Reproductive and Maternal Health Services Unit Monitoring and Evaluation Capacity

End Line Assessment Report

August 2017

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MEASURE Evaluation PIMA

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ICF editorial staff and the MEASURE Evaluation Knowledge Management team at the University of North Carolina and Chapel Hill provided editorial and design input for the report.

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ABBREVIATIONS

AWP	annual work plan
DFID	UK Department for International Development
DQA	data quality audit
EmONC	emergency obstetrical and neonatal care
HMIS	health management information system
ICD	International Classification of Diseases
ISO	International Standards Organization
M&E	monitoring and evaluation
MECAT	Monitoring and Evaluation Capacity Assessment Toolkit
MEval-PIMA	MEASURE Evaluation PIMA
MOH	Ministry of Health
MPDSR	maternal and perinatal death surveillance and response
MSC	Most Significant Change
MTEF	medium-term expenditure framework
NCPD	National Council for Population and Development
RMHSU	Reproductive and Maternal Health Services Unit
RMNCAH	reproductive, maternal, newborn, child, and adolescent health
TWG	technical working group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development

1. INTRODUCTION

The MEASURE Evaluation PIMA (MEval-PIMA) project has been implemented in Kenya over the last five years, and key achievements have been made across the various results areas. These have been documented through the periodic project reporting mechanisms, including the quarterly and annual reports and a midterm review. Achievements have also been shared and disseminated using a variety of methods, such as technical documents, quarterly newsletters, thematic updates, fact sheets, and the MEval-PIMA Community of Practice.

As part of the project closeout, MEval-PIMA conducted an end-of-project assessment to document achievements and impact and provide lessons learned toward strengthening the monitoring and evaluation (M&E) capacity of the Ministry of Health (MOH) at the national and subnational levels, to provide data demand and use information for decision making, and to communicate and share the project legacy and closure with stakeholders and beneficiaries. As part of this assessment, the systematic documentation of the project legacy had two areas of focus: (1) capturing the experiences of the beneficiaries of key project support toward M&E capacity building, and (2) sharing end-of-project communications, culminating in a project closeout event in Nairobi.

2. OBJECTIVES

The main purpose of the end line assessment is to evaluate the changes in M&E capacity against the baseline to measure progress toward achievement of the project's Intermediate Result, "Improved Capacity of the MOH to identify and respond to M&E information needs." Specifically, the end line aimed to:

- Determine the change in M&E capacity in the programs by using the quantitative Monitoring and Evaluation Capacity Assessment Toolkit (MECAT) group assessment.
- Document the key drivers to the changes in M&E capacity using participatory approaches.
- Document MEval-PIMA's contribution to the changes in M&E capacity.
- Document lessons learned in terms of strengthening M&E capacity at individual and program levels.

3. BACKGROUND

3.1 About MEval-PIMA

The MEASURE Evaluation Phase III Kenya Associate Award, the MEval-PIMA project, was funded through the United States Agency for International Development (USAID)/Kenya to build sustainable M&E capacity among Kenyan health officials at the national and subnational levels.

A sustainable and strengthened M&E system was expected to yield high-quality data for use in evidence-based decision making, improving the effectiveness of Kenya's health system and the lives of the Kenyan people. To achieve this, MEval-PIMA focused on priority M&E programs at the national and county levels and selected sub-systems that were expected to contribute high-quality data to the national health system. At the national level, MEval-PIMA worked to strengthen the M&E systems of five target programs:

- National Malaria Control Programme (formerly the Malaria Control Unit)
- Reproductive and Maternal Health Services Unit (RMHSU)
- Community Health Services Unit
- Disease Surveillance and Response Unit (formerly the Division of Disease Surveillance and Response)
- Civil Registration Services (formerly the Civil Registration Department)

The targeted systems included:

- Health referral system and services
- Civil registration and vital statistics system
- Community health information system
- Child protection and orphans and vulnerable children information systems

This report focuses on the assessment of the RMHSU.

3.2 Reproductive and Maternal Health Services Unit

The reproductive, maternal, and newborn health program in Kenya is coordinated at the national level by the RMHSU in the Division of Family Health. The role of the RMHSU is to coordinate the development of strategies, provide technical support for the implementation of activities aimed at achieving the national reproductive health goals, and monitor and evaluate progress and achievements. During the project period, the RMHSU continued implementation of the extended National Reproductive Health Strategy 2009–2015, whose key objectives were aimed at improving service delivery specific to reproductive health actions (Ministry of Public Health and Sanitation & Ministry of Medical Services, 2009). As with other MOH health programs, M&E is central to the implementation of reproductive and maternal health interventions. The RMHSU M&E unit was formed in 2005 and received previous support from MEASURE Evaluation from 2007 to 2010 and from the USAID Capacity project from 2011 to 2014 build human resource capacity for M&E. Capacity strengthening for M&E is essential to enable RMHSU to perform its M&E functions as part of sector-wide efforts to improve MOH M&E systems in Kenya.

3.3 Support Provided to the RMHSU

MEval-PIMA provided both technical and financial support to the RMHSU. The support was classified along five domains of capacity strengthening, described as follows:

Domain 1: Strengthening structures and mechanisms for M&E coordination

- Baseline M&E capacity assessment (MOH, 2013)
- Technical and financial assistance for review of guidelines for family planning and maternal and perinatal death surveillance and response (MPDSR)
- Technical and financial support for convening technical working groups (TWGs)
- Technical assistance for the joint development of comprehensive annual work plans (AWPs) and annual reporting
- Technical assistance to provide reproductive health and family planning M&E support to counties

Domain 2: Ensuring availability of quality data

- Technical and financial assistance for the review of guidelines and tools for family planning and emergency obstetrical and neonatal care (EmONC) and MPDSR
- Financial support to convene quarterly data review meetings with county health management teams and stakeholders, using data from the national DHIS 2 and other sources
- Training program for M&E, logistics, and records officers on data management for family planning and reproductive and maternal health services and commodities

Domain 3: Promoting data use practices

- Financial support for the printing and dissemination of reproductive, maternal, newborn, child, and adolescent health (RMNCAH) scorecards; maternal and newborn health and EmONC county profiles; family planning fact sheets; and MPDSR advocacy posters
- Financial support for data dissemination and review meetings

Domain 4: Building M&E leadership competencies

- Training and mentorship for M&E officers
- Technical assistance for the development of annual RMHSU work plans and annual program reports
- Technical assistance for planning and implementation of program surveys and evaluations, such as emergency obstetrical and neonatal care preparedness

Domain 5: Building capacity of MOH staff

- Technical and financial assistance for training of health workers on guidelines, tools, indicator measurement, and essential M&E practices

4. METHOD

The end line assessment was conducted in a workshop setting using three participatory methods and an individual capacity assessment. Respondents for this exercise were program managers and program officers, including RMHSU M&E officers and data managers.

The first participatory method used as was the MECAT group assessment. This tool guided participants through an assessment of the RMHSU's M&E capacity in 12 capacity areas. The Most Significant Change (MSC) approach[1] was used to identify and prioritize the MSCs within five domains (see Section 4.1) since the baseline assessment was conducted. After an MSC was identified, participants also identified the reasons it was considered a change, the main drivers of the change, MEval-PIMA's contribution to the change (if any), and threats to the sustainability of the change. Outcome mapping methodology was used to map desired outcomes as a condition to sustain the gains made in strengthening M&E capacity. Using the threats to sustainability identified with the MSCs, facilitators guided participants through individual, group, and plenary

[1] MSC is a participatory monitoring system that enables the identification of desired outcomes without using defined indicators. The MSC approach involves analyzing actual events to draw meaning out of them as a means of evaluating the impact of a project and to improve future planning and implementation.

sessions to identify expected changes in behavior, suggested partnerships to develop, and example activities to be undertaken to sustain the progress in M&E strengthening. In addition, the individual competency-based assessment was administered to individual participants for them to self-assess themselves and their M&E competencies.

4.1 Five MSC Domains

The evaluation used five broad domains in which MEval-PIMA intended to make an impact on based on the project's mandate and findings from the baseline assessment. During the end line assessment, participants were asked to identify the changes they believed were most significant within each of the following domains:

- **Domain 1: Strengthening structure and mechanisms for M&E coordination.** Capacity building in this domain focused on strengthening structures and mechanisms for M&E coordination involved in building and supporting M&E process, policies, guidelines, and coordination of stakeholders and resources. This domain maps to many of the elements in the organizational, partnerships and governance, county M&E plan, and annual costed M&E work plan capacity areas of the MECAT group assessment.
- **Domain 2: Availability of quality data.** Capacity building in this domain focused on improving, developing, and printing data collection and reporting tools; training on proper coding for ICD-10; strengthening surveillance systems; and supporting the research agenda. This domain maps to many of the elements in the routine monitoring, surveys and surveillance, and supervision and auditing capacity areas of the MECAT group assessment.
- **Domain 3: Promoting data use practices.** The capacity-building domain of promoting data use focused on interventions to improve data use plans, promote and use data analysis tools, convene data review meetings and other data-sharing forums, and develop information products. This domain maps to some of the elements in the data demand and use and the advocacy, communication, and cultural behavior capacity areas.
- **Domain 4: M&E leadership.** The capacity-building domain of development of M&E leadership competencies focused on ownership, involvement, partnerships, and coordination for M&E as well as advocacy for the resources needed to support programs using M&E data. This domain maps to some of the elements in the advocacy, communication, and cultural behavior and the evaluation and research capacity areas.
- **Domain 5: Building capacity of staff in M&E.** The capacity-building domain for building capacity of MOH staff in M&E focused on developing training curricula, conducting trainings, mentoring RMHSU and county staff, and evaluating programs. This capacity area maps to the human capacity for M&E capacity area.

4.2 Data Analysis

Scores obtained from the MECAT group assessment at end line were analyzed to compute an organizational capacity index score, and changes between baseline and end line were used to document achievements toward strengthening the M&E capacity of the RMHSU. The organizational capacity index was calculated by first summing the possible scores of the 12 M&E components for the status and quality dimensions. The financial and technical autonomy dimensions were excluded because the effect of these measures was not

unidirectional, and the presence or absence of these dimensions could affect the performance of RMHSU either positively or negatively. Technical and financial autonomy require long-term investment and depend on the status and quality dimensions. The organizational capacity index was then computed by dividing the actual score on the 12 M&E functions under the two dimensions of status and quality by the total maximum possible score. Individual assessment data were analyzed to understand changes in human capacity for M&E. The MSC data were analyzed to understand what the program found to be the MSCs resulting from the changes in the M&E system since baseline. The outcome mapping data were used to understand what the threats to the changes made to the M&E system are and to propose recommendations to mitigate these threats.

5. RESULTS

5.1 Findings from the MECAT Group Assessment

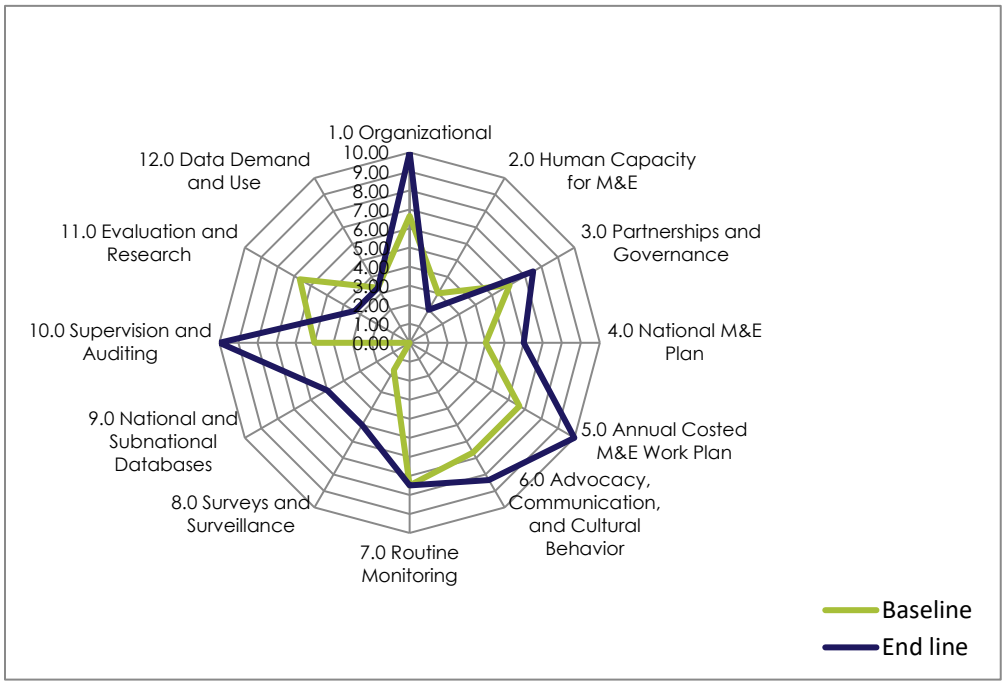
5.1.1 Overall Performance

The RMHSU's organizational capacity index increased, from 38.2 percent at baseline to 65.1 percent at end line, indicating overall improvement in status and quality across the 12 capacity areas of its M&E program. Figures 1a–1d show specific changes in the capacity areas in the 2017 end line evaluation (red), compared to the 2013 baseline assessment (blue), and by the various dimensions of interest—status, quality, and two measures of sustainability (technical and financial autonomy).

5.1.1.1 Status

Figure 1a shows that at baseline, the status of a number of capacity areas was at or above an average score of 5, except for the capacity areas of national and subnational databases, surveys and surveillance, and data demand and use, which were below an average score of 5. At end line, improvements were noted in several capacity areas. The status of the data demand and use and routine monitoring capacity areas remained unchanged, and the performance of the evaluation and research and human capacity for M&E decreased. The low performance in status of human capacity for M&E was attributed to inadequate personnel for M&E activities.

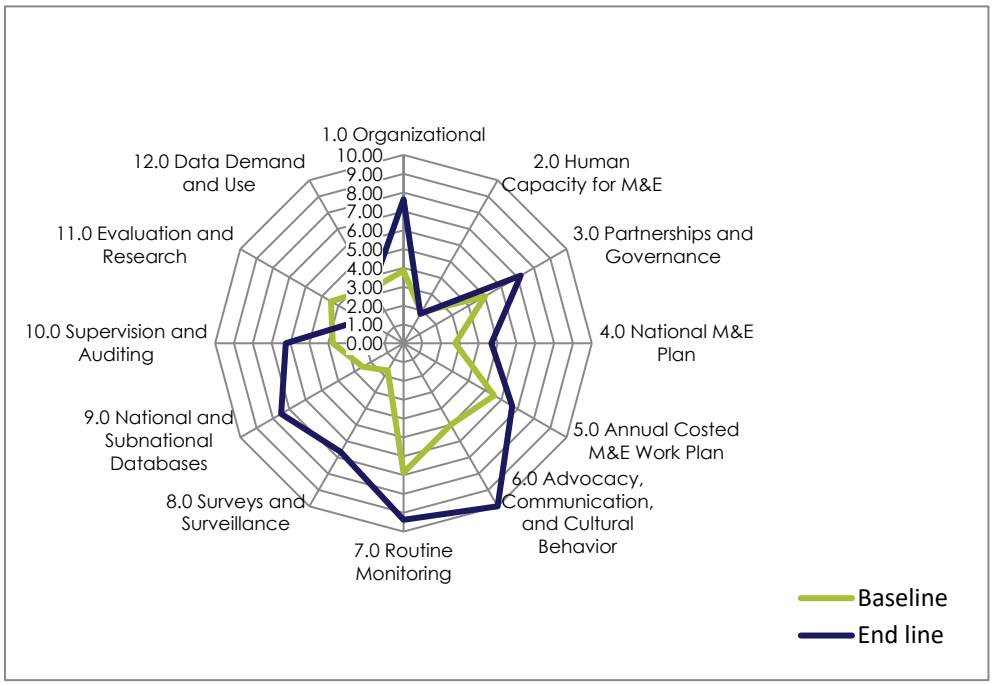
Figure 1a. Status of capacity areas at RMHSU



5.1.1.2 Quality

Figure 1b shows that at end line, the quality dimension improved in most capacity areas, except for human capacity for M&E, data demand and use, and evaluation and research, compared with baseline. These three critical capacity areas had below average performance at both baseline and end line. For human resource capacity for M&E, this meant that the staff responsible for M&E did not feel sufficiently skilled to implement all required M&E tasks for the RMHSU. The most improved capacity areas were advocacy, communication, and cultural behavior; surveys and surveillance; routine monitoring; and national and subnational databases.

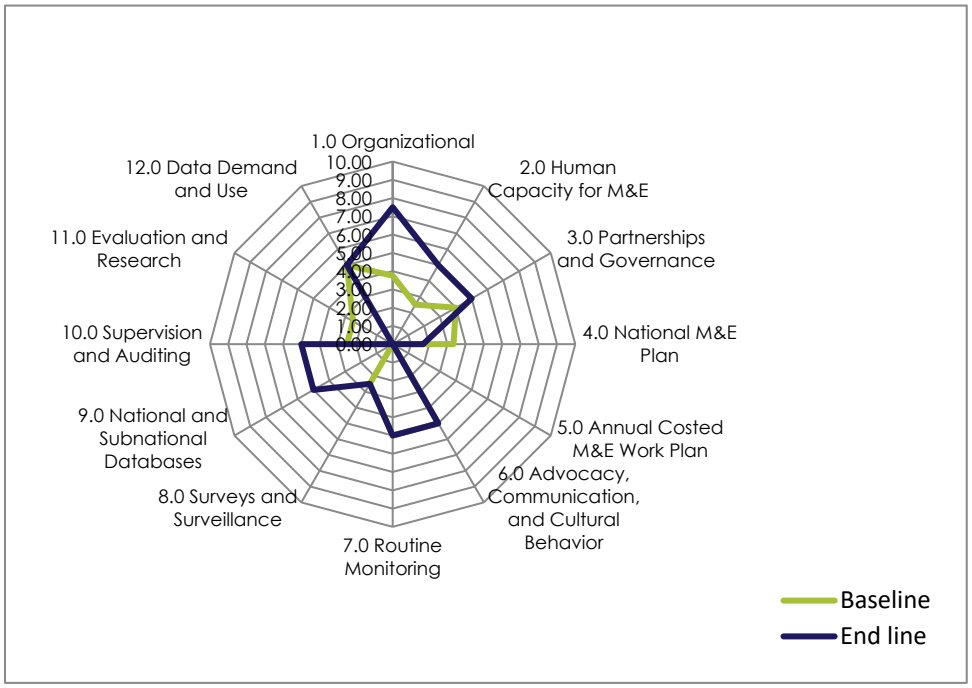
Figure 1b. Quality of capacity areas at RMHSU



5.1.1.3 Technical Autonomy

As shown in Figure 1c, under technical autonomy, improvements were made in organizational and human capacity for M&E, partnerships and governance, and routine monitoring. Performance in all other capacity areas remained unchanged or decreased.

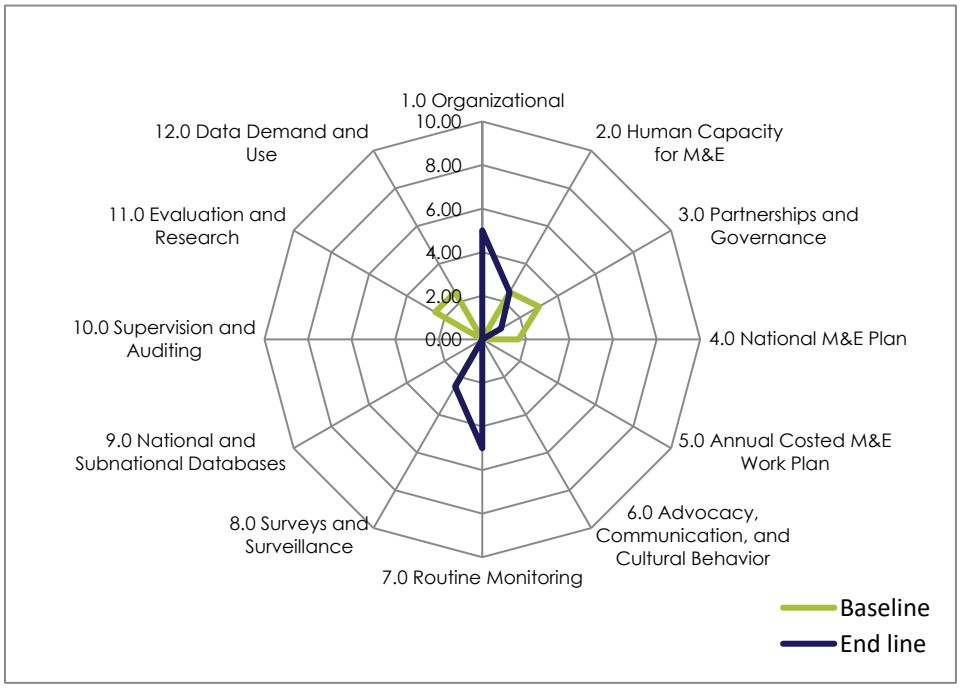
Figure 1c. Technical autonomy at RMHSU



5.1.1.4 Financial Autonomy

The RMHSU did not demonstrate financial autonomy in any capacity areas at baseline. At end line, there was some improvement in financial autonomy for organizational capacity, routine monitoring, and surveys and surveillance, although RMHSU was still primarily dependent on external resources for implementing activities in the 12 capacity areas (see Figure 1d). The decrease in the financial score for some of the capacity areas was attributed different parameters used to assess the financial aspect at baseline and end line; staff time was considered a financial investment during the baseline assessment but not at end line.

Figure 1d. Financial autonomy at RMHSU

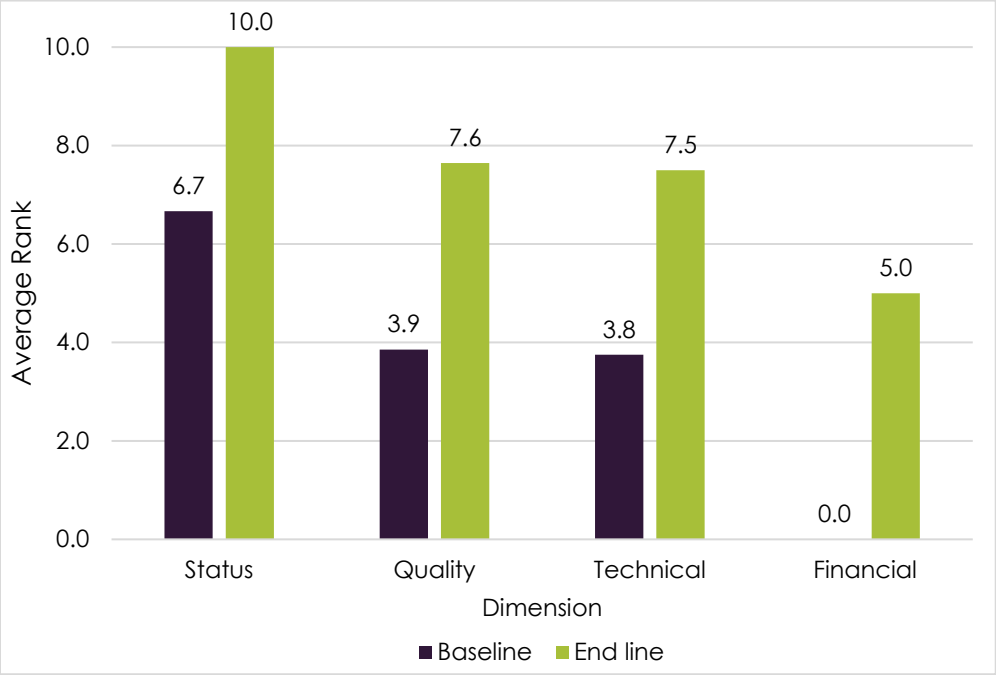


5.1.2 Performance by Capacity Area

5.1.2.1 Organizational Capacity

At end line, all aspects of organizational capacity for the RMHSU showed an overall improvement, compared with baseline (see Figure 2). The staff were mostly aware of RMHSU's vision, mission, and stated objectives, and they apply the stated values and ethics in their daily work. The RMHSU has a written mandate to implement its M&E functions found in the 1997–2007 M&E plan as well as the 2009-2015 strategy document. Although the RMHSU did not have adequate personnel for M&E activities, staff reported that the unit did not rely on external technical support for routine M&E tasks. TWG meetings are held regularly to plan, coordinate implementation of activities, and monitor progress. Routine mechanisms for M&E planning and management are in place, including development of AWPs, quarterly reviews of progress, and quarterly reporting on key performance indicators for the MOH. Incentives for M&E system performance are not provided, although verbal appreciation is sometimes given to staff. M&E unit meetings do not require technical or financial assistance from external stakeholders.

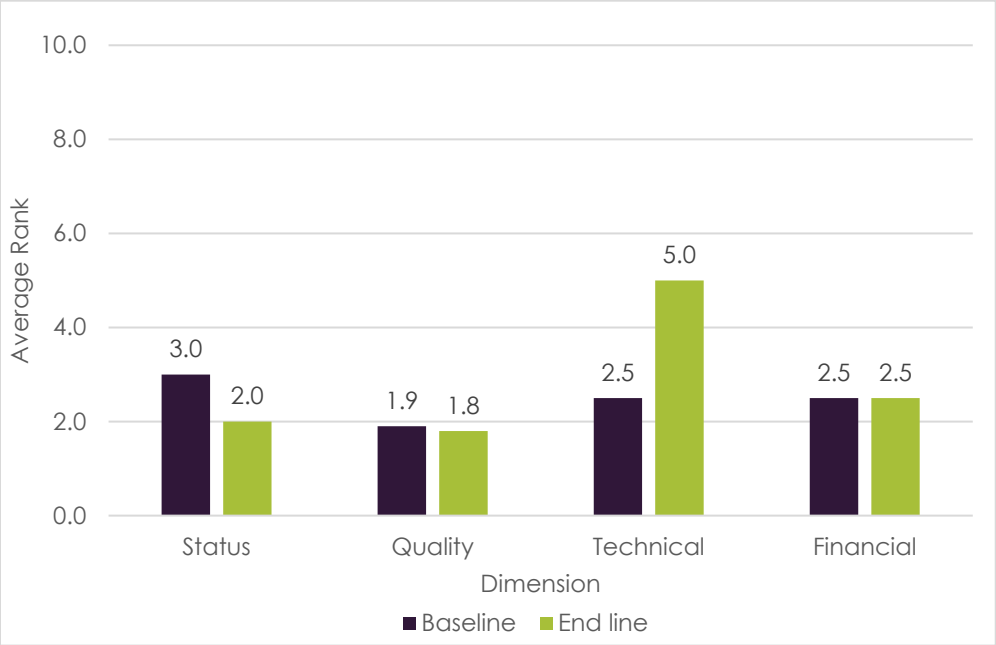
Figure 2. Organizational capacity



5.1.2.2 Human Capacity for M&E

Human capacity for M&E remained below average throughout the project implementation period, although it showed a slight improvement in technical capacity (see Figure 3). Despite previous capacity-building efforts, due to staff reassignments not all the staff in the M&E unit have an M&E background or have received training in M&E. The M&E officers are, however, able to undertake data analyses and produce various data products, including annual reports, policy briefs, and summary reports.

Figure 3. Human capacity for M&E

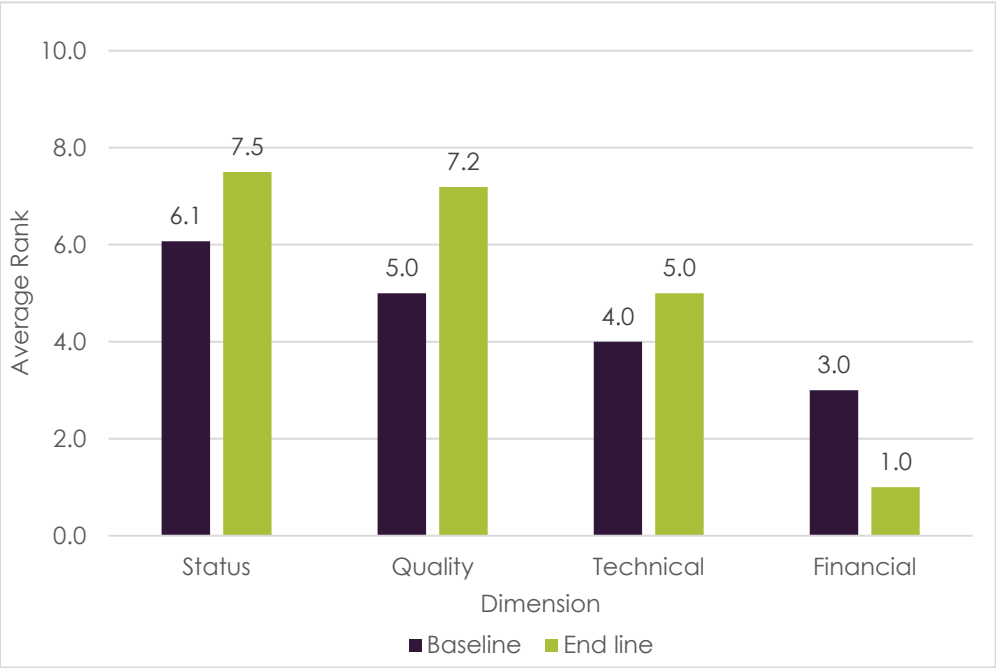


The RMHSU has undergone a capacity needs assessment, and the team is aware of the gaps. Appropriate trainings have been planned, with external financial resources from partners. The program lacks a human resources capacity development plan, however. The poor performance in this area is largely due to the lack of capacity identification and the lack of a capacity development plan for the RMHSU.

5.1.2.3 Partnerships and Governance

The RMHSU was in the process of updating the National Reproductive Strategy 2009–2015 and planned to develop an appropriate accompanying M&E plan. Standard operating procedures that define roles and responsibilities related to M&E functions and activities were developed with external technical and financial support. A multi-stakeholder M&E TWG meets quarterly to discuss RMHSU M&E activities, although operational research partners have not been actively engaged. Terms of reference for the TWG have been adapted from the MOH and define roles of members, including approving documents, providing technical leadership, and coordinating the M&E system. The TWG meetings are convened without external technical support, but they require external financial support when held out of the office. This capacity area had a slight improvement in status, quality, and technical performance at end line, compared to baseline (see Figure 4).

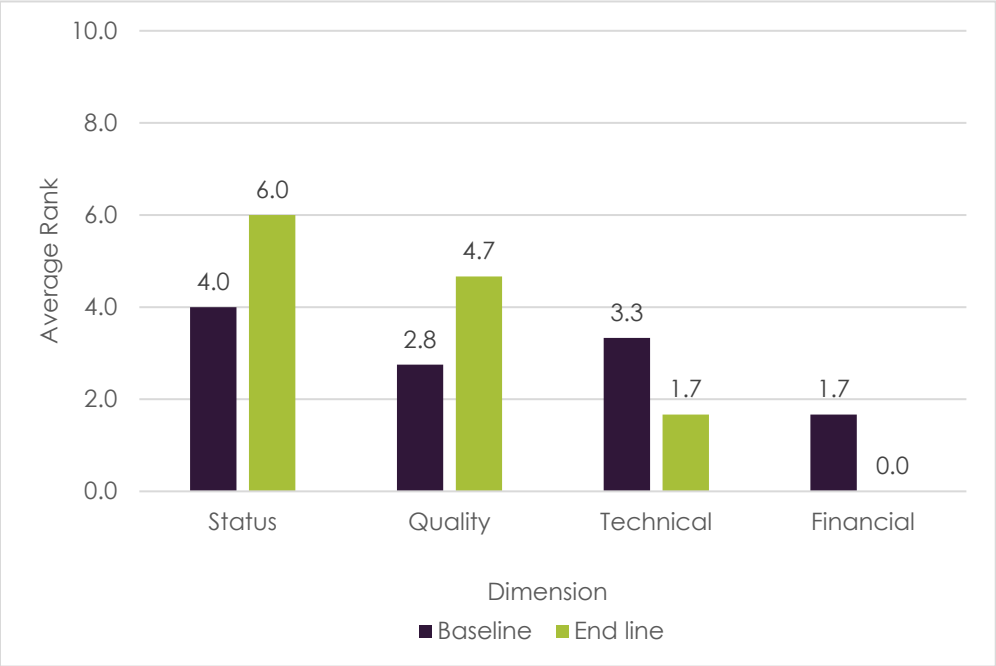
Figure 4. Partnerships and governance



5.1.2.4 National M&E Plan

RMHSU did not have an M&E plan during the project period. Although AWPs for M&E were developed and used, they did not include the typical M&E framework with results and activities. Intervention program areas prepared their own logical frameworks and submitted them to the M&E unit for consolidation. A budget monitoring process that includes request date, responses, date approved, and percentage of requested funding received has not been implemented. The RMHSU does have a costed procurement plan that is developed from the AWP and includes request date, responses, date approved, and percentage of funding received for procurement. The procurement plan is created based on the budget allocated through government resources for the RMHSU. The current project AWP was developed with external technical assistance from MEval-PIMA and the United Nations Children's Fund (UNICEF). Status and quality of the M&E plan showed some improvement at end line, compared to baseline (see Figure 5). The technical and financial autonomy scores decreased at end line.

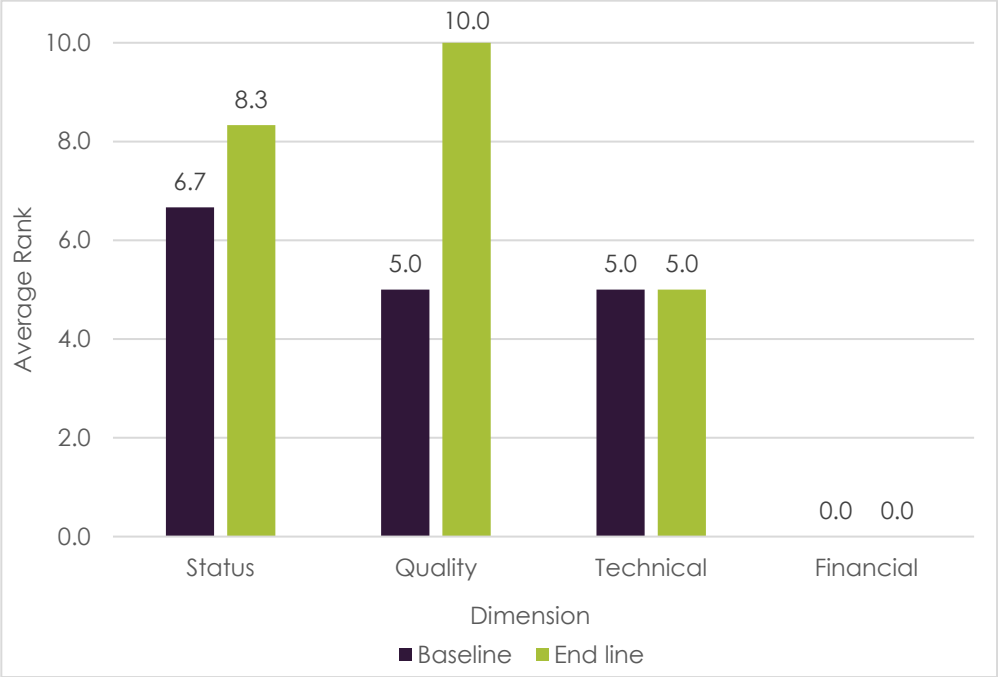
Figure 5. National M&E plan



5.1.2.5 Annual Costed M&E Work plan

The annual M&E work plan available at end line was costed. The activities were clearly outlined with responsible officer and timeframe for implementation. The costed work plan was linked to the medium-term expenditure framework (MTEF) and budgeting timelines from July to June, although there were delays in finalizing the plan with stakeholders. The M&E work plan was developed with significant external technical and financial support. Specific resources (human, financial, and physical) have been committed to implement the M&E work plan, but they are inadequate. Other than improvement in the status of the work plans (costing, linkage to MTEF, commitment of resources), there was little change in the performance of the other capacity areas, and the RMHSU still relied significantly on external technical and financial assistance (see Figure 6).

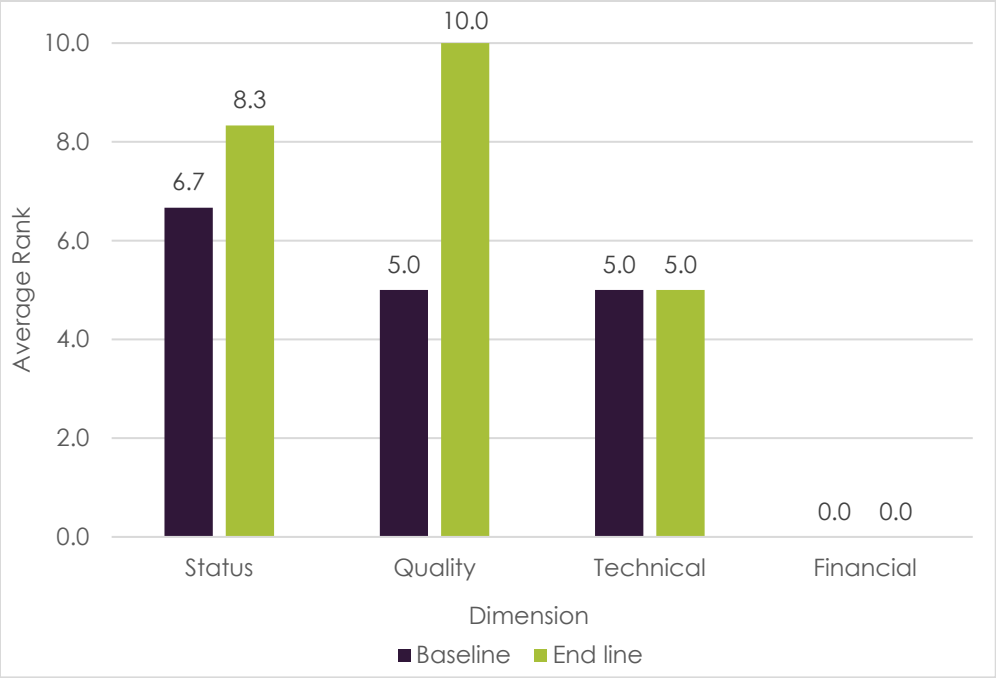
Figure 6. Annual costed M&E work plan



5.1.2.6 Advocacy, Communication, and Cultural Behavior

RMHSU has an advocacy and communications and social mobilization program. Since baseline, it has developed and launched a communications strategy, with external technical and financial assistance from partners. In addition to the strategy, the RMHSU management strongly advocates for support for M&E activities, particularly regarding the mobilization and allocation of resources to ensure that key activities are implemented. Although the program retains some technical capacity to advocate for and mobilize resources for M&E activities, it is reliant on external technical and financial support for development, production, and dissemination. This is reflected in the results showing a significant change in status and quality and no change in technical and financial autonomy (see Figure 7).

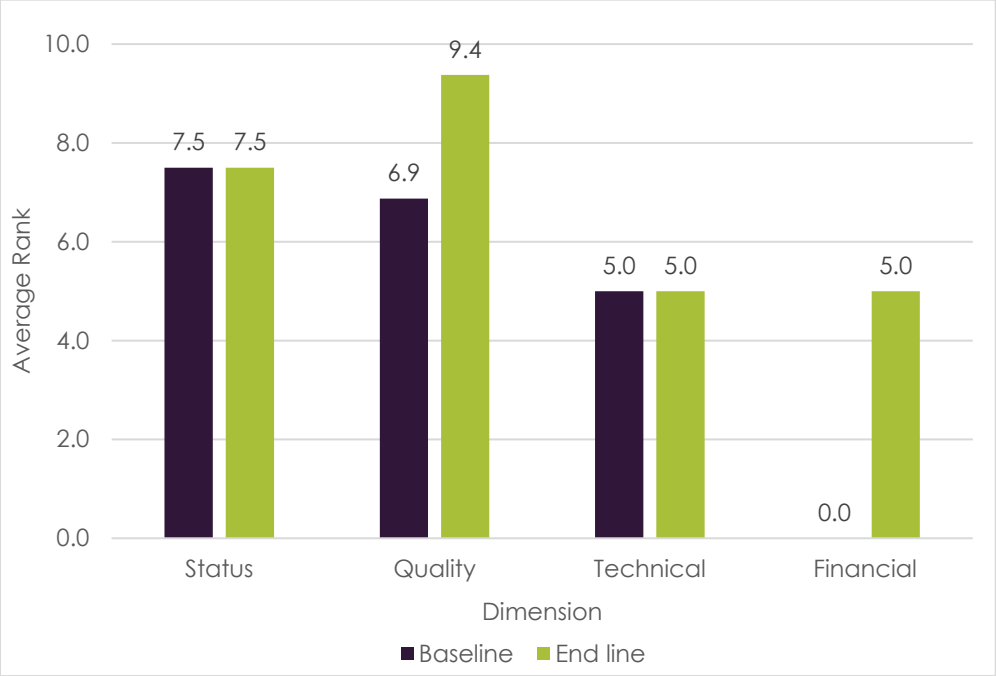
Figure 7. Advocacy, communication, and cultural behavior



5.1.2.7 Routine Monitoring

The quality of routine monitoring actions improved from baseline to end line, status and quality remained unchanged at end line, and financial autonomy increased, compared with baseline (see Figure 8). The improvement in quality was due to the identification of gaps in existing tools and the revision of the tools to ensure standardization and the collection of data required for indicator monitoring. National guidelines that document the procedures for recording, collecting, collating, and reporting program monitoring data from the health information system are available. There were reported shortages of printed tools for data collection at service delivery points. As with many MOH programs, the RMHSU had challenges with insufficient hardware and software for data management and dissemination as well as unreliable internet connectivity.

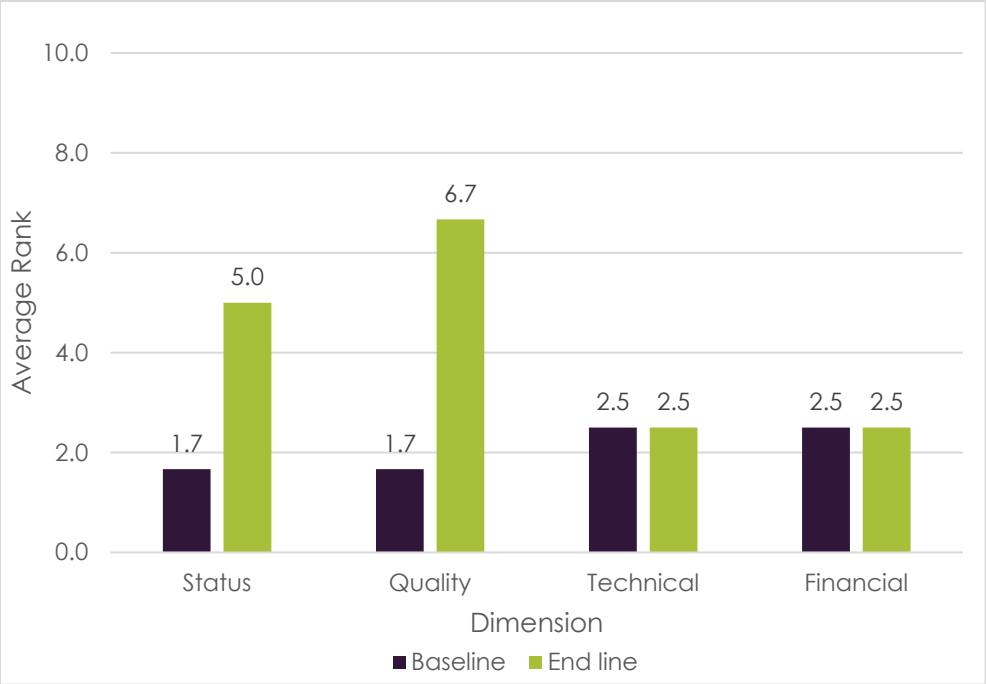
Figure 8. Routine monitoring



5.1.2.8 Surveys and Surveillance

The RMHSU collaborates with relevant stakeholders from the M&E TWG, academic and research institutions and other Ministry departments in surveys and surveillance activities. MPDSR and verbal autopsy are the main surveillance activities. Data are reported weekly, and a summary weekly surveillance bulletin is produced and discussed. The surveillance system and tools were developed with support from partners and are now part of the national integrated disease surveillance system. Surveys are conducted, but the RMHSU does not have a survey inventory or repository. The RMHSU M&E unit and officers knew the status of all surveys conducted in the previous year. All survey protocols are approved by nationally recognized ethics committees. These factors contributed to the improvement in the status and quality of this capacity area at end line, compared to baseline. The technical and financial autonomy remained unchanged (see Figure 9).

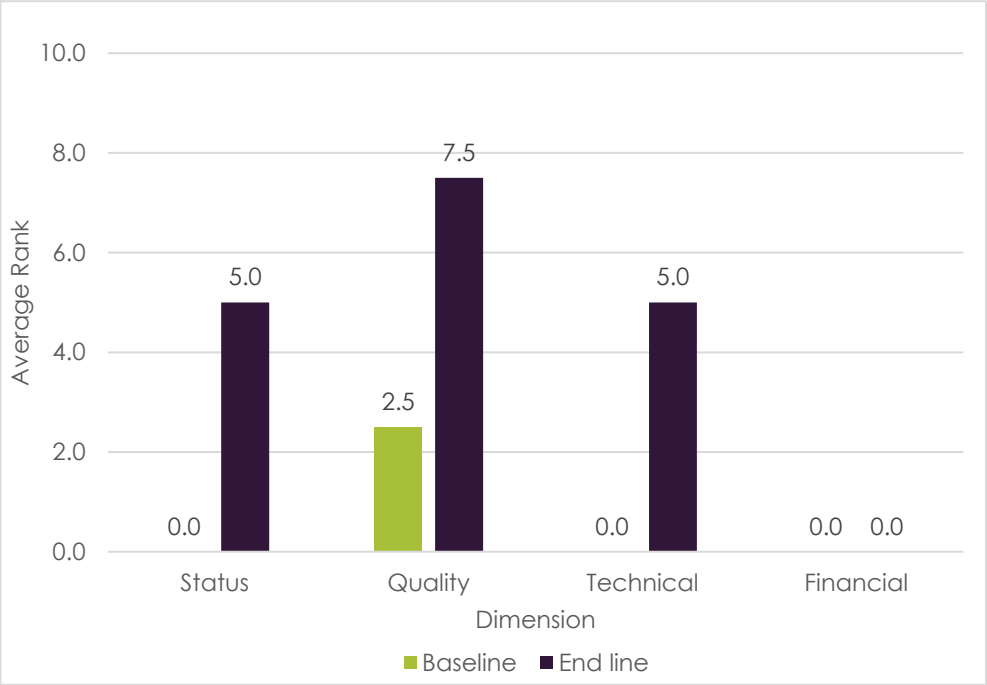
Figure 9. Surveys and surveillance



5.1.2.9 National and Subnational Databases

The national health services delivery database for capturing and storing data, DHIS 2, is up to date and accessible at national and subnational levels. Data elements used by the RMHSU had varying levels of completeness. Other databases available since baseline include the human resources information system and the logistics management information system for reproductive health commodities, both providing information for reporting progress on indicators in the family planning and other dashboards. Access to these national databases is limited by poor internet connectivity, although this issue was being addressed at end line. Status, quality, and technical autonomy showed improvement in this capacity area at end line, compared with baseline (see Figure 10).

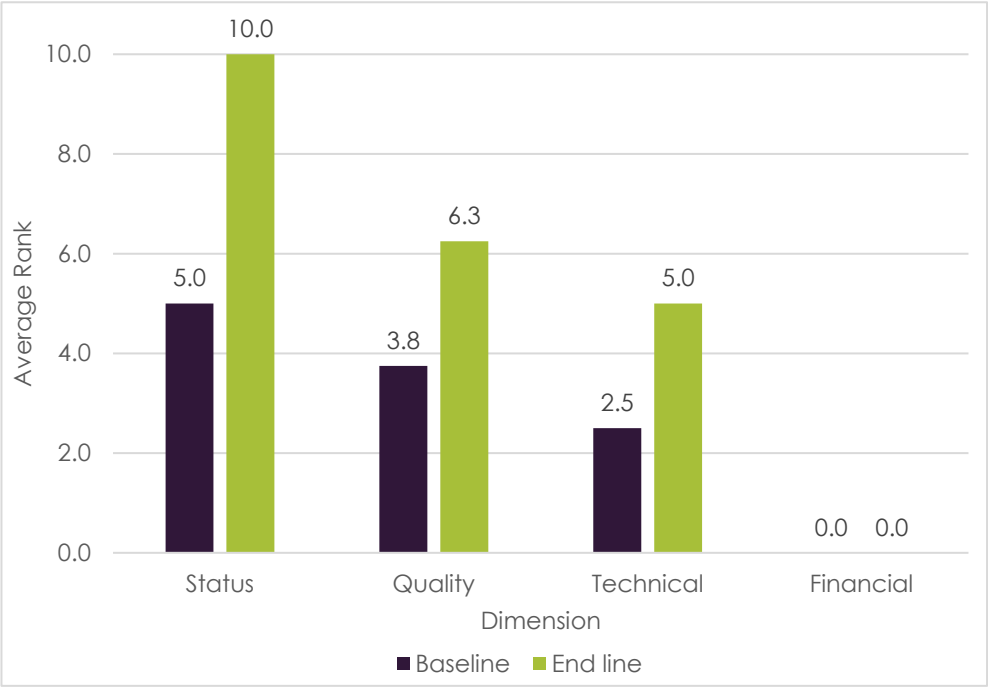
Figure 10. National and subnational databases



5.1.2.10 Supervision and Auditing

Guidelines, manuals and checklists, a planning tool, a scoring mechanism, and a structured report and feedback and action plan for supportive supervision of RMHSU program activities were available at end line. The last supportive supervision was conducted in December 2016 for family planning and sexual- and gender-based violence activities. There were challenges with planning for the supervision visits per the guidelines and a dependence on external financial assistance for the activity. Documented processes for DQAs adapted from the Division of Health Information Systems were also available. Implementation of supportive supervision and DQA activities are primarily supported by external financial resources. The status, quality, and technical autonomy of supportive supervision actions showed improvement. Financial autonomy remained unchanged at end line, compared with baseline (see Figure 11).

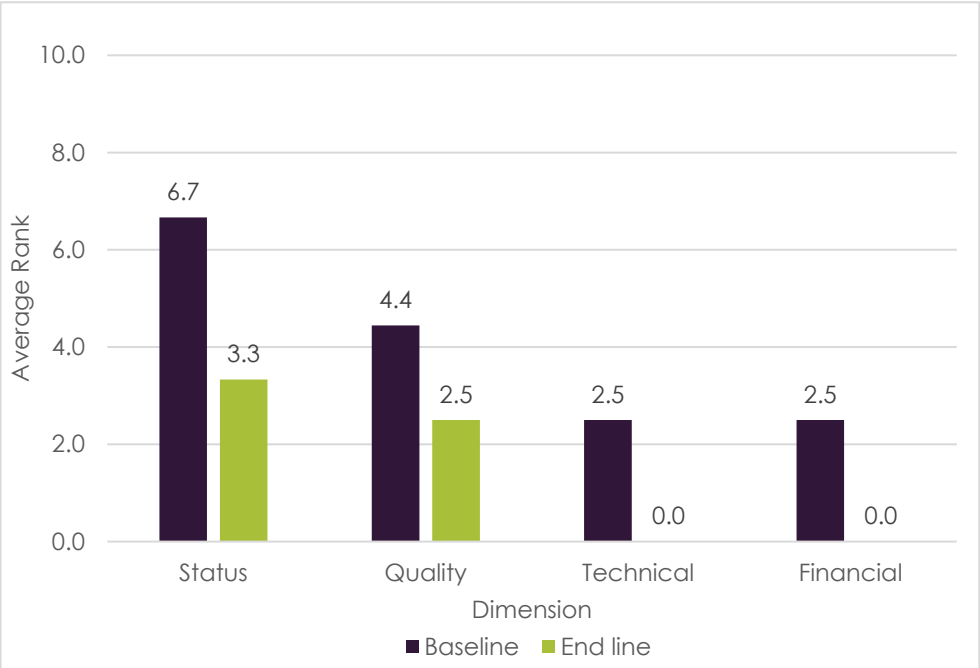
Figure 11. Supervision and auditing



5.1.2.11 Evaluation and Research

The performance in this capacity area decreased at end line, compared with baseline (see Figure 12). The RMHSU-specific research agenda was out of date at end line because it was for the period 2010–2014, when it was approved by M&E TWG stakeholders. A designated national forum for disseminating research findings does not exist, although evaluation and research findings were shared during TWG meetings and review and planning meetings with county teams and other stakeholder forums convened for that purpose. Findings on post-abortion care from the Population Council and findings on the high burden of maternal deaths were disseminated at a national forum, and the county representatives were invited to attend. These findings were disseminated with external financial resources by the agencies conducting the studies.

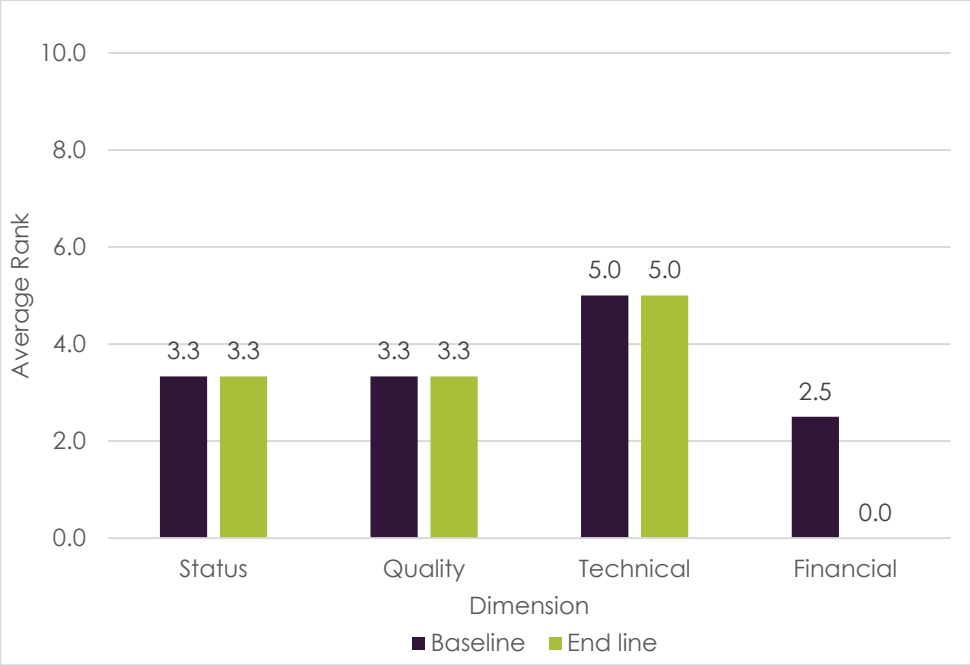
Figure 12. Evaluation and research



5.1.2.12 Data Demand and Use

The RMHSU did not have a data use plan at baseline or at end line, resulting in below average performance in status and quality in this capacity area. However, it did produce and disseminate M&E products (policy briefs, reports, fact sheets, scorecards, indicator performance reports) to stakeholders and data users. These products have helped influence policy and practice; for example, adolescent and youth sexual and reproductive health policy briefs and fact sheets have influenced counties to include these issues in their work plans. Most of these products are produced with external technical and financial assistance.

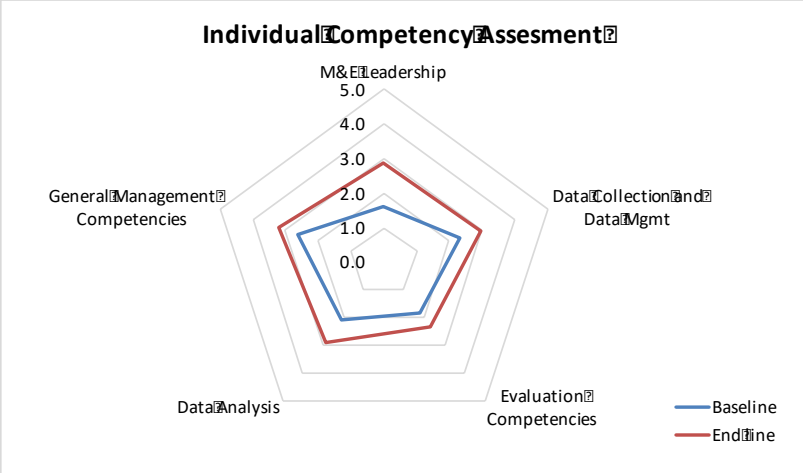
Figure 13. Data demand and use



5.2 Individual Capacity Assessment

An individual self-assessment tool was administered to assess the competencies of M&E staff in M&E leadership; data collection and management; data analysis, data dissemination and use; evaluation; and general management. The RMHSU staff who participated in the group assessment took part in the process and rated their skills, resulting in an overall composite score for each competency area, on a scale of 0–5, with 0 being entry-level capacity and 5 being an expert. The results of the self-assessment show that at baseline, the team members, on average, scored themselves between 1 (novice) and 2 (proficient) in most areas, and at end line, the average score improved slightly to between 2 (proficient) and 3 (skilled), as shown in Figure 14. It is important to note that some of the M&E officers interviewed were different between baseline and end line.

Figure 14. Individual competencies



5.3 MSC and Outcome Mapping

5.3.1 Story Collection and Selection

Program officers engaged in M&E activities were invited to document their change stories during workshops. Afterward, the participants had opportunities to review their stories and select one or two based on their consensus of its significance.

5.3.2 Domain 1: Strengthening Structures and Mechanisms for M&E Coordination

One of the MSCs identified for this domain is the ability of the RMHSU to better engage partners to improve resource mobilization and efficient allocation for M&E activities. Before the project, partners presented the RMHSU with predetermined activities, including M&E activities, that they wanted implemented. Although some of these activities were included in the program work plans, some were not, and the most popular activities were double or triple funded from these partner resources. The ability of the RMHSU to prevent duplication of resources has been driven by the RMHSU's ability to map stakeholders and engage them through regular TWG meetings. The TWG has become a forum for partners to provide updates on activities that they are responsible for implementing. This coordination has enabled partners to commit to joint planning and has prevented duplication of efforts and resources, ensuring that limited resources are available for more activities. This has been replicated at the county level, where M&E TWGs have helped coordinate activities among partners. The M&E TWGs cover all aspects of health, resulting in better coordination of partners and efficient use of resources available to support county-level health priorities.

MEval-PIMA's contributions:

- Technical assistance in identifying gaps through the administration of the MECAT assessment
- Technical and financial assistance for the RMHSU M&E TWG
- Technical assistance in setting up and organizing the county TWGs

- Assistance in developing terms of reference for the county TWGs
- Financial support for holding the county TWGs

Another MSC for the RMHSU in this domain has been the improved performance of the program in achieving the objectives set out in the national reproductive health strategy. Previously, AWPs were developed with activities and costs, but they did not have a means of monitoring performance. MEval-PIMA provided technical support that enabled the RMHSU to develop more meaningful work plans drawn from strategic plan goals and objectives that included indicators for performance monitoring. Partners have been engaged in the joint development of the AWP, which has been shared after finalization to help partners develop their own work plans to support the RMHSU. In addition, MEval-PIMA provided technical support for quarterly review meetings to track progress on the implementation of the AWP. The program officers are now able to develop better work plans and to monitor progress. RMHSU has seen improved use of data for decision making and commitment by team members toward ensuring that the AWP is implemented as planned.

MEval-PIMA's contribution:

- Technical assistance for producing the annual progress report for financial years 2012/2013, 2013/2014, and 2014/2015
- Technical assistance for developing comprehensive AWPs
- Technical and financial assistance for holding RMHSU quarterly review meetings

5.3.3 Domain 2: Ensuring Availability of Quality Data

One of the MSCs identified in the availability of quality data is the ability of the RMHSU and counties to review, analyze, and interpret their data, and to use the data to make evidence-based decisions and target interventions based on this evidence. For example, the RMHSU could use reported commodity data to convene a stakeholders' meeting to raise resources to help redistribute commodities from counties that have excess commodities to those counties that have stockouts. Previously, the RMHSU faced challenges in obtaining high-quality data from routine systems for decision making, yet using data was one of the ways to improve the quality of data available. With technical support from MEval-PIMA and other partners, the RMHSU and the Division of Health Informatics, Monitoring and Evaluation have been producing an RMNCAH scorecard. The scorecard has helped counties track their progress on achieving key interventions. Use of the scorecard has added impetus to counties to interrogate their data, and it has resulted in improved reporting for service delivery and commodities. Counties that received financial and technical assistance to conduct data review meetings reported improvement in the quality of data reported in DHIS 2 and were more interested in using the data to plan interventions improve service provision. The M&E officers have improved capacities to develop various information products, such as briefs, forecasting and quantification of commodities, and annual reports, using routine and other survey data.

MEval-PIