarily as an organ for policy formulation, rather than as a body to supervise counties. This change in governance has affected program implementation.

The capacity-building baseline assessment findings led to the following recommendations to strengthen DRH:

- Tailor trainings to help the M&E unit improve data interpretation.
- Address nontechnical issues for behavior change. Because the M&E program has been operating in silos, the program needs stronger integration into the reproductive health program.
- Encourage leaders to take bolder steps in promoting M&E, especially to strengthen data demand and use.
- Harmonize partners' activities and streamline them into the DRH workplan.
- Encourage partners to impart technical skills to DRH staff to reduce the high turnaround rate of the technical advisors.

CHAPTER 1: REPRODUCTIVE HEALTH—A GLOBAL PERSPECTIVE

Major national and international public health initiatives, such as the Safe Motherhood Initiative of 1987; International Conference on Population and Development (ICPD) of 1994; the Millennium Summit in 2000, with its adoption of the Millennium Development Goals (MDG), and the universal goal to improve access to reproductive health to achieve MDG 5 by global stakeholders (Ministry of Health, 1997); among others, have called for improved reproductive health interventions.

Despite considerable progress since the ICPD, millions of people, mostly disadvantaged women and adolescents, still lack access to sexual and reproductive health information and services. In developing countries, about 201 million married women lack access to modern contraceptives. About 340 million new cases of sexually transmitted infections (STI) are reported each year, and 6,000 young people are infected with HIV every day. Millions of women and adolescent girls continue to suffer from death and disabilities during pregnancy and childbirth. Women are also victims of the rise in noncommunicable diseases, such as cervical and breast cancers, which are the leading cancers among women. The leading malignant diseases among women highlight the need to promote awareness of cancer and the availability of services for women to get early detection of the disease (Ministry of Health, 2010d; UNFPA, 2008).

Globally, six priority areas are the focus for reproductive health interventions: (1) support for the provision of a basic package of sexual and reproductive health services that include family planning; (2) pregnancy-related services, including skilled attendance at delivery and emergency obstetric care; (3) HIV prevention and diagnosis and treatment of STI; (4) prevention and early diagnosis of breast and cervical cancers; (5) adolescent sexual and reproductive health (ASRH); and (6)care for survivors of gender-based violence, with reproductive health commodity security (UNFPA, 2008).

UNFPA, the United Nation's Population Fund, strategy covers the rationale behind strengthening collaboration among United Nations organizations, especially with the World Health Organization, United Nations Children's Fund (UNICEF), the Joint United Nations Program on HIV/AIDS (UNAIDS), and other institutions, such as the World Bank that fosters partnerships with civil society, women, youth, and faith-based organizations. These organizations have set out to address funding and technical assistance gaps and assess progress of reproductive health and family planning interventions globally to advance reproductive health (UNFPA).

1.1 REPRODUCTIVE HEALTH POLICY IN KENYA

Reproductive health continues to be recognized in Kenya as a national priority. In 1997, in an effort to respond to the ICPD program of action, Kenya developed the first Reproductive Health Strategy 1997–2010 (Ministry of Health, 1997), which recognized the importance of a multisectoral approach and collaboration in the implementation of a full range of reproductive health components, although the health sector has had a crucial role to play in the prevention and management of most reproductive health problems (Ministry of Health, 1997). The National Health Reproductive Strategy 1997–2010 has provided a common reference point for all reproductive health stakeholders in Kenya and focused efforts and resources on the goal of improving reproductive health services in Kenya. The strategy, along with other national policy documents, formed the basis for the development of the DRH mandate and guides the execution of programs on reproductive health. DRH also established key programs: Maternal and Newborn Health (MNH), Family Planning, ASRH, Gender, Reproductive Tract Cancer, and Infertility.

In 2009, the second Kenyan Reproductive Health Strategy 2009–2015 was developed to provide overall guidance and response for implementing the Reproductive Health and Rights elements of the UNFPA Strategic Plan 2008–2011 (Ministry of Health, 2009). The reproductive health strategy in Kenya for 2009–2015 guides partners to support government to take leadership on the promise of improved reproductive health, as stated in MDGs 4, 5, and 6, particularly with the addition of the new target on universal access to reproductive health. Key strategies proposed to accelerate the attainment of MDGs 4 and 5 include improving availability of, access to, and use of quality MNH care; reducing unmet needs through expanding access to good quality family planning options for men, women, and adolescents; strengthening the referral system; advocating for increased commitment and resources for MNH and family planning services; strengthening community-based MNH care approaches; and strengthening the M&E system and operations research.

Maternal and neonatal morbidity and mortality continue to be recognized internationally as performance indicators for maternal and child health. More than 15 years since the launch of the Safe Motherhood Initiative, maternal mortality levels in Africa continued to rise, although recently the trends for child mortality have reversed and started to decline. In the 2003 Kenya Demographic Health Survey (DHS), the maternal mortality rate was 414 per 100,000 live births, compared to 488 per 100,000 live births in 2009. Although the newborn mortality rate declined only slightly, from 33 deaths per 1,000 live births in 2003, to 31 deaths per 1,000 live births in 2008, the newborn mortality rate is contributing to 67% of the infant mortality rate. Kenya is, therefore, on track to attain its MDG 4 (Ministry of Health, 2010b).

The slow progress in attainment of MNH targets in Kenya can be attributed to several causes: limited availability and accessibility to services; low use of skilled birth attendance during pregnancy, child birth, and postnatal period; low basic emergency obstetric and newborn care coverage; poor involvement of communities in maternal and newborn care; and limited national commitment of resources for MNH.

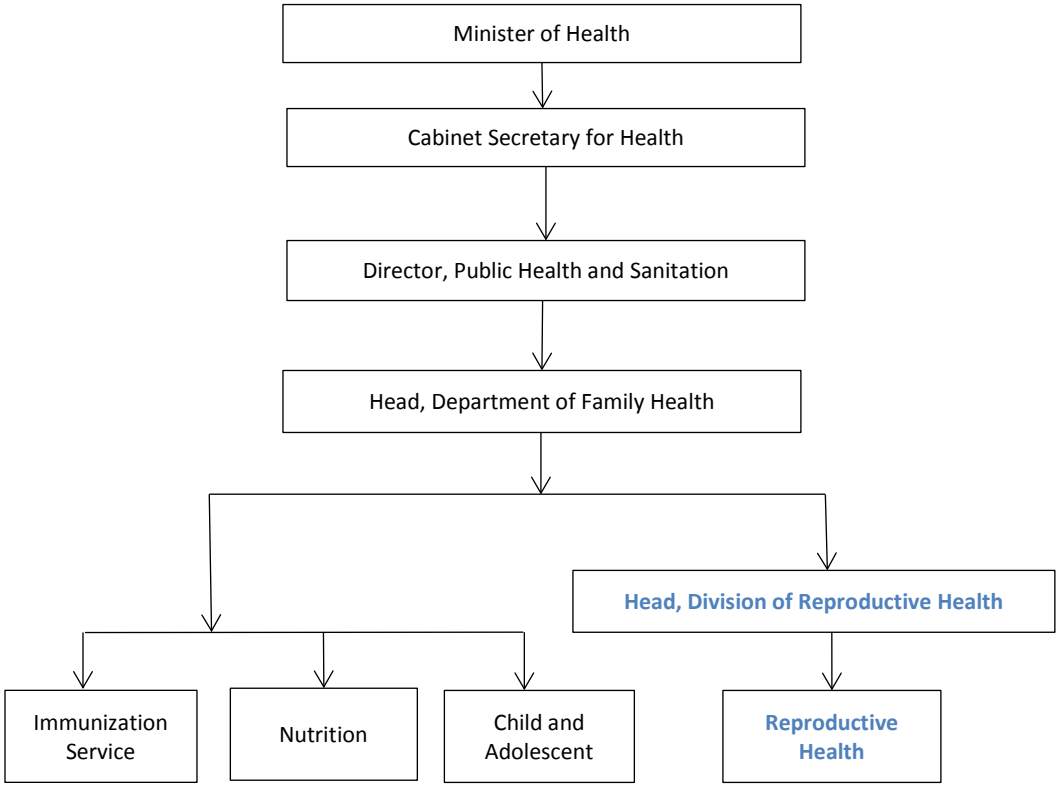
Kenya now has in place a national road map to accelerate the reduction of maternal and newborn morbidity and mortality to achieve its MDG (Ministry of Health, 2010c). DRH has a Reproductive Health Communication Strategy (Ministry of Health, 2010d) that seeks to increase the proportion of national-level policymakers that are knowledgeable in the socioeconomic significance of reproductive health. The strategy also seeks to devote sufficient resources to meet the reproductive health needs of Kenyans, increase awareness of reproductive issues that affect Kenyans, raise the level of knowledge in the community, and expand available services to increase the proportion of individuals of reproductive age who use available reproductive health services.

Vision 2030 aims to provide equitable, affordable health care by focusing the health care delivery system to emphasize preventive and promotive health care. The emphasis is on access, equity, capacity, and institutional framework. The Health Ministries' core function is to support the attainment of health goals by implementing priority interventions in health, based on its mandate, as guided by the Strategic Framework for National Transformation 2008–2012, the National Health National Health Sector Strategic Plan (NHSSP), and the wider health sector (Vision 2030, 2013).

1.2 ROLE OF MINISTRY OF PUBLIC HEALTH AND SANITATION

The Kenyan Ministry of Public Health and Sanitation provides an overall reproductive health strategy through DRH, which oversees reproductive health policy formulation and development; strategic planning; coordination of donor, partner, and line ministries' activities; and equitable allocation of national reproductive health resources. Figure 1 shows the Department of Family Health organogram.

Figure 1: Organogram of reproductive health services in the Kenya Ministry of Health

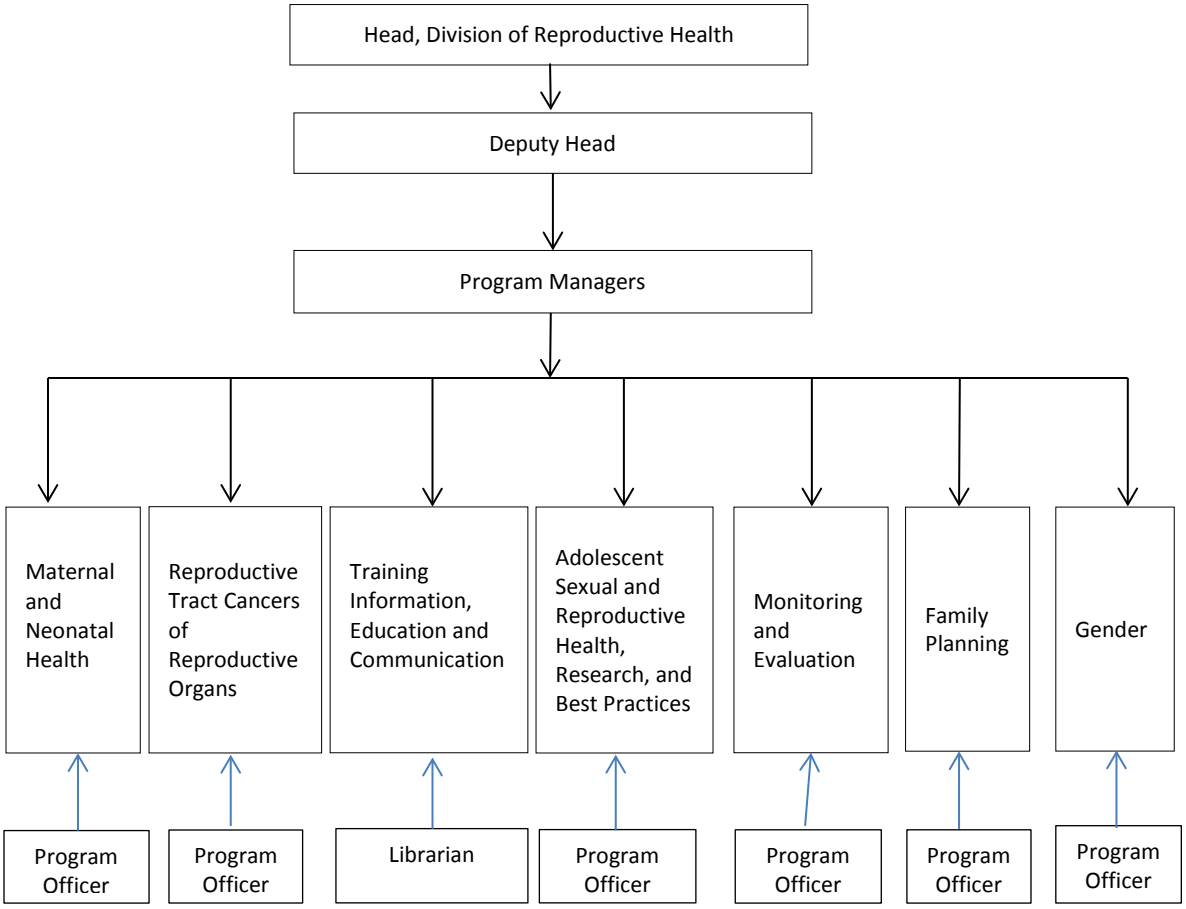


Source: Department of Family Health, 2013

1.3 DRH ROLE AND RESPONSIBILITIES

DRH, one of four divisions in the Department of Family Health under Ministry of Public Health and Sanitation, is led by a division head and deputy. A librarian provides support and oversees information, education, and communication materials. A management team comprises four program managers who manage ASRH, Gender, Family Planning, MNH, Reproductive Tract Cancer, and M&E programs at DRH. Each program manager supervises program officers, as shown in Figure 2. Staff changes have resulted in the need for current program managers to oversee more than two programs, as shown in Figure 2 (Ministry of Health, 2010b).

Figure 2: DRH organogram



Source: Division of Reproductive Health, 2013

The following section gives a background on DRH's ongoing work, based on the results of the desk review during the baseline assessment. Additional information has been gained from the working relationship that MEASURE Evaluation has with DRH. DRH is led by a head who provides overall coordination of the program and reports to the Head of the Department of Family Health. The head of DRH works closely with program managers, who in turn supervise project officers in their various programs (see Figure 1). DRH has approximately 20 staff members who are engaged in technical and administrative positions. A Costed Implementation Plan was developed in collaboration with reproductive health stakeholders in 2012 for the Family Planning program, which aims to reposition contraceptive services in Kenya by making them more accessible and equitable. The Family Planning Costed Implementation Plan provides a vision with clearly defined and costed activities to be implemented at different levels by different organizations and institutions over a specified time (Ministry of Health, 2012).

DRH is mandated, through its advocacy, communications, and culture function, to support implementation of the Reproductive Health Communication Strategy with a focus on developing capacity of the Community Own Resource Persons and exploring options for using retired midwives as skilled providers in the community to ensure that behavior change and communication is based on the evidence of the most effective methods for different target groups. Routine program monitoring service statistics are collected monthly for each program. For surveys and surveillance, DRH participates in surveys, such as the Rapid Results Initiative established by the Ministry of

Health, which involves the use of a tool called the Rapid Results Approach Tool that uses short-term (120 days) results-based goals to encourage rapid, sustainable growth in organizational capacity.

DRH uses databases to capture information on its programs and the DRH M&E system to monitor and evaluate maternal mortality audits, reproductive health supervision, reproductive health meeting summaries, reproductive health training summaries, state of contraceptives, documents from national meetings, data from facilities that offer post rape services, and reproductive health research summaries. The existing databases at DRH include the Maternal Death Review and geographical information system, developed by FHI 360, a U.S. Government implementing partner that supports DRH; however, the geographical information system is not in use because current officers have not received training on how to use it. DRH has an Excel file with service statistics for all DRH programs from 2010–2012; however, supervision and data auditing are not active at this time. Evaluation and research tends to be discussed by partners in meetings, such as the technical working groups (TWG) and Joint Interagency Committee; however, DRH is not engaged in any research studies with partners. For data dissemination and use activities, DRH has been involved in the development of the 2011annual report, Joint Program Report, special reports, the DRH website, reproductive health digest newsletter, and information products for external reporting requirements, such as the U.S. President's Emergency Plan for AIDS Relief. DRH also has engaged in the launch of national programs, such as the Rapid Results Initiative and the national roadmap for attaining MDGs related to maternal and newborn health in Kenya. DRH also participates in campaigns, such as the national immunization campaign.

1.4 DRH PUBLICATIONS

DRH has produced the following information products that include policies and guidelines: The National Reproductive Health Policy, National Reproductive Health M&E Plan, National Reproductive Health Research Guidelines, National Population Policy for Sustainable Development, National Cervical Cancer Prevention Plan, National Guidelines for Provision of Youth Friendly Services, DRH M&E Framework (2011–2012), Adolescent Reproductive Health and Development Policy Plan and Action 2005–2015, Family Planning Guidelines for Service Providers, National Guidelines on Medical Management of Rape and Sexual Violence, Facility-based Maternal Death Review Guidelines, National Reproductive Health Strategy 2009–2015, Community Midwifery Services in Kenya: Implementation Guidelines, Minimum Package for Reproductive Health and HIV Integrated Services, National Family Planning Costed Implementation Plan (2012–2016), The Balance Counseling Strategy Plus: A Toolkit for Family Planning Service Providers Working in High STI/HIV Prevalence Settings, and the National Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Kenya (Division of Reproductive Health, 2013).

1.5 ROLE OF THE MONITORING AND EVALUATION UNIT

The goal of the M&E system for the national reproductive health program is to generate information that is used in evidence-based decisionmaking to improve the reproductive health of the people of Kenya. Monitoring and evaluation is essential to assess how policies and programs are designed and conducted (Ministry of Health, 2007; Ministry of Kenya, 2010). DRH uses a collaborative approach to harness the resources and expertise of various partner agencies and donors to monitor and evaluate priority reproductive health programs. Monitoring is important in program management to determine how well programs are carried out at different levels and at what cost. DRH strives to ensure that M&E tools are used in all reproductive health programs by maintaining M&E data at all stages of project implementations.

The DRH M&E unit started in 2005 during implementation of NHSSP II, following recommendations for the strengthening of DRH M&E during the evaluation of NHSSP I. In 2007, DRH, with support from MEASURE Evaluation, developed a Reproductive Health M&E Plan to enable DRH to perform the following tasks (Ministry of Health, 2007):

- Coordinate and manage reproductive health M&E
- Maintain functional databases with updated data
- Store and analyze data, produce information products disseminated to stakeholders at all levels, and provide feedback to subnational levels
- Supervise and ensure data and information use
- Coordinate capacity building
- Develop and review DRH M&E Framework
- Conduct operational research
- Develop and review reproductive health data collection and reporting tools
- Assess and ensure data quality
- Develop and review the DRH M&E Plan
- Strengthen commodity security

The unit was further strengthened in October 2011 when the USAID-funded Capacity Project sponsored a full-time M&E technical advisor to work at DRH to build capacity of DRH staff in M&E. MEASURE Evaluation, one of the key partners working with DRH, has worked with the M&E unit to accomplish these tasks:

- Develop AOP8 (July 2012–June 2013)
- Develop a Maternal Death Review database
- Develop the first annual DRH report
- Institutionalize the Reproductive Health M&E Framework
- Train two M&E officers in STATA data analysis software
- Support the DRH M&E Technical Working Group

1.6 HEALTH INFORMATION SYSTEM

The Division of Health Information System (DivHIS), a core unit in the Ministry of Health, is an integral part of health systems strengthening. The role of DivHIS is to collect national routine health service data and facilitate evidence-based decisionmaking at all health levels. The DivHIS ultimately aims to improve the health status of the population in the Kenyan health system (Ministry of Kenya, 2010). The first Medium-Term Plan of Vision 2030 identified a number of shortfalls: weak health information systems use, lack of policy and guidelines, inadequate capacities of HIS staff, unskilled personnel handling data, and other factors that affect the efficiency of data compilation, collation, transmission, and use in the health system. The computerization of the District Health Information System (DHIS) has been a step toward increasing accessibility of the data and encouraging data use in the system. This new system has faced some challenges, including protecting the rights of users and giving full access to the database only to certain users, such as County Health Record

Information Officers. The tool also may be underused because of infrastructure challenges that many health providers and program officers face because users need a computer, access to the Internet, and electricity to access the system (Ministry of Health, 2009).

1.7 Role of Interagency Committees and Technical Working Groups

Two bodies, the Joint Interagency Committee and the Reproductive Health Interagency Committee, help identify critical problems and provide solutions to technical issues that affect implementation of reproductive health services. The Joint Interagency Committee involves other ministries and development partners in the coordination of resources and mobilization. The Reproductive Health Interagency Committee mandate includes developing strategic plans, protocols, procedures, and guidelines. Following is a list of some of these expert panels:

- Adolescent and Youth Reproductive Health TWG
- Family Planning TWG
- Gender and Reproductive Health Rights TWG
- Reproductive Health Interagency Committee
- Reproductive Health and HIV Integration TWG
- Maternal, Child, and Newborn Health TWG
- Prevention of Mother-to-Child Transmission of HIV TWG
- Monitoring, Evaluation, and Research TWG
- Reproductive Tract Organ Cancers TWG

1.8 Partners at DRH

DRH also works closely with partners, such as the National AIDS and STI Control Program and the Division of Malaria Control, by providing technical assistance on communications on reproductive health. Other partners, such as the U.S. Centers for Disease Control and Prevention, Marie Stopes Kenya, the National Coordinating Agency for Population and Development, USAID, Intrahealth, EngenderHealth, UNICEF, MEASURE Evaluation, APHIA Plus, UNFPA, Maternal and Child Health Integration Project, Liverpool Voluntary Counseling and Testing, JHPIEGO (an affiliate of Johns Hopkins University), Population Sciences International/Kenya, Management Sciences for Health (MSH), and WHO provide technical and financial support.

1.9 Role of Training and Research Institutions

Trained health workers are an important component in the delivery of productive health services. Several public and private colleges and universities conform to the standardized reproductive health curriculum to ensure well-trained personnel who can deliver high-quality reproductive health services. Several research institutions are involved in reproductive health and family planning research studies to guide evidence-based policy. They include international organizations, such as the African Population and Health Research Centre, National AIDS and STI Control Program, and the Kenya Medical Research Institute, and university-based research programs, such as the University of Nairobi's Population Studies and Research Institute and Moi University's Department of Reproductive Health (Division of Reproductive Health, 2013).

CHAPTER 2: DESIGN AND METHODOLOGY

2.1 INTRODUCTION

The DRH M&E capacity baseline assessment used a cross-sectional observational study design with a mixed methods approach. MEASURE Evaluation collected quantitative and qualitative data by using group-administered and self-administered assessment tools and a range of qualitative data collection techniques, such as key informant interviews and group discussions, where appropriate. The goal of this assessment was to understand and document DRH's current organizational and individual capacity to successfully achieve its performance objectives in program-level monitoring and evaluation. The assessment had these specific objectives:

- Understand, document, and clarify performance objectives for Division-level M&E
- Determine the current performance in key M&E functional areas for the Division
- Identify gaps in DRH's national program capacity to meet performance expectations

2.2 STUDY SITE

This assessment focused primarily on DRH at the national level. The group assessment tool was implemented in a 3-day workshop with representatives and stakeholders from the national program; key informant interviews took place with the interviewees at their respective workstations.

2.3 STUDY POPULATION AND SAMPLING

MEASURE Evaluation conducted interviews for this assessment with the head of the division, program managers, M&E personnel, thematic focal points in target programs, and selected M&E stakeholders that work with DRH. Fourteen DRH staff participated in the group assessment, and each also participated in the individual assessment. The interviews also included focal personnel from UNICEF, UNFPA, IntraHealth, and MSH.

The baseline assessment, which targeted DRH as an institution, drew participants from DRH senior management, which primarily comprises program managers and program officers who work in various DRH programs, including an administrative staff and the librarian. Assessment participants were identified through a purposive sampling, which was adopted to make it possible to interview all program staff engaged in activities that require support from M&E staff and other staff who oversee and perform DRH M&E functions.

2.4 STUDY PROCEDURES

MEASURE Evaluation used a number of approaches during the baseline assessment. First was stakeholder engagement and consensus building, which involved consultations with DRH on the rationale, objectives, and intended outcomes of the exercise. A comprehensive desk review of relevant documents and literature on the M&E capacity of DRH followed. The desk review provided the following information:

- History and structure of M&E activities
- Current status of M&E activities

- Existing documentation related to M&E capacity
- Existing documentation about the gaps in M&E capacity

Results of the desk review revealed important gaps in existing documentation about the current status of M&E capacity, information that further guided the development of the assessment protocol and data collection instruments. MEASURE Evaluation developed three data collection instruments: (1) a group assessment tool, (2) an individual assessment tool, and (3) a key informant guide, and used them to collect primary data from respondents.

Both the group and individual self-assessment tools were administered during a workshop held July 29–31, 2013, at Maanzoni Lodge in Machakos, Kenya. Responses to questions under each key competency were captured in an Excel self-assessment tool. A total of 20 respondents were involved in the group assessment, 19 respondents in the individual assessment, and 7 respondents in the key informant interviews.

2.4.1 Group Assessment Tools

For the group assessment, MEASURE Evaluation developed the Monitoring and Evaluation Capacity Assessment Tool (MECAT), based on the 12 components approach used by UNAIDS for M&E systems strengthening. The customized tool captured various dimensions of capacity, such as organizational, technical, and behavioral activities, to provide an overall approach to data collection during the assessment. The tool captured data on four dimensions (status, quality, technical autonomy, and financial autonomy) in the 12 components. Each component had specific questions that targeted different areas of M&E. Figure 3 illustrates the 12 components of the monitoring and evaluation system strengthening tool and Table 1 shows the 12 capacity areas assessed and the focus of specific aspects.

Figure 3: The 12 components of the monitoring and evaluation system strengthening tool

Table 1: The 12 capacity areas and their main focus for the assessment

No.	Capacity Area	Main Focus
1	Organizational Capacity	• Leadership: Effective leadership for M&E in the organization • Human Resources: Job descriptions for M&E staff; adequate number of skilled M&E staff; defined career path in M&E • Organizational Culture: National commitment to ensure M&E system performance • Organizational Roles and Functions: Well-defined organizational structure, including a national M&E unit; M&E units or M&E focal points in other public, private, and civil society organizations; written mandates for planning, coordinating, and managing the M&E system; well-defined M&E roles and responsibilities for key individuals and organizations at all levels • Organizational Mechanisms: Routine mechanisms for M&E planning and management, stakeholder coordination and consensus building, and monitoring the performance of the M&E system; incentives for M&E system performance • Organizational Performance: annual workplan objectives for M&E
2	Human Capacity for M&E	• Defined skill set for individuals at national, subnational, and service delivery levels • Workforce development plan, including career paths for M&E • Costed human capacity-building plan • Standard curricula for organizational and technical capacity building • Local or regional training capacity, including links to training institutions • Supervision, in-service training, and mentoring

No.	Capacity Area	Main Focus
3	Partnership and Governance	• National M&E Technical Working Group • Mechanism to coordinate all stakeholders • Local leadership and capacity for stakeholder coordination • Routine communication channel to facilitate exchange of information among stakeholders
4	National M&E Plan	• Broad-based participation in developing the national M&E plan • M&E plan explicitly linked to the National Strategic Plan • M&E plan adheres to international and national technical standards • M&E system assessments and recommendations for system strengthening addressed in the M&E plan
5	Annual M&E Costed Workplan	• M&E workplan contains activities, responsible implementers, timeframe, activity costs, and identified funding • M&E workplan explicitly links to workplans and government Medium-Term Expenditure Framework (MTEF) budgets • Resources (human, physical, financial) are committed to implement M&E workplan • All relevant stakeholders endorsed the national M&E workplan • M&E workplan is updated annually, based on performance monitoring
6	Advocacy, Communication, Culture and Behavior	• Communication strategy includes a specific M&E communication and advocacy plan • M&E is explicitly referenced in national policies and the National Strategic Plan • M&E champions among high-level officials are identified and actively endorsing M&E actions • M&E advocacy activities are implemented according to the M&E advocacy plan • M&E materials are available that target different audiences and support data sharing and use
7	Routine Monitoring	• Data collection strategy is explicitly linked to data use • Clearly defined data collection, transfer, and reporting mechanisms, including collaboration and coordination among different stakeholders • Essential tools and equipment for data management (e.g., collection, transfer, storage, analysis) are available • Routine procedures for data transfer from subnational to national levels
8	Surveys and Surveillance	• Protocols for all surveys and surveillance based on international standards • Specified schedule for data collection linked to stakeholders' needs, including identification of resources for implementation • Inventory of surveys conducted • Well-functioning surveillance system
9	National and Subnational Databases	• Databases designed to respond to the decisionmaking and reporting needs of different stakeholders • Linkages between different relevant databases to ensure data consistency and avoid duplication of effort • Well-defined and managed national database to capture, verify, analyze, and present program-monitoring data from all levels and sectors
10	Supervision and Auditing	• Guidelines for supervising routine data collection at facility- and community-based levels • Routine supervision visits, including data assessments and feedback to local staff • Periodic data quality audits • Supervision and audit reports

No.	Capacity Area	Main Focus
11	Evaluation and Research	• Inventory of completed and ongoing country-specific evaluation and research studies • Inventory of local evaluation and research capacity, including major research institutions and their focus of work • National evaluation and research agenda • Guidance on evaluation and research standards and appropriate methods • National conference or forum for dissemination and discussion of research and evaluation findings
12	Data Demand and Use	• DRH program's National Strategic Plan and National M&E Plan include a data use plan • Analysis of program data needs and data users • Data use calendar to guide the timetable for major data collection efforts and reporting requirements • Evidence of information use (e.g., data referenced in funding proposals and planning documents)

The assessment comprised questions that focus on the following four dimensions: status, quality, technical autonomy, and financial autonomy for each of the 12 capacity component areas:

- **Status** indicates existence or otherwise of specific elements that constitute a capacity area.
- **Quality** is a measure of how robust these elements are for the established norms or standards.
- **Technical autonomy** is the ability of the institution to develop and execute M&E functions without depending on external support.
- **Financial autonomy** is the ability of the institution to financially support specific M&E functions without depending on external funding.

The results of the four dimensions are reported on a 10-point scale, where 0, the least, implies no capacity, and 10, the highest, implies a high level of capacity. The 12 capacity areas of the assessment were scored using a series of statements based on three response scales:

- 3-point scale (Yes Mostly, Yes Partly, Not at All)
- 4-point scale (Strongly Agree, Agree, Disagree, Strongly Disagree), (Less than 1 Year, 1–2 Years, 2–3 Years, Greater than 3 Years)
- 5-point scale (Weekly, Monthly, Quarterly, Biannually, Annually)

The group assessment tool was administered to respondents in a workshop format and facilitated by a team of experienced moderators. The final score for each question was arrived at through group consensus, as facilitated by the moderator of each session. Where consensus was not apparent, a democratic process of voting was applied. Textual information that qualified a response was included in the comment box provided, which added a depth of important information to consider in discussions of necessary actions to be taken. All data were collected using the MECAT workbook in Excel.

2.4.2 Individual Self-assessment Tool

MEASURE Evaluation also developed the individual capacity self-assessment tool based on the UNAIDS guidelines for M&E competencies for M&E personnel to assess competencies that pertain

to M&E leadership, data collection and management, data analysis, data dissemination and use, and evaluation and general management at the individual level. The design of individual assessments scored the knowledge, skills, and competencies that are critical for job performance. The scores from the assessment form a benchmark for use to implement professional development for improved organizational capacity.

In the self-assessment, participants were asked to rate their own level of competency based on a scale of 0–6. The levels were entry or novice (a rating between 0 and 2); proficient or skilled (a rating between 2 and 4); or mastery or expert (a rating between 4 and 6). At the end of the self-assessment, participants summarized key strengths and weaknesses and listed concrete actions to be taken, such as short-term or long-term training, on-the-job and off-the-job training, and other capacity-building approaches, to strengthen specific competencies that are considered critical to job performance and a timeline for achieving improvements.

2.4.3 Key Informant Guides

MEASURE Evaluation developed two key interview guides, one for key informants in DRH and the other for DRH key stakeholders. These guides were developed on the basis of the results of the document review and focused on the 12 capacity areas that were assessed in the group assessment tool. The interviews sought to generate further insights into issues that affect DRH M&E performance on the basis of interviewees' views and opinions.

2.4.4 Data Storage

MEASURE Evaluation developed a workbook for entering and storing quantitative data using MS Excel 2010 software. This workbook was accessible only to participants in the group self-assessment, authorized study investigators, and trained data management personnel. Datasets were made accessible to authorized study investigators and trained data management personnel only. Completed study tools were stored in a secure cabinet with access that was limited to only authorized personnel in the study. Summaries from the assessment will be shared with DRH before the report is finalized.

2.4.5 Data Analysis

MEASURE Evaluation analyzed quantitative data responses from the group and individual assessment tools using simple scoring for each question. Overall scores for each capacity area were automatically analyzed and displayed in easy to interpret dashboards. For the MECAT, scores were normalized to a scale of 10.

Simple descriptive statistics, such as means and frequencies, were used to analyze the quantitative data in MS Excel. Qualitative data, or notes entered in the workbook to explain various responses in MS Excel 2010, were analyzed manually. Notes from the key informant interviews were typed in MS Word 2010. The data subsequently were coded into themes aligned with the 12 capacity areas. At least two people coded the themes, and the results were compared and discussed. Unanticipated themes arising from the data were incorporated into a second round of coding, with free nodes representing broad categories. Any further arising nodes were created by grouping some of the free nodes into tree nodes by making logical connections and incorporating emerging themes. The final stage was a layered analysis that entailed identification of the main themes and underlying causes of reported experiences and observations.

2.5 GROUP SELF-ASSESSMENT ANALYSIS

Using the MECAT, MEASURE Evaluation calculated the Organizational Capacity Index by first summing up the possible scores on the 12 M&E components for the status and quality dimensions. The financial and technical autonomy dimensions were excluded in this case because the effect of these measures was not unidirectional and the presence or absence of these dimensions could affect the performance of DRH either positively or negatively. This is primarily because technical and financial autonomy require long-term investment and depend on the status and quality dimensions. Further, not all the elements for the 12 components of a functional M&E system asked questions on financial and technical autonomy. The index was then computed by dividing the actual score on the 12 M&E functions under the two dimensions of status and quality, with the total possible maximum score.

2.6 STUDY LIMITATIONS

One of the major limitations of self-assessments at group and individual levels is the temptation to exaggerate actual scores due to the social desirability effect. Because this tool was specifically tailored to assess M&E in DRH, findings cannot be generalized to all divisions in the Ministry of Health, especially because the organizational structure, institutional arrangements, and mandates are different.

2.7 ETHICAL CONSIDERATIONS

Ethical approval for this assessment was granted by the Kenya Medical Research Institute's Ethical Review Committee. The voluntary nature of the assessment was clearly explained to all participants, and they were told that there was no obligation to respond to any of the questions during assessments and administration of the various tools. Before each interview and the administration of other tools, participants had an opportunity to query the aim, objectives, and benefits of the assessment. They were asked to sign an informed consent sheet, when appropriate.

To ensure the safety of the documents used in this study, all original documentation was kept in a secured location at ICF International offices. The documentation was available only to the study team concerned with the assessment. For protection of research participants' confidentiality, data collected were kept anonymous by ensuring that participant names were not recorded; participant codes were used instead. All participants were told they could voluntarily withdraw from the assessment at any time without consequences or implication on their careers.

CHAPTER 3: PRESENTATION OF RESULTS

Results of the assessment are presented in two parts. Section 3.1 summarizes the responses according to the four dimensions (status, quality, financial autonomy, and technical autonomy) in each of the 12 capacity areas. The summary represents a snapshot of the nature and level of capacity that exists at DRH in terms of (1) whether specific elements that constitute capacity exist (status), (2) how these elements measure against established standards (quality), (3) the extent to which DRH has been able to develop and execute (technical autonomy), and (4) fund the elements without depending on external support (financial autonomy). For each of the four dimensions, the results summary is presented using a 10-point scale, where no capacity is ranked 0, and a high level of capacity is ranked 10. Part 3.2 describes specific elements results under each of the 12 capacity areas, with similar ranking as in Part 3.1. A score below 5 is interpreted as an indication of weak capacity, and is thus an area of focus for an intervention to strengthen capacity.

3.1 RESULTS ON THE FOUR DIMENSIONS OF THE 12 CAPACITY AREAS

The results for DRH are managed in the MECAT- a customized MS Excel tool for group assessment with customized dashboards. For each capacity area, a number of capacity elements were evaluated through a series of questions with the following dimensions:

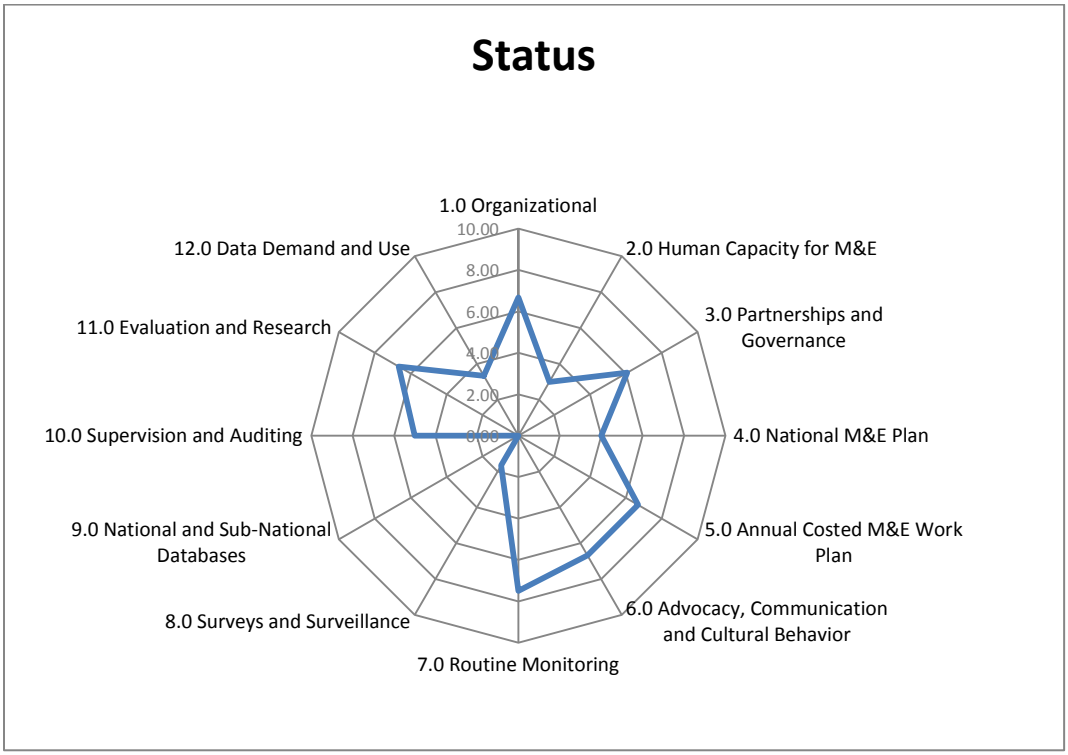
- **Status:** Whether a given element exists (e.g., a national M&E plan)
- **Quality:** Whether the element conforms to established norms of quality
- **Technical autonomy:** The extent to which a given program can develop and execute the element on its own
- **Financial autonomy:** The extent to which a given program can develop and execute the element using its own resources

For overall capacity, DRH's organizational capacity index was 38.23%, which implies that the requisite capacity skills for DRH to effectively carry out the mandate for M&E is weak and needs to be strengthened. DRH's average scores for the dimensions of status, quality, technical autonomy, and financial autonomy were below 5 out of 10, indicating a need to strengthen M&E leadership and human resources, establish clear roles and responsibilities for staff, and put systems into place that can enable M&E to play a key role in DRH. DRH also scored low on technical and financial autonomy because it relies heavily on external parties to help with technical and financial input to support M&E.

3.1.1 Status Dimension

The DRH status for M&E activities rated at an average of 4.87 out of 10. Out of the 12 capacity areas, four areas rated below 5 out of 10: (1) human capacity for M&E Plan (score, 3.0), National M&E Plan (score, 4.0), Data Demand and Use (score, 3.0), and national and subnational databases (score, 0). The highest functional area was routine monitoring (score, 7.5). Other areas that scored higher than 5.0 were having an annual costed workplan (score, 6.7); having an advocacy, communication, and cultural behavior strategy (score, 6.7); organizational capacity (score, 6.7); and partnership and governance (score, 6.1). See Figure 4 for the DRH scores for status.

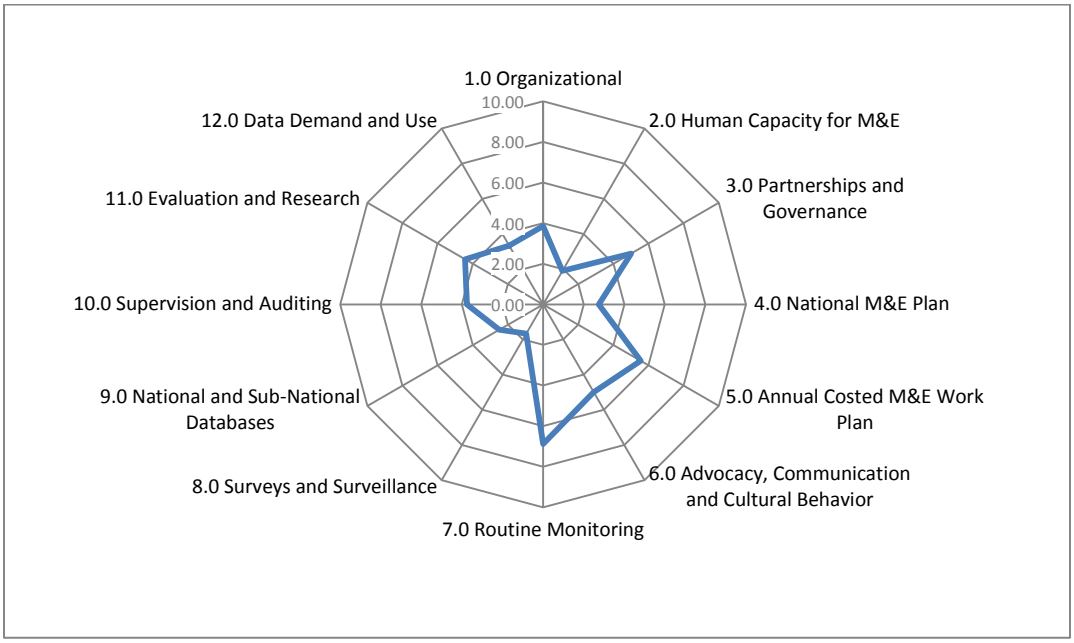
Figure 4: DRH's status dimension for the 12 capacity areas



3.1.2 Quality Dimension

After each question related to the status of specific M&E activities, participants were asked to score the quality in which each M&E activity was implemented. The quality dimension of DRH M&E rated at an average of 3.89. For established standards, most of the 12 components scored below 5 out of 10, with annual costed M&E workplan (score, 5.6), and routine monitoring (score, 6.7) scoring above 5. Partnerships and governance and advocacy, communication, and cultural behavior both scored at 5. The lowest scores were for surveys and surveillance (score, 1.7) and human capacity for M&E (score, 1.9). This means that despite making progress in the implementation of M&E activities, the quality of the work needs to be improved. Figure 5 shows DRH scores for the quality dimension.

Figure 5: DRH's quality dimension in 12 capacity areas



3.1.3 Technical Autonomy Dimension

The average DRH score for technical autonomy in implementing M&E activities was 3.01. Results revealed a dearth in technical autonomy in DRH, with some components having no internal technical capacity at all. This means that, for M&E activities undertaken by DRH, substantial external technical assistance was required.

The only components where participants found that DRH had scores of at least 5 for technical autonomy were in the areas of data demand and use, routine monitoring, and communication and cultural behavior. DRH lacked internal technical capacity to design an annual costed M&E workplan and national and subnational databases. Several areas also scored 2.5 out of 10: human capacity for M&E, surveys and surveillance, supervision and auditing, and evaluation and research. See Figure 6.

One key informant stated, *"A lot of requests come from stakeholders and partners, and then DRH gets to work."* Adding to this was the view from another key informant that during the M&E TWG meetings they have had input and support for guiding the unit.

Specifically, key informants noted where technical support was provided:

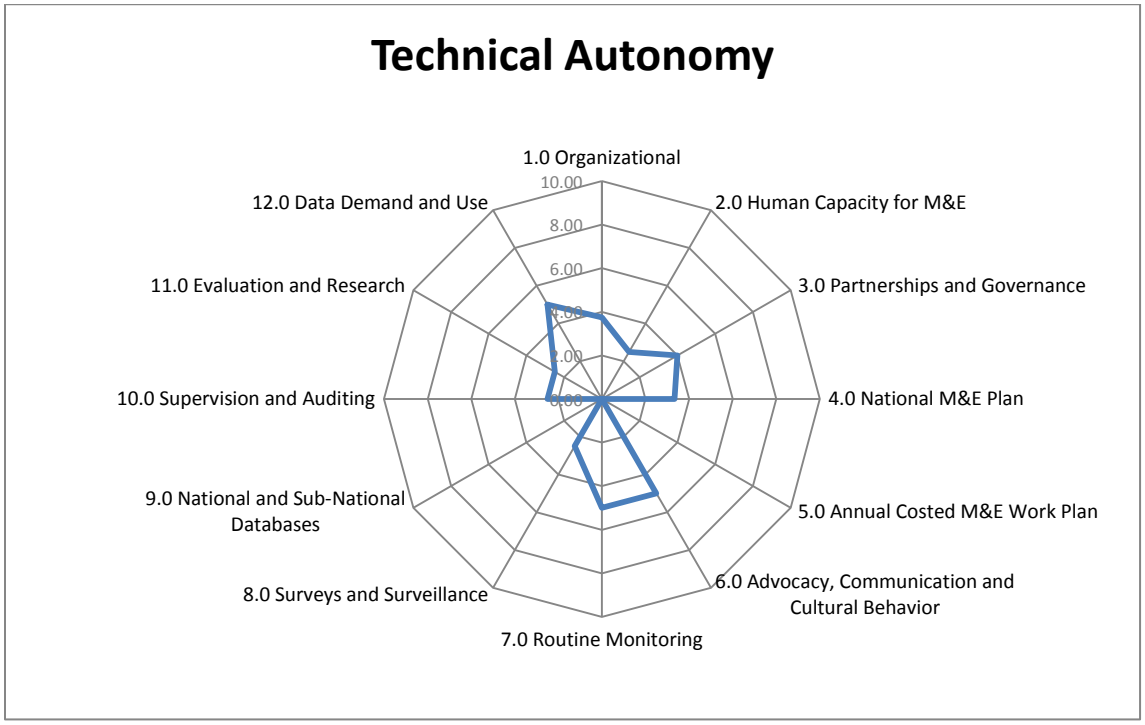
- Advising the M&E unit through the placement of an M&E Advisor from a USAID-funded project
- Printing of data collection tools and teaching health workers how to fill in the forms
- Supporting DRH from the beginning of a project being implemented
- Assisting with the maternal mortality review through technical and financial help

Key informants made the following statements:

> *"The previous technical advisor was instrumental in trying to turn around the M&E unit so that it is more efficient, more effective in provision of its support to the other programs. The M&E unit is supposed to lead the implementation of the M&E framework through interaction with the other programs in the Division."* Key Informant

> *"The M&E unit also received support from MSH in 2010 to support the Division in terms of restructuring and reorganizing. One of the key outputs was making sure we have SOPs for meetings, so we give it a business structure approach…that has worked for a while, but sometimes you face difficulties that do not allow that to be followed or adhered to. That would be useful when someone has a calendar that is predictable, not only for the Division, but also for the partners…over time we have seen a huge improvement in terms of even the Division having the capacity."* Key informant

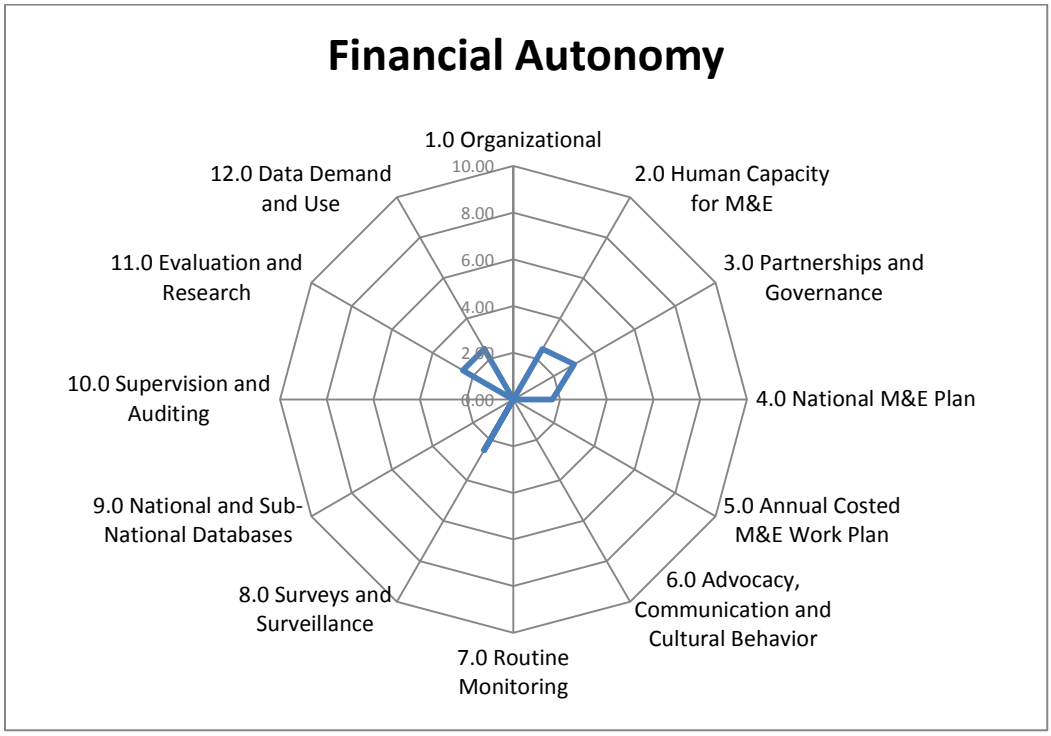
Figure 6: DRH's technical autonomy dimension in 12 capacity areas



3.1.4 Financial Autonomy Dimension

The average DRH score in the financial autonomy dimension for M&E capacity was 1.22 out of 10. Participants selected a low score in financial autonomy for most of components, with none exceeding a score of 3. The highest capacity area, partnerships and governance, scored 3. Many capacity areas have no financial autonomy: organization; annual costed M&E workplan; advocacy, communication, and cultural behavior; routine monitoring; national and subnational databases; and supervision and auditing. This lack of financial autonomy implies that DRH depends to a large extent on external financial assistance. Figure 7 shows DRH's financial autonomy dimension in 12 capacity areas.

Figure 7: DRH's financial autonomy dimension in 12 capacity areas



3.2 RESULTS FOR THE 12 CAPACITY AREAS

As with the four dimensions, the overall picture of M&E capacity at DRH is that virtually all the elements across the 12 M&E capacity areas are not in place. Only two capacity areas had an average score that exceeded 5.0 out of 10; national and subnational databases received a rating of 6.1, and routine monitoring received a rating of 7.3. The other 10 capacity areas were ranked below 5.0 out of 10. Three capacity areas scored 0 out of 10: human capacity for M&E, supervision and auditing, and evaluation and research.

Table 2 summarizes the results of the DRH baseline assessment for human capacity in the 12 capacity areas.

Table 2: Average scores for M&E capacity in DRH by capacity area

No.	Capacity area	Average score
7	Routine Monitoring	4.84
3	Partnerships and Governance	4.52
6	Advocacy, Communication, and Cultural Behavior	4.17
11	Evaluation and Research	4.03
1	Organizational	3.57
12	Data Demand and Use	3.54
5	Annual Costed M&E Workplan	3.06
4	National M&E Plan	2.94
10	Supervision and Auditing	2.81

No.	Capacity area	Average score
2	Human Capacity for M&E	2.48
8	Surveys and Surveillance	2.08
9	National and Subnational Databases	0.63

3.2.1 Capacity Area 1: Organizational Capacity

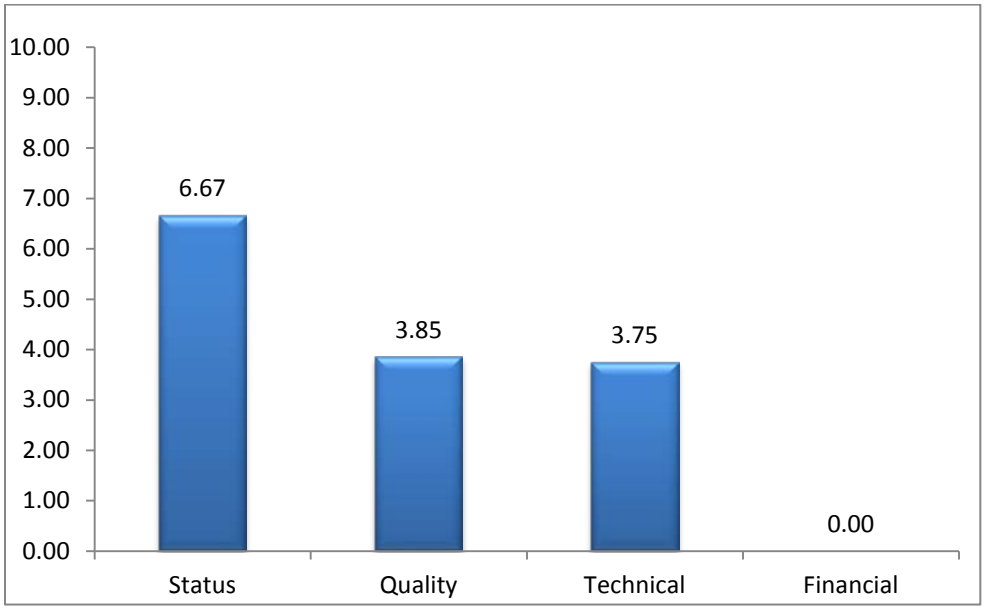
Organizational Culture

The key questions under organizational capacity focused on DRH's mission statement and the alignment of M&E activities to the mission and stated objectives. The questions asked if a written mandate exists for the M&E unit and, if so, if known M&E responsibilities are assigned in the division, including the frequency, if any, of M&E meetings.

A desk review noted that DRH is responsible for planning, implementing, and monitoring reproductive health programs in the country. The sole purpose of DRH is to provide a comprehensive, integrated system of reproductive health care that offers a full range of services by the government, nongovernment organizations, and the private sector, as outlined in the National Population Policy for Sustainable Development and the Kenya Health Policy Framework of 1994 (Ministry of Health, 2010a).

As shown in Figure 8, the overall rating in the four dimensions indicates that organizational capacity at DRH is strongest in the status dimension (6.7), and then diminishes progressively for the quality dimension (3.9), technical autonomy dimension (3.8), and financial autonomy dimension (0.0). The average score for organizational capacity area 1 across the four dimensions was 3.57. The high score for status resulted because DRH instituted an organizational structure because it has a mission statement with values and ethics; however, very few staff could state the DRH mission statement, and more staff were familiar with the ethics and values. Also, DRH has an M&E unit with dedicated staff. Staff members mentioned that the mission and vision were developed with technical assistance from partners, in collaboration with DRH staff. Staff members also mentioned several organizational challenges, such as no clear roles and responsibilities stated for DRH M&E staff and no written mandate to execute M&E functions. Staff members also mentioned that they do not have regular staff meetings to assess and coordinate activities. The M&E unit's reliance on external technical support contributed to its low score for technical autonomy.

Figure 8: DRH scores in four dimensions for M&E human capacity in organizational capacity



DRH has a mission to ensure an efficient and high-quality reproductive health care system that is accessible, equitable, and affordable for every Kenyan. The vision is to ensure high-quality, integrated, promotive, preventive, curative, and rehabilitative reproductive health services to all Kenyans (Division of Reproductive Health, 2013). Although DRH has a mission and stated objectives, group discussions noted that DRH's M&E activities are not fully aligned to the Division's vision and mission.

Organizational Roles and Functions

Key informants were fairly consistent in their assessment of the role of the M&E unit as an organization, noting that the unit is responsible for setting up and managing an M&E system in alignment with DRH strategy to monitor and report on progress to realize the Division's mission. Key informants commented on the following functions:

- Formalize, standardize, and link reproductive health indicators with DHIS
- Keep DRH and the nation abreast of key findings from DHS
- Inform DRH of progress against performance contracts by quarterly monitoring of key indicators
- Track DRH progress against the annual workplan
- Determine the effect of DRH programs

Although these points included specific tasks, one key informant said that the role of the M&E unit is to *"…coordinate so that things come to a point whereby you can be able to synthesize them and be able to create something that can be used for reporting, planning, or programming.*"

The informant also stated that the M&E unit does not seem to be very well integrated into DRH programs. A respondent in the Division explained that sometimes the M&E unit is expected to be responsive to programmatic data needs, yet because the M&E unit was not involved in the design of specific programs, it is unable to provide the data requested. A respondent explained that the M&E

unit does a good job of addressing the needs for service data, but it is challenged in monitoring commodities. A senior manager from the Division said the M&E unit is not prepared to undertake these functions. Stakeholders working with DRH have advocated for increased M&E support. For example, another key informant mentioned that his dream as a stakeholder would be to have an M&E unit that can provide real-time data and analyze it and give feedback. He stated, *"We want a unit that not only receives data, but we want a unit that receives, analyses, and provides feedback to the counties. We want a unit that is able to use the data it receives to provide information and guidance to county governments for them to be able to do programming."*

Another key informant noted that DRH would benefit from learning how other organizations have successfully established and supported an M&E unit to meet their information needs and what works and what doesn't work. He said this information will help DRH understand the advantages of having an M&E unit. Contrary to this view was a statement from a key informant noting that DRH is aware of the need to focus on M&E in whatever activity is underway so that the programs know that M&E is important and critical for any interventions that have been planned or are being implemented. This informant also expressed how important it is for people in DRH to appreciate that M&E is the responsibility of everyone in the Division, including those who implement programs.

Organizational Performance

Key informants acknowledged that the M&E unit faces challenges and that it is not performing well in monitoring and using the information collected to guide DRH programs. Respondents indicated that while staff may need more skills, the real problem is not so much and issue of poor data collection as data collection is not the primary work of the unit. The key issue is that staff members are not using the information that is being collected. According to one respondent, *"For most things they have data collection tools; the issue is what happens to that data after that."*

With the new constitution in place, the role of DRH has changed slightly. DRH no longer oversees county governments; however, DRH remains a policymaking organization and provides guidance in the implementation of reproductive health activities nationally. DRH also provides capacity-building support for the counties to implement reproductive health services. Considering this role, one informant noted, *"They need a structure to tell them how they can build the capacity of the health workers, even if not them directly, they need to help the counties be able to do that also."*

The interviews also revealed that DRH programs contribute to poor performance in the M&E unit because program leaders ask for results at the end of the process, but the M&E unit was not included as part of the initial process. A key informant stated, *"Currently what happens is that the M&E unit is not much integrated into other programs (MNH, Gender, Family Planning, ASRH, Reproductive Tract Cancer)."*

Changes in DRH staff have been rampant. At some point, DRH lost some of its M&E staff because of internal issues. The arrival of new staff resulted in transitional issues. The M&E unit received support from the Capacity Project (IntraHealth) in the form of an M&E Technical Advisor, who was placed at DRH to build staff capacity. According to a key respondent, DRH greatly benefited from the Advisor's support; however, the benefit did not last long because the Advisor left after six months to pursue another job opportunity. Improvements in DRH M&E have been unsteady and not sustainable. It improves in the right direction for a while, but then fluctuates back to difficulties. Currently there are three M&E staff members, none of whom have a graduate degree, which was viewed as important by a number of key respondents.

Leadership Capacity

A key informant described the organizational challenge to the M&E unit: *"The Division knows where it wants to go in terms of reproductive health services but they are not very clear where they want to go in terms of M&E because at the management level they are a bit handicapped when it comes to understanding how M&E can be used and where it can be improved because they are not experts in that field. It is not just the DRH but the whole of MOH is challenged in that aspect."*

A respondent from an implementing partner explained that the M&E unit is not properly positioned in DRH, making it challenging for the staff to prioritize M&E. Often, the M&E unit is found working on program work before it focuses on M&E-specific activities.

According to a key informant the following areas need to be strengthened:

- Governance: DRH has capacity at the management level, and most staff members have been trained in strategic planning and strategic leadership and development.
- Organizational management: DRH is not so badly off; staff can think in the right direction and make decisions, but actual implementation in smaller DRH units face challenges.
- Data needed by DRH to make policy or program decisions: The information DRH has should be accurate and complete. For example, DRH cannot make many decisions on the program on adolescents' reproductive health because although data on family planning is available, it has not been disaggregated by age, which renders it useless.

To address these challenges, key informants noted that all DRH policies, action plans and strategies include an M&E component and that DRH has an M&E framework. A key informant described M&E staff capability for leadership and management this way:

- *Staff really value M&E and it is just a matter of being given opportunities to explore it and be in the forefront.*
- *In as much as managers might complain that M&E staff are not working properly to deliver on the objectives, the M&E staff are also complaining that the managers do not see their role as important.*
- *There should be perceptions and behavior change from both sides as the managers need to see how useful they are in the daily operations and the M&E staff need to see that they are useful and need to implement targeted interventions to prove their usefulness.*
- *The leaders play a very key role as managers; they are the ones who facilitate all the offices under them to operate the best.*
- *Unless the management realizes and understands the importance of M&E and how it can be used to improve the division of DRH, the support will be limited.*
- *There is a capacity needed for the managers to understand M&E and how it can be used. Not theory but practically see an example of an organization which is operating very well on M&E and see the systems they have put in place, and how they monitor their things and learn from the best practices.*

The informant also explained that a good leader in the division needs to understand M&E and the systems and be in a position to serve as a liaison between M&E officers and other managers, to bring forth M&E at every point.

Challenges to Organizational Capacity

Key informants mentioned several M&E challenges:

- *There are many things that are not in the annual plan that just come (e.g., international meetings that they do attend, they are just told about them in two weeks' time). Though it is part of their work, it is not in included in their plan so you have to abandon what you have. Same to meetings at Afya house, one just receives a letter and maybe the meeting is even the next day. "It is like a day-to-day thing."*
- *There are too many meetings and sometimes with partners, depending on what kind of partners and what meeting because these partners fund DRH*
- *Other challenges faced in implementation include: prioritization of work, using a project approach, lack of interrogation of M&E tool and the use of the M&E framework.*

DRH has some nontechnical challenges:

- *Attitude, though this may also be due to poor skills and understanding of M&E. Generally the feeling that people are overworked is always there. They do not know how to prioritize very well, and it is not just DRH but where the actual work is happening.*
- *DRH does not generate the data but feels that people at the point of collection of data do not appreciate the usefulness of that data.*

Despite these challenges, key informants highlighted the following observations:

> *"Even though we don't have an Advisor now I still feel there is significant improvement from how we have transacted business in the past. There in awareness of the need to focus on M&E…the programs know that M&E is critical for the programs that are being planned or being implemented."* Key informant

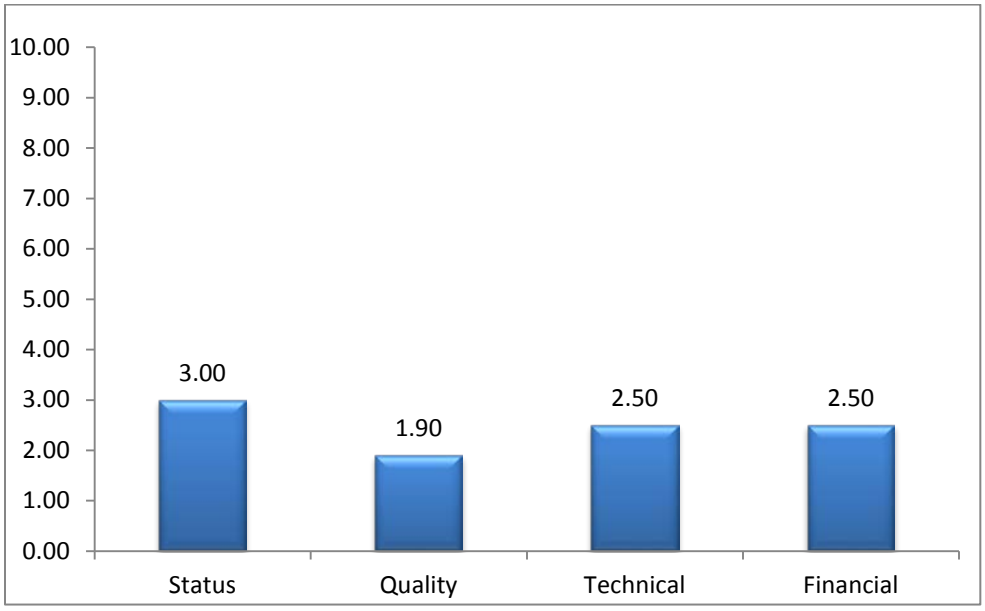
> *"There have been successes, especially coordinating meetings that are programmatic and mainly the TWGs that are related to the program…particularly for the major programs MNH, ASRH and Gender."* Key informant

3.2.2 Capacity Area 2: Human Capacity for M&E

The assessment examined staffing issues and staff capacity skills and competencies to undertake M&E activities. It addressed the existence of a human capacity development plan and whether such a plan existed for organizational development. It explored data demand and use and whether the division had adequate M&E staff to handle demands.

DRH rated at 2.58 out of 10 on average for all dimensions of human capacity for M&E. Among the four dimensions, status ranked highest at 3.0. The quality dimension ranked lowest at 1.9 out of 10. The other two dimensions, technical and financial autonomy, both rated 2.5, as shown in Figure 9.

Figure 9: DRH scores in four dimensions for M&E human capacity



DRH had four M&E staff members who were deemed adequate by the M&E unit to implement M&E activities for DRH programs; however, the group assessment revealed that no clear job descriptions had been given M&E staff, and each program in DRH worked independently, including doing M&E work without involving the M&E unit.

In the individual assessment tool, DRH staff filled out additional M&E competencies based on UNAIDS guidelines for five key areas of M&E leadership: data management, evaluation, data analysis and use, and general management. Data from 19 DRH officers who were assessed during the July workshop are shown in the box and whisker plots in Figures 10, 11, and 12. Figure 10 shows the average performance rating of all DRH staff. Apart from general management, the performance rating for the other components was less than 3 out of 5, the average rating for M&E competency, a clear indication of low overall M&E capacity as reflected in the findings from the organizational assessment. The aggregate individual scores revealed that the majority of respondents scored below 3 for M&E leadership, data management, evaluation, and data analysis and use.

The scale used to rank the M&E competencies for the individual assessment tool were 0–1 for entry or novice, 2–3 for proficient or skilled, and 4–5 for mastery or expert.

Figure 10 masks the capacity in DRH for M&E because not all staff members have job responsibilities in M&E. An analysis of the data using box plots helped explain the responses on the M&E unit. Results from Figure 11 show that performance ratings for the M&E staff were not significantly different from those of the general staff. The graph in Figure 11 shows that M&E officers score better than the overall DRH staff for M&E leadership, data management, evaluation, data analysis and use, and general management; however, findings from the organizational assessment that revealed that M&E staff have low capacity indicate that the results of the self-assessment should be interpreted with caution because self-reporting assessments have biases that result from a social desirability effect. It is likely that M&E officers may have overestimated their M&E competencies, considering that the M&E unit is viewed as an organ to support all DRH programs. Also, because this tool was specifically tailored to assess M&E capacity in DRH, findings

cannot be generalized to all Ministry of Health Divisions, especially because the organizational structure, institutional arrangements, and mandates are different.

Figure 10: Overall range and distribution of M&E competencies and skills at DRH

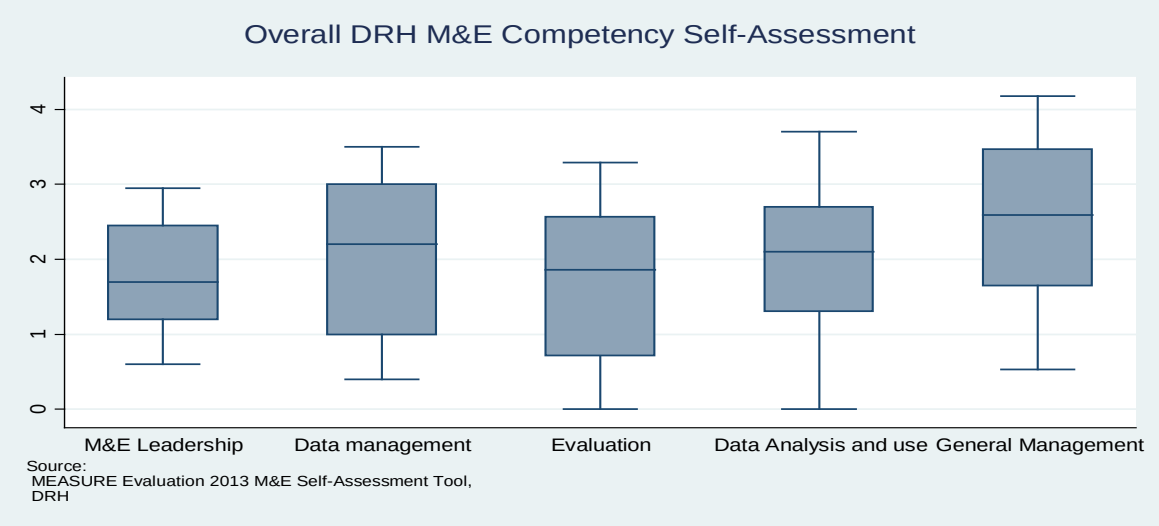


Figure 11: Overall range and distribution of M&E competencies and skills among DRH M&E officers

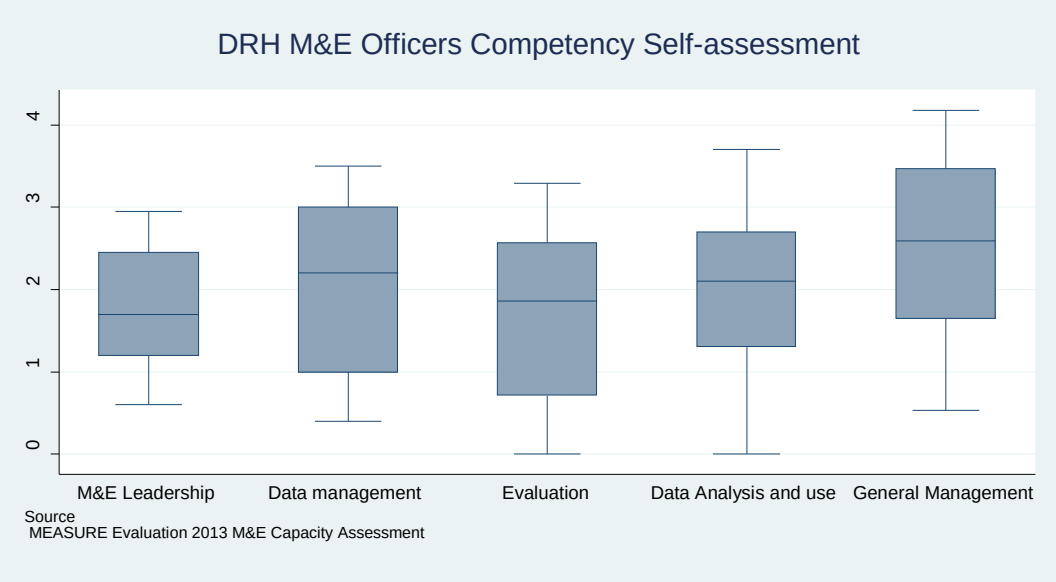
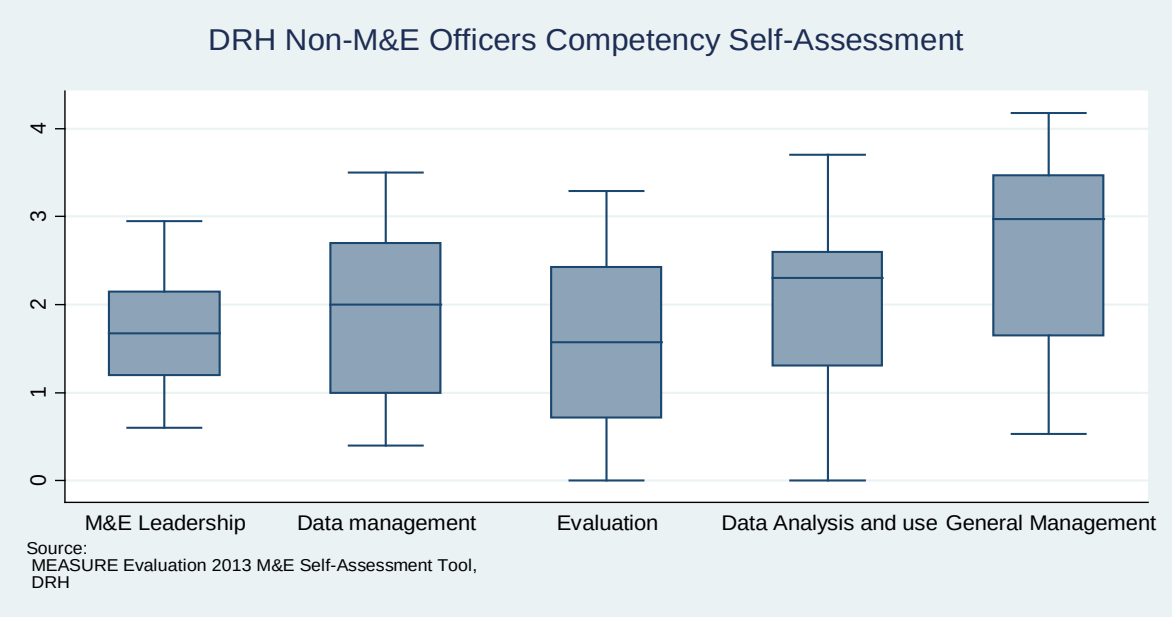


Figure 12 shows that the non M&E staff had better performance ratings overall than the M&E staff, which was particularly evident in the general management and data analysis and use components.

Figure 12: Overall range and distribution of M&E competencies and skills among non-M&E staff



For DRH M&E staff members to organize their work and improve strategies to strengthen M&E, they need additional skills. The interviews revealed that DRH has few staff trained specifically in M&E; most staff members are health professionals and their training often does not include M&E. A prevalent attitude among staff is that M&E work should be done by M&E officers. A key informant who works in DRH noted that the attitude of staff needs to change; the attitude needs to be that all staff members need to be aware of and perform M&E. M&E staff need to coordinate, but also, the entire DRH staff needs to follow and strengthen the M&E system and put the data collected to use.

A key informant from DRH also expressed the need for the unit staff to have a background in M&E, be motivated to work together as a team, have achievements to look forward to, and to feel as though they are contributing to the organization in a positive way. The informant specifically expressed the need for appropriate posting of staff, based on qualifications and the need to define the role of M&E staff. For example, a records officer should not be tasked with data analysis and extensive decisionmaking. *"Furthering the idea of teamwork"* was the statement from an implementing partner key informant to point out the need to create a team approach so that *"everybody knows what the other is doing in order to make it easier to push things forward."*

Respondents also expressed that the M&E unit needs clearly defined roles and responsibilities so that staff members know what they are supposed to do and be accountable for it, *"so that at the end of the day or at the end of the month you can be able to monitor what they have been doing according to what had initially been planned."* The following quotes demonstrate how key informants felt that the capacity of the M&E staff was weak and in need of support from M&E technical experts. A stakeholder commented on the existing M&E program officers:

> *"The ones whom we have as program officers have limited capacity in reference to M&E, although some are currently undergoing studies in M&E and we hope that this will improve. There is still some gap that needs to be improved in terms of technical expertise in M&E so as to move forward."* Key Informant

"I think with the staff we have now I don't think the number is the issue. I think it is the quality of their work. Maybe we have not given them proper direction. Maybe as a Division we need to be helped to come up with the proper structure within which they can work… Otherwise, for the number we have, I feel is ok. What we need is to structure and to really know what it is that we should be doing so they can understand what they are doing." Key informant training is one part of it, but my assessment is that they need to be more focused on what is M&E and what it is that we need to do…so that we give guide to the other program officers and managers…if we refocus and have the integrated approach in managing our programs, we can still deliver." Key Informant

"M&E is not a preserve of the M&E unit, it is a responsibility for everyone working in the Division and, in fact, people out implementing; but of course the role of the M&E unit is mainly to coordinate." Key Informant

"The most desirable thing in my office would be to access data and make sense of it, but that might also require maybe capacity building amongst the whole team in the Division… Data is very useful for planning…and without it we would be in a lot of trouble." Key Informant

The DRH M&E unit faces several nontechnical challenges, such as gaining experience in M&E, including managing DRH affairs and calendar and the necessary teamwork and coordination required to perform on DRH programs. One key informant said:

[They need to know…] "At least what data they need to collect…after collection the analysis and data use." Key Informant

A key informant expressed strongly the opinion that the M&E unit needs to improve in its M&E behavioral capacity. The informant noted several gaps, such as being unavailable to support M&E unit activities when expected, being accountable for their work, developing and embodying an organizational vision, and promoting a positive and team-based approach. Quotes from key informants further expanded on the attitude and motivation of M&E staff:

"[The M&E program staff members] have been trained from [year] 2000 by many projects but it has not changed them."

"People in DRH are very busy, which is a challenge but it [M&E] is something that they should be able to do."

Overall, respondents noted some important gaps and challenges in DRH's capacity to undertake M&E functions:

- DRH is understaffed and the quality of the work is not strong.
- M&E is not prioritized in DRH.
- M&E staff members have skills to gather information and keep records, but improvement is needed to better use data in a meaningful way to influence policymaking decisions.
- DRH M&E staff skills and competencies in M&E have not been assessed; routine assessments are used only for performance contracts.

3.2.3 Capacity Area 3: Partnerships and Governance

It is critical to work with stakeholders in reproductive health and institutionalize governance structures to realize the DRH mandate. This baseline assessment explored governance structures and the M&E National Technical Working Group to coordinate stakeholders at the national level. It also explored the existence of a routine communication channel to facilitate exchange of information among stakeholders. Some questions focused on local leadership and capacity for stakeholder coordination.

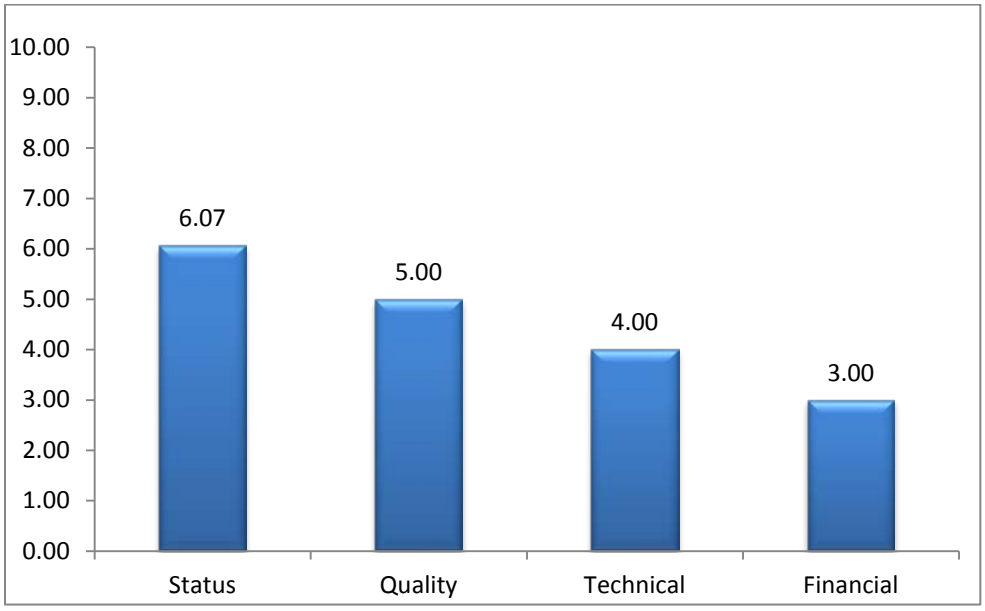
DRH has many partners that collaborate on different facets of their work. Participants noted the need to conduct a stakeholder mapping exercise and establish a comprehensive inventory of all stakeholders and their roles in reproductive health. Participants also suggested that the inventory should be updated at least quarterly.

DRH has an approved strategic plan for the period 2009–2015. Participants noted, however, that with the enactment of the new constitution in 2010, the strategy will need to be amended to reflect how DRH services will be implemented and monitored at national and subnational levels. Internal capacity to formulate the strategic plan was inadequate, and participants acknowledged that they sought technical assistance from partners. Partners funded development of the strategy.

Despite the existence of the strategy, DRH did not have standard operating procedures that defined the roles and responsibilities of M&E functions and activities.

DRH on average scored 4.52 out of 10 for all dimensions of M&E capacity in partnership and governance. Among the four dimensions, status rated highest at 6.07. The financial autonomy dimension rated lowest at 3.0 out of 10. The other two dimensions, quality and technical autonomy, rated at 4 and 3 out of 10, respectively, as shown in Figure 13. The high status score for partnerships and governance was the result of a reproductive health strategy and policy for a 5-year period that outlines strategic areas for M&E for partners to support and strengthen reproductive health nationally. DRH has several active stakeholders who convene quarterly to discuss reproductive health issues at TWGs. Technical and financial autonomy was low because partners often contribute financially toward activities and provide technical staff to support DRH.

Figure 13: DRH scores in four dimensions for M&E human capacity in partnerships and governance



M&E partnership was discussed among key informants from the perspective of how the DRH M&E unit works with its key stakeholders and partners to coordinate and communicate M&E efforts. DRH holds quarterly M&E TWGs. Before the baseline assessment, the last meeting was held in February 2013. Some of the partners participating in the TWG include MEASURE Evaluation, Afya Info, UNICEF, WHO, FHI 360, MSH, Jhpiego, and Population Council. Assessment participants commented that it would be important for top leadership, such as the program managers and head of DRH, to attend the TWGs. Participants also noted that DRH has no clear mechanisms for communicating M&E activities because no active M&E stakeholder meetings take place to supplement the TWGs.

According to a key informant, stakeholders, led by partner representatives, have worked to support different forms of reporting, from paper-based formats to paper-based and electronic forms, in an effort to move to electronic reporting. For maternal death reporting, partners have concentrated primarily on deaths in facilities; they have been less successful in improving reporting on community deaths and verbal autopsies. The informant stated, *"However, we have not had the capacity to actually sit and hold the hand of government for them to continue with the process. We have actually left it to them to try and figure out from the normative guidance on how the [Maternal Death Review] system should look and the funds. If we had the capacity to be able to put someone who can then guide the process until its logical conclusion we would not have that long-term presence in that project."*

A key informant also noted a conflict in data ownership; partners keep good records of data, but sometimes partners retain the data for their own use. In addition, partner requests for meetings and specific agenda items are often given priority because of their financial support, thus making it difficult for the M&E team to adhere to their own planned course of action.

3.2.4 Capacity Area 4: National M&E Plan

MEASURE Evaluation interviewed participants to find out if DRH played a role in bringing stakeholders together to develop the national M&E plan. MEASURE Evaluation also explored if the

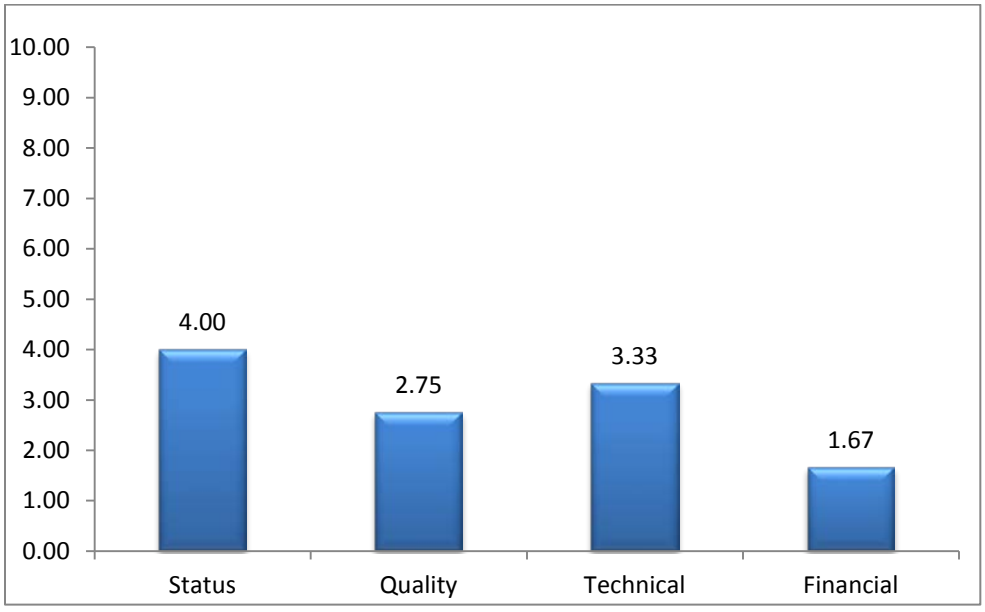
M&E plan was linked to the national DRH strategy and whether the M&E plan adhered to national and international technical standards. This section discusses whether an assessment was done on the M&E system to guide approaches to strengthen the revised M&E plan.

Although MEASURE Evaluation helped DRH formulate an M&E plan in the late 2000s, participants noted that DRH does not have an updated M&E plan. Efforts have been made to revise the M&E plan, but it remains in draft form. Participants also noted that the M&E unit has not been involved in a review of the draft M&E plan. The group assessment confirmed that DRH lacks reporting guidelines, and the DRH M&E system has not been assessed. In summary, responses from the key informants stated similar beliefs that although there is an M&E plan, it is currently outdated. Two of the respondents noted that the M&E plan is linked to the National Multi-sector M&E Plan.

Data that DRH has used for planning or monitoring goals, as set out in the M&E plan, involved the receipt of reports on some indicators that are part of the summary tools by the programs that come from districts. Those reports have been used and placed in the performance contract signed by the Permanent Secretary. DRH programs receive the reports quarterly from the districts, and then aggregate them and send information to headquarters.

On average, DRH scored 2.94 out of 10 for all dimensions of the National M&E Workplan. None of the dimensions scored 5 out of 10 or higher. Among the four dimensions, status scored highest at 4.0 out of 10, followed by technical autonomy at 3.33 out of 10.0. The other two dimensions, quality and financial autonomy, scored 2.75 and 1.67, respectively, as shown in Figure 14. The Division achieved a low score of 2.94 because, although a workplan exists, it did not include a comprehensive results-based M&E framework. The Division experienced delays in the finalization of the workplan as a result of the new MoH governance structures. The workplan did not include a system to track the DRH budget against planned activities. The DRH M&E plan did not undergo a wide consultative process to include all Division programs. The M&E system has never been assessed since it was implemented at DRH.

Figure 14: DRH scores in four dimensions for M&E human capacity in the National M&E Plan



Most key informants said they were aware of the DRH M&E Framework, which expired in 2012, although one informant stated that it was rarely mentioned. Key respondents mentioned the value of an M&E Framework, and one stated that it had been shared widely. Informants suggested all programs need to converge and use and M&E Framework as a tool and referred to a need to further strengthen the link between the M&E Framework and M&E unit activities. The group was unclear on whether the DRH M&E Framework was linked to the Multisectoral M&E Framework; however, one respondent mentioned that indicators from the DRH M&E Framework appear in the Multisectoral M&E Framework.

3.2.5 Capacity Area 5: Annual Costed M&E Workplan

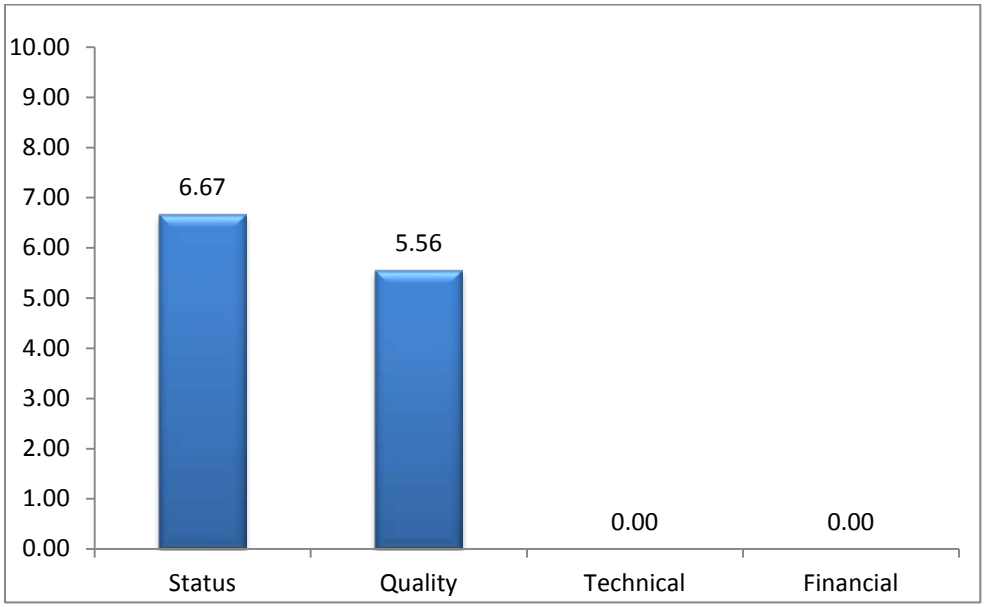
The assessment explored the following questions on the DRH M&E workplan:

- Whether it contains activities, responsible implementers, timeframe, activity costs, and identified funding
- Whether it explicitly links to workplans and the government Medium-Term Expenditure Framework budgets
- Whether resources (human, physical, financial) are committed to implement the M&E workplan
- Whether all relevant stakeholders endorsed the national M&E workplan
- Whether it is updated annually, based on performance monitoring

DRH has a draft costed annual workplan; however, the current M&E workplan has not been endorsed by relevant stakeholders, and consequently, stakeholders have not committed resources to implement the M&E workplan. The workplan is in draft and has not been costed, although it usually is costed with sources of funding. This was consistent with findings from the key informant interviews, in which a number of the respondents made statements about the difficulties in having an actual workplan because of the need to attend ad hoc meetings at the request of partners and implement unplanned activities.

Results shown in Figure 15 indicate that while the draft M&E workplan existed, it was not developed with internal technical and financial support, an indicator that DRH lacks financial and technical autonomy for a costed M&E workplan. DRH on average scored 3.06 out of 10 for all dimensions of the annual costed M&E workplan. Among the four dimensions, status scored highest at 6.67 out of 10, followed by the quality dimension, which scored 5.56 out of 10.0. The other two dimensions for technical and financial autonomy scored 0.

Figure 15: DRH scores in four dimensions for M&E human capacity in the annual costed M&E workplan



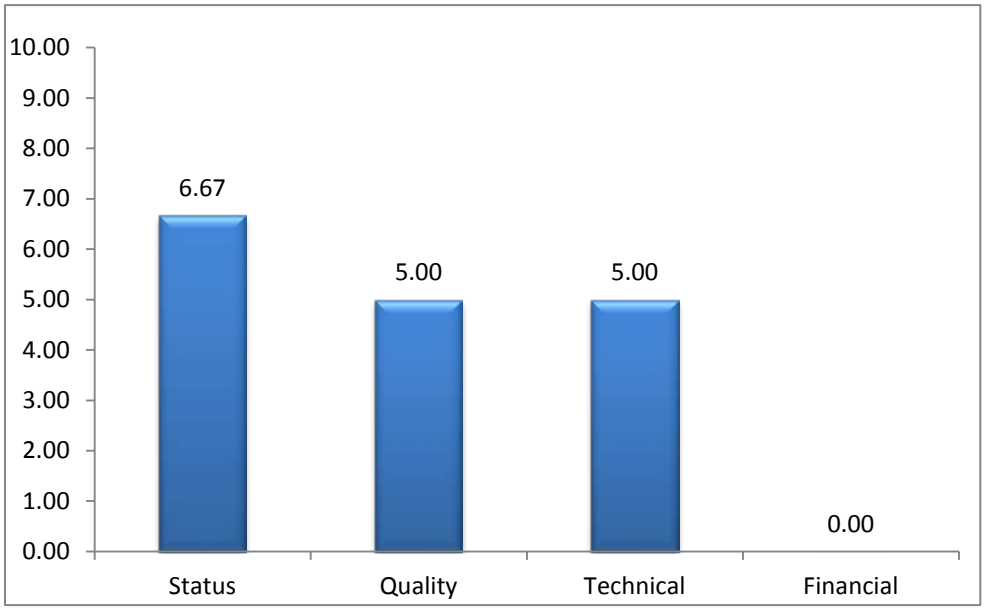
A DRH senior manager mentioned several barriers that affect implementation of the workplan. He said M&E is a stand-alone unit and not fully integrated into all programs and stated, *"By having an M&E stand-alone, every program should have a component of M&E. This has handicapped the M&E unit because it is not integrated into the programs. M&E should be part and parcel of daily activities of the programs of DRH."* He explained that often unplanned activities prevent the team from implementing their planned activities.

2.6 CAPACITY AREA 6: ADVOCACY, COMMUNICATION, AND CULTURAL BEHAVIOR

The assessment capacity area of Advocacy, Communication, and Cultural Behavior explored DRH's communication strategy to determine if it includes a specific M&E communication and advocacy plan; if M&E is explicitly referenced in national policies and the National Strategic Plan; if M&E champions among high-level officials are identified and are actively endorsing M&E actions; if M&E advocacy activities are implemented according to the M&E advocacy plan; and if M&E materials are available that target different audiences and support data sharing and use. Participants noted that DRH does not have M&E program champions. Similar results were found during an indepth discussion with a DRH staff member, who said that *"currently, we do not have a focal person on M&E within the Division, but we are looking into this matter."*

DRH scored an average of 4.17 out of 10 for all dimensions of M&E capacity in advocacy, communication, and cultural behavior. Among the four dimensions, status had the highest score at 6.67 out of 10; quality and technical autonomy had equal scores at 5 out of 10. Financial autonomy scored 0, as shown in Figure 16. The high score for status was as a result of the Division having a communication strategy that addresses all activities and that is being implemented by a focal person at the Division. Quality and technical autonomy had slightly lower scores because the Division did not have M&E champions who can advocate for M&E at DRH. Partners provided external assistance for communication strategy.

Figure 16: DRH scores in four dimensions for M&E human capacity in advocacy, communication, and cultural behavior

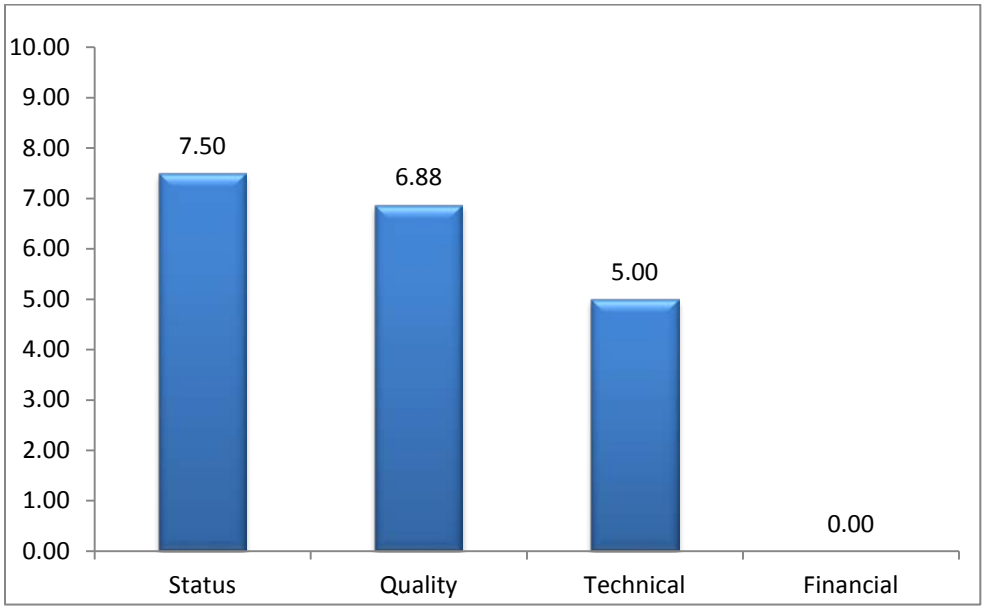


3.2.7 Capacity Area 7: Routine Monitoring

The assessment for this component explored whether DRH has an explicit strategy of data collection and if it is linked to data use. It also explored whether the Division had clear data tools and equipment for data management and routine procedures for data transfer from subnational to national levels. Participants noted a lack of adequate routine monitoring of activities.

DRH on average scored 4.84 out of 10 for all dimensions of routine monitoring. Among the four dimensions, status had the highest score at 7.5 out of 10. Quality and technical autonomy dimensions scored 6.88 and 5 out of 10, respectively. Financial autonomy scored 0, as shown in Figure 17. Status received a high score because of the availability of standardized data collection forms (checklists) to conduct supportive supervision in health facilities. MoH supplies DRH with national guidelines on data management. The data management process, part of the routine monitoring, occurs because DRH integrates gaps in DHIS data after they are identified. Financial autonomy received a score of 0 because partners finance all activities.

Figure 17: DRH scores in four dimensions for M&E human capacity in routine monitoring



Although two of the respondents said that the M&E unit did not have the capacity to implement a routine system, a key informant, felt that the team does, in fact, have this capacity and it just requires them to do proper planning to improve their performance. This person added that monitoring indicators is not complex and that, although they may not be doing it perfectly, this may be more an issue of planning rather than a lack of the resources. The key informant noted that, *"Now with devolution….an officer at the county level could be charged with that responsibility of going out to do supportive supervision then that would be better than having people at the national level going to the counties because they cannot cover the whole country and they are not that many."*

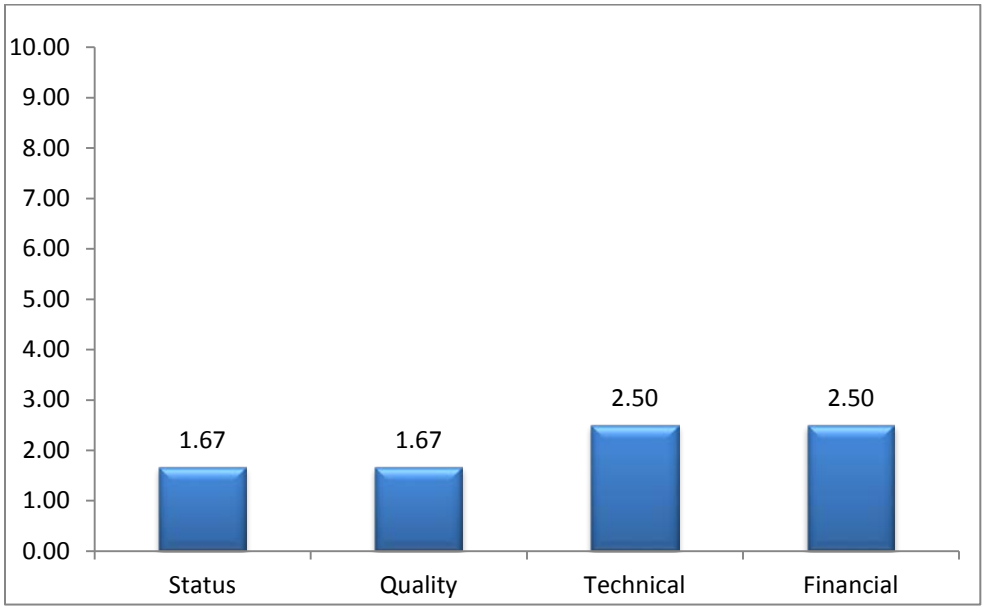
In addition, a key informant shared the idea of further decentralizing the role of routine M&E to align with devolution, suggesting that this function may be more effective at the county level.

3.2.8 Capacity Area 8: Surveys and Surveillance

The baseline assessment explored M&E capacity for surveys and surveillance, and sought the following information: are protocols for all surveys and surveillance based on international standards; is data collection done on a specified schedule linked to stakeholders' needs, including identification of resources for implementation; is an inventory of surveys conducted; and is a well-functioning surveillance system in place.

DRH on average scored 2.08 out of 10 for all dimensions of M&E capacity for surveys and surveillance. Among the four dimensions, the technical and financial autonomy dimensions had the highest score, at 2.5 out of 10, followed by the status and quality dimensions, which both scored 1.67 out of 10 (Figure 18). The low scores primarily resulted because DRH does not implement surveys. DRH provides technical support to other agencies, such as KNBS or partners that conduct surveys, such as DHS and MICS. The Department of Disease Surveillance and Control spearheads surveillance activities to detect, notify, report, and provide feedback. DRH undertakes surveillance activities on a smaller scale, such as the Maternal and Perinatal Death Surveillance Response, an activity financed by UNICEF to assess maternal and perinatal death reporting.

Figure 18: DRH scores in four dimensions for M&E human capacity in surveys and surveillance



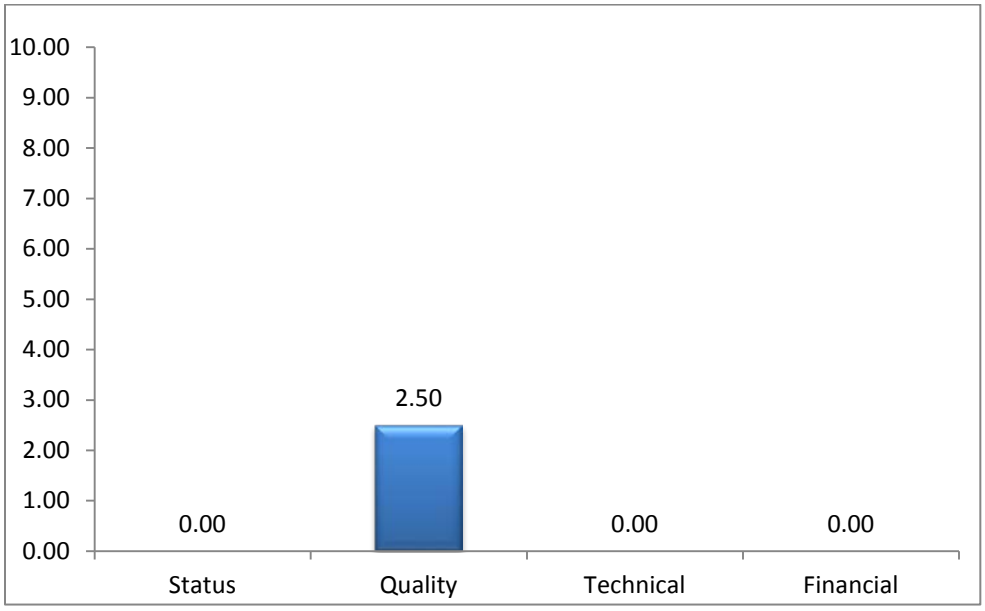
One key informant mentioned that for disease surveillance, DRH is responsible for tracking maternal mortality; however, this tracking is not done, but DRH expressed a hope it will happen. DRH is engaged in major surveys, such as the Demographic Health Survey and Kenya Service Provision Assessment, which assess the status of reproductive health and family planning services and outcomes.

3.2.9 Capacity Area 9: National and Subnational Databases

The assessment explored DRH's M&E capacity for national and subnational databases. It explored DRH's capabilities for databases to respond to the decisionmaking and reporting needs of different stakeholders; linkages between different relevant databases to ensure data consistency and avoid duplication of effort; and if the national databases are well-defined and managed to capture, verify, analyze, and present program monitoring data from all levels and sectors.

DRH on average scored low at 0.63 out of 10 across all dimensions of M&E capacity national and subnational databases. DRH scored only in the dimension of quality for M&E capacity, at a low 2.5 out of 10. The other dimensions of status and technical and financial autonomy scored 0 (Figure 19). The low score results from the lack of DRH program databases. DRH currently relies on DHIS 2, the national reporting system. The current system does not capture all indicators that reproductive health programs need. Another factor that lowers DRH capacity is parallel reporting systems that were created by development partners to capture data. The development of parallel systems decreases interoperability, which makes it difficult to link databases to verify data quality.

Figure 19: DRH scores in four dimensions for M&E human capacity in national and subnational databases



A key informant stated that DRH does not have a database where the team records M&E trainings. The unit also lacks a database for trainers or other people who provide technical assistance for M&E. In addition, she said that DRH has not worked with partners to establish a database for M&E trainers. The only M&E technical working group DRH has focuses on program implementation, but not training in particular. Designing and managing databases are a weakness in DRH because DRH does not keep good records. The senior manager said it would be very good if DRH had a structure for keeping records.

Another informant noted that the M&E unit has established a relationship with the DivHIS, the entity that coordinates and implements DHIS, to manage routine data collection DRH works closely with the DivHIS to ensure that reproductive health indicators are included in the system. Another key informant explained that because of the availability of data in DHIS, an opportunity exists to increase the use of data. Another respondent generally supported this statement and added that the use of the data is limited by its lack of timeliness.

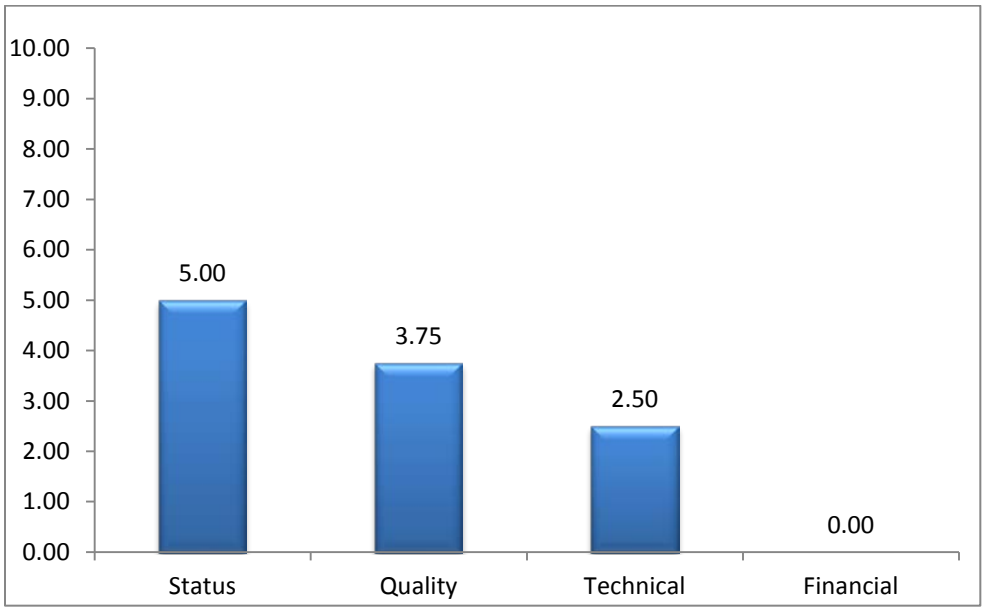
3.2.10 Capacity Area 10: Supervision and Auditing

During the group discussion, participants noted that DRH lacks a planning tool to aid supervision and auditing; however, such tools occasionally are developed when the need arises. The planning tool, therefore, becomes a scoring and feedback mechanism and sometimes an action plan. The only exception to this norm, participants reported, is the DRH family planning program where family planning standards have scoring mechanisms; however, integrated supervision uses only a checklist with a comment section. Participants also noted that the supervision guideline is too long and repetitious.

DRH had an overall score of 2.81 out of 10 for all dimensions of M&E capacity for supervision and auditing. The status dimension had the highest score, with 5 out of 10, followed by the quality (3.75) and technical autonomy (2.5) dimensions, respectively. Because partners paid for all activities, financial autonomy scored 0, as shown in Figure 20. DRH had guidelines for supportive supervision available; however, the data collection tool for supportive supervision is not

institutionalized. Guidelines were developed with technical and financial support from partners. Policies and procedures for data quality audits are not available at DRH.

Figure 20: DRH scores in four dimensions for M&E human capacity in supervision and auditing



Another key informant mentioned that previously in DRH managers would work with their team and monitor the progress of the team and then the manager and the entire program team would then monitor the program implementation at the level of the province, where their mandate ended. With the constitutional changes, DRH's mandate no longer covers supervision; DRH will not supervise counties, but will work only in DRH and provide counties with the policies, guidelines, and standards.

Another key informant stated that the M&E unit does not perform supervision. Occasionally the M&E unit goes to the subnational level to assist with capacity building on how to properly implement activities, but not to supervise Ministry of Health staff directly. The M&E unit usually receives information on what is happening in policy implementation and provides feedback. A key informant addressed the type of staff that conduct supervision visits and suggested that individuals who participate in supervision and data quality assurance activities should be well trained in data quality assessments and data analytics.

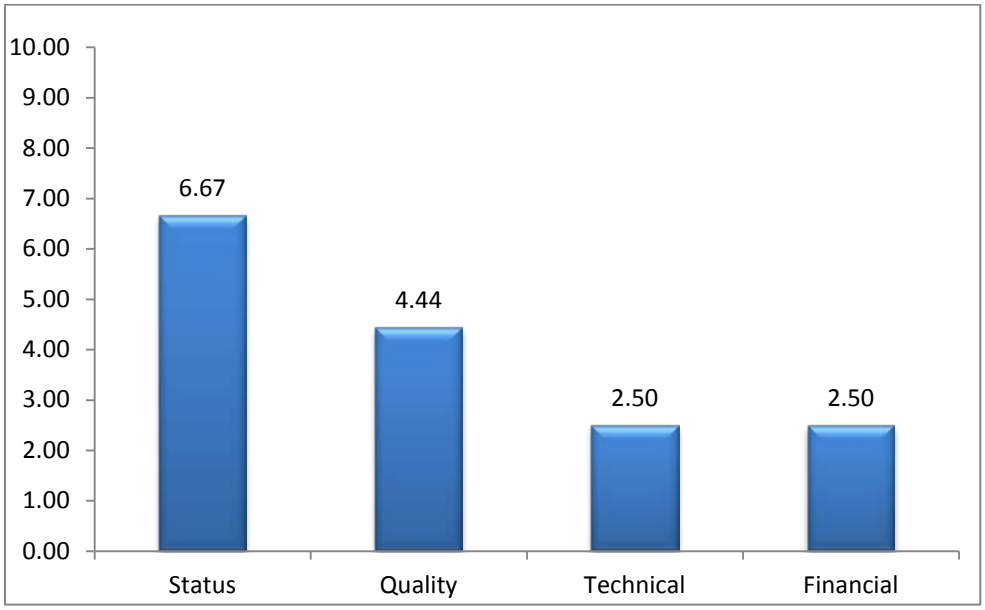
3.2.11 Capacity Area 11: Evaluation and Research

A desk review of literature showed that DRH formulated and published the first national reproductive health research guidelines in 2006. The guidelines are meant to provide direction to any researcher who is interested in addressing reproductive health gaps in Kenya. During the assessment, participants noted that DRH has no inventory or register to undertake research and evaluation. They also noted that the national forum did not involve all the key stakeholders in M&E, and deliberations from such forums did not identify clear action plans on research and evaluation. It was also noted that DRH has little financial and technical autonomy to organize the national forum. The national forum is organized with external technical assistance.

On average, DRH scored 4.03 out of 10 for all dimensions of evaluation and research, as shown in Figure 21. The highest rating was the status dimension, which scored 6.67 out of 10, followed by

quality (4.44), and then technical and financial autonomy (2.5), respectively. According to a key informant, the decisionmakers at DRH agreed that the research agenda should be part of the M&E unit. Status scored highly because DRH had an approved research agenda ratified by the TWG. DRH staff also mentioned several national forums, funded by the Government of Kenya, where they had participated and disseminated reproductive health findings. DRH could strengthen its engagement in research by developing a database for new institutions or entrants undertaking research and evaluation at national and subnational levels.

Figure 21: DRH scores in four dimensions for M&E human capacity in evaluation and research



DRH has a clear research agenda, and the M&E unit needs to focus on it; however, participants report problems with following through and completing activities:

> *"Recently we had an assessment of what the needs are and what kind of research we need to carry on. There is the M&E Research agenda that was revised in 2010 and is supposed to go until 2014 and it includes critical elements that require targeting."* Key Informant

According to a key informant, DRH has done little research, although the lead is coming from the program manager, who has an interest in research. Research is not institutionalized in the M&E unit. When DRH was considering restructuring the Division, consideration was given to combining M&E with research in one unit. Also noted by another informant was that, considering day-to-day responsibilities, implementing research has not been a priority. That said, research is important and DRH needs data available to support research.

To further strengthen research and evaluation, one key informant suggested that staff be trained in report writing because it is a challenge for the Division. Three of the key informants shared the same view that research plans and activities usually are driven and supported by partners. Respondents noted a gap in the need for information on the reasons for neonatal death and maternal mortality to supplement verbal autopsy data. DRH is challenged in the nontechnical financial and work environments to share survey and research data, such as priorities of competing tasks. A possible solution is to have a comprehensive monthly schedule of activities.. Currently activities just pop up in the middle of the month and staff must divide duties and responsibilities.

DRH is then left in a position of not being able to hold a meeting that might ensure that data are disseminated.

3.2.12 Capacity Area 12: Data Demand and Use

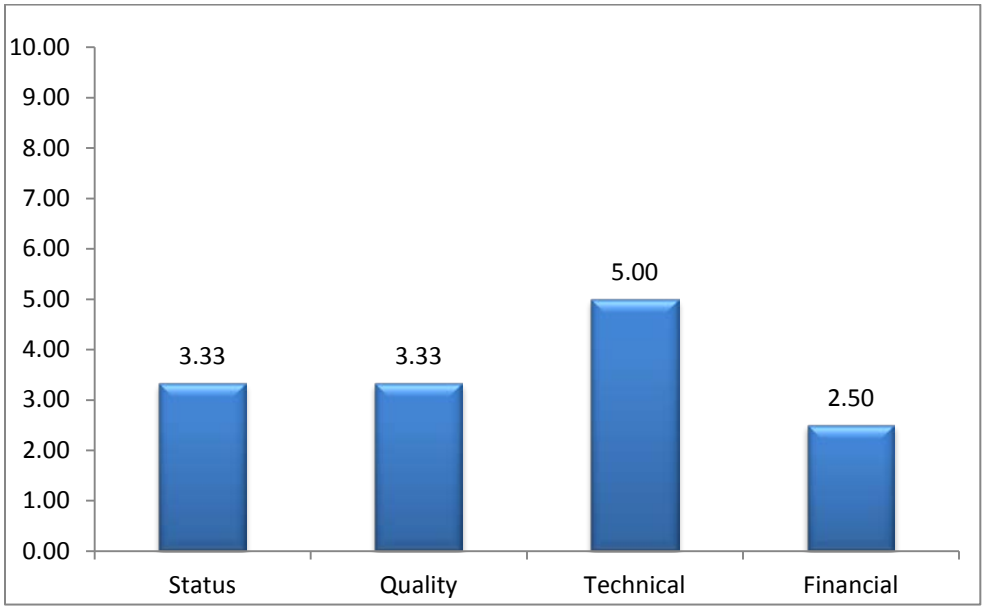
The assessment of DRH's M&E capacity for data demand and use explored the following topics: whether the program's national strategic plan and national M&E plan include a data use plan; whether DRH has an analysis of program data needs and data users; whether a data use calendar exists to guide the timetable for major data collection efforts and reporting requirements; and whether DRH has evidence of information use (e.g., data referenced in funding proposals and planning documents).

Data demand and use is a useful component of M&E, especially in fostering evidence-based programming. Results from this assessment revealed that DRH lacks a data use plan and analysis and presentation guidelines do not exist.

DRH on average scored 3.54 out of 10 for all dimensions of M&E capacity for data demand and use. Its highest rating was for technical autonomy, at 5 out of 10, followed by quality and status dimensions with equal scores of 3.33. The lowest score, 2.5, was for the financial autonomy dimension (Figure 22). Overall DRH scored low for data demand and use capacity because it does not have the required infrastructure in place, such as a strategy or plan or standard operating procedures to promote data use. The staff members, however, rated themselves highly for technical autonomy because they have received training on data demand and use (DDU) through MEASURE Evaluation and other partners over the past 3 years, they are aware of the principles of DDU, and they know why it is important to use data for decisionmaking. Currently the Division relies on technical support from partners to strengthen DDU.

For specific activities, such as dissemination of information products to data users, staff members rated themselves highly because there is a demand for information products, such as strategic plans, policies, and guidelines from MoH and stakeholders. DRH is willing to work with partners to produce these products and disseminate them. All staff concurred that information products have contributed to influence policy and practice. Respondents mentioned the lack of data analysis and presentation guidelines as the weakest area for DDU at DRH.

Figure 22: DRH scores in four dimensions for M&E human capacity in data demand and use



As explained by a key informant, DRH is the national policymaking organization for reproductive health. The Division has data that can be useful when analyzed and applied to guide DRH program officers and managers to improve performance and reorganize operations. Another key informant noted that although there is goodwill to use information, time to put the information to use is a constrained, and it is difficult to receive periodic reports aside from those available in DHIS. Another key informant stated that DRH program managers barely use DHIS to relate their programs, but during the annual workplan process, officers are keener to use the information.

Another key informant emphasized the importance of staff roles and responsibilities for data use. The manager said, *"The leader can only lead; he cannot do the M&E work of an expert. Even if you build the program manager's capacity to look at the data, I think that is not their major role, they need to be supported to do policy issues."*

One key informant gave an example of the need for disaggregated data by age to understand adolescent health issues and pregnancy cohorts. The informant explained that often this lack of detail is because healthcare workers at the data collection point do not know how data can be used. The informant also mentioned that the sensitively of data can be a barrier to use. For example, investigation into the cause of maternal deaths sometimes uncovers deaths that could have been prevented, which results in negative consequences for healthcare workers. The informant explained, *"Health information can be very sensitive because people do not want to be known that they have some issues especially reproductive health."*

A key informant said an area of weakness is the lack of planning in DRH. For example, DRH has no plan that clearly outlines which data need to be analyzed or when and how the information should be used to guide program activities. Another key informant suggested that the M&E unit needs a clear system for how often data are analyzed, which aspects should be analyzed, and direct how the information is used to guide the program. The informant said, *"They need a structure to tell them how this can be done."*

Informants suggested that to help program staff better use and interpret data, the M&E unit could prepare quarterly briefs on key indicators for every program. The M&E unit works on the annual

planning process, but reports of results from the previous year focus on activities rather than indicators, which are a better basis for decisionmaking. One key informant suggested that officers are in a position to analyze, create briefs, and be the backbone of the institution, *"M&E should be the guiding institution in DRH, but unfortunately it is not up to standards right now. M&E should be there during planning, implementation, and at the end to show if they are clear with their objectives, what the gaps are, and how they can plan for the next."*

CHAPTER 4: DISCUSSION

The goal of this assessment was to understand and document DRH's current organizational and individual capacity to successfully achieve its performance objectives in program-level monitoring and evaluation. The assessment had these specific objectives:

- Understand, document, and clarify performance objectives for Division-level M&E
- Determine the current performance in key M&E functional areas for the Division
- Identify gaps in DRH's national program capacity to meet performance expectations

Results revealed a dire need for capacity building, especially in the dimensions of financial and technical autonomy capacity to implement M&E functions. Key results highlighted leadership issues in M&E, including lack of strategic documents, such as an M &E plan. Although the M&E unit exists, staff members in the unit are not fully involved across various DRH programs, although the unit's role is cross-cutting. The M&E plan has not been updated for more than three years, which implies that it may not fully address the country's reproductive health needs, especially in Kenya's devolved structures.

High attrition at DRH, coupled with a perceived lack of commitment and leadership, has affected DRH in its ability to carry out the full execution of its mandate, including its M&E functions. An overall organizational capacity index of 38.2% indicates that major capacity gaps in most M&E components still exist in the Division. A clear costed action plan is necessary to identify in detail the M&E gaps and how to address them to strengthen capacity.

The group assessment highlighted that the strongest capacity areas for DRH were routine monitoring; partnerships and governance; and advocacy, communication, and cultural behavior. The weakest areas in DRH are supervision and auditing processes, human capacity for M&E, implementation of surveys and surveillance, and development of national and subnational databases.

CHAPTER 5: CONCLUSION

While DRH had some moderate capacity in a few components of M&E, most areas require urgent strengthening to enable the Division to realize its mandate. DRH has some human capacity for M&E; however, staff roles and responsibilities in various DRH programs are unclear. The following observations and recommendations are derived from results of the DRH baseline assessment of M&E capacity.

Capacity Area 1

- Provide stronger leadership and support for the M&E unit to enable staff to execute their cross-cutting role. The assessment revealed that leadership perceives a lack of commitment on the part of DRH staff; staff perceives a lack of leadership to support the work they do. A need exists for a team-building workshop and an orientation on leadership and management to strengthen M&E. A further need is for performance management for mutual accountability.
- Develop policies that streamline M&E into the DRH program.

Capacity Area 2

- Provide basic M&E courses for all heads of various units to increase M&E champions and help the M&E unit fully execute its mandate.
- Provide focused training in basic data analysis. Skills in data analysis and presentation are critical for M&E personnel; however, the assessment found that M&E staff members have limited skills, especially in the use of professional statistical packages, such as SPSS and Stata. Also, provide mentoring and supportive supervision to equip staff with basic data analysis skills.
- Strengthen M&E reporting throughout the DRH program.
- Encourage staff to develop diverse skills in data management, reporting, and development of guidelines and provide training so they can support other DRH programs.

Capacity Area 3

- Focus on providing leadership to improve coordination among DRH partners for reproductive health activities so that the M&E unit can provide the required support. Existing staff lack a clear coordination mechanism for partner activities.
- Build internal capacity in DRH by taking the lead in partner activities, such as TWG meetings and reporting on reproductive health indicators.
- Reduce DRH's high dependency on partners for technical and financial support. Additional efforts are needed to strengthen DRH M&E staff capacity for technical roles.

Capacity Area 4

- Update the DRH M&E workplan and review it periodically to assess progress.
- Sensitize staff to the importance of getting the M&E workplan into operation.

Capacity Area 5

- Realign major guidelines, such as the strategic plan and the M&E plan, to incorporate changes in governance structures following enactment of the new constitution in Kenya in 2010. These realigned guidelines are needed to support DRH activities at the subnational level.

Capacity Area 6

- Put DRH's communication strategy into operation so that advocacy for reproductive health becomes a core Division activity.
- Develop more effective communication products to work more effectively with stakeholders, such as bulletins, policy briefs, fact sheets, and annual reports.

Capacity Area 7

- Seek assistance from stakeholders, such as commitments of technical and financial support, to strengthen routine monitoring and finalize the DRH annual workplan.
- Develop dashboards on key indicators of interest at tier one, especially the 11 maternal, newborn, and child health indicators, to help management make fast, reliable decisions.

Capacity Area 8

- Establish surveys and surveillance guidelines and protocols to provide technical support for reproductive health programs and stakeholders who work in reproductive health.

Capacity Area 9

- Initiate an internal database that tracks partner activities and core reproductive health indicators for performance to evaluate trends and monitor the progress toward accomplishment of MDGs.

Capacity Area 10

- Develop a planning tool to assist with supervision and auditing.
- Streamline regular supervision in the DRH workplan and monitor progress; provide feedback and indicate action.

Capacity Area 11

- Use ongoing research to strengthen national reproductive health programs. Strengthen advocacy for research among partners and implement a routine forum where research findings are discussed and shared with implementing partners. Use research findings to inform national policies.

Capacity Area 12

- Promote data use by addressing issues of data flow, data storage, data processing, and data demand for decisionmaking.

- Develop a data use plan to map out gaps in data use and strengthen existing reproductive health data.
- Strengthen data usability for decisionmaking so that programs support the use of evidence for planning and allocating resources.
- Implement activities that are guided by evidence.

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APPENDIX: DRH ACTION PLAN FOR THE 12 M&E COMPONENTS

Capacity Area	Identified Weaknesses and Gaps	Action to be Taken
1.0 Organization	• No staff meetings • No clear workplans for staff • No clear integration of M&E in DRH programs • No clear feedback mechanisms from program to the M&E team	• Align all M&E activities with DRH vision and mission Orientation of DRH staff on the divisions vision and mission and alignment of the activities with the mission, vision and core values • Establish M&E posts in the division • Identify M&E needs • Finalize DRH staff draft job descriptions, including M&E • Conduct regular internal meetings for M&E staff
2: Human capacity for monitoring and evaluation	• Inadequate skills in M & E	• Provide training on M&E fundamentals • Support M&E staff to complete master's degrees in M&E • Provide statistical package training and training on data demand and use, quality assessment for staff • Develop costed human capacity plan, and plan for data demand and use
3: Partnerships and governance	• Presence of multiple stakeholders • Staff seconded to DRH by partners have a high turnover	• Develop a comprehensive stakeholder engagement plan • Review the 2009–2015 strategic plan after devolution takes shape • Conduct a stakeholder mapping and establish an inventory of stakeholders and partners; updated quarterly • Conduct annual M&E stakeholders meetings • Require attendance at M&E TWG by Head of DRH and program managers • Review current reporting template to make it more comprehensive • Coordinate stakeholder activities

Capacity Area	Identified Weaknesses and Gaps	Action to be Taken
4: National M&E Plan	• Project and Division workplan is available only in draft form • Budget monitoring process does not include request date, responses, date and % of requested funding received • No guidelines on receipt of reports • Information and data are not received according to stipulated guidelines because guidelines not finalized • M&E program not involved in the development of the plan • No updated DRH M&E plan • M&E program not involved in the development of the plan • No updated M&E plan for the division • Current M&E system has not been assessed	• Finalize consolidation of the draft workplan in progress • Develop a mechanism for using the resource envelop by both partners and Government of Kenya • Finalize guidelines for reports as quickly as possible • Involve M&E unit in multisectoral plan development • Develop M&E plan for the division • Assess M&E system; conduct the analysis and midterm reviews
5: Annual Costed M&E Workplan	• M&E workplan has not been endorsed by relevant stakeholders • Lack of committed resources to implement M&E workplan	• Hold stakeholders' meetings to endorse the M&E workplan • Advocate for resources from Government of Kenya to implement M&E workplan
6: Advocacy, Communication and Cultural Behavior	• M&E program has no champions	• Encourage all leaders and staff to be champions for M&E
7: Routine monitoring	• Inadequate routine monitoring	• Review and revise existing M&E tools: scoring scale, print, orient staff on the tools • Train staff on M&E capacity-building skills and supportive supervision; lobby, advocate, or solicit for financial allocation from Government of Kenya for routine supervision
8: Surveys and surveillance	• Technical knowledge and skills	• Provide training on surveys and the importance of surveillance and establish survey and surveillance inventory, include protocols
9: National and subnational databases	• Weak linkage	• Strengthen linkages in database through use of M&E technology • Review data and reporting collection tools and explore possibilities of going digital
10: Supervision and Auditing	• Planning, scheduling tool missing; developed only when need arises; need scoring mechanism, feedback, and action plan • Facilities with family planning standards have scoring mechanisms but integrated supervision uses only a checklist with comment section • Supervision guideline long, repetitious	• Revise supervision tool to include missing elements and develop standards for all programs to accommodate scoring • Review supervision guidelines to make user friendly

Capacity Area	Identified Weaknesses and Gaps	Action to be Taken
11: Evaluation and Research	• No inventory, register, or database to undertake research and evaluation • National forum does not involve all key stakeholders in M&E • Deliberations from national forum does not identify clear action plans for the Division (policy and practice) • National forum organized with external technical assistance	• Develop an inventory, register, or database relevant for undertaking research • Develop a comprehensive list of key national stakeholders to participate in M&E • Develop a guideline to ensure national forums draw up action plans for the Division • Develop capacity of DRH staff to organize national forums
12: Data Demand and Use	• National data use plan does not exist • No analysis and presentation guidelines	• Develop comprehensive National Data Use Plan • Develop a Data Analysis and Presentation Guidelines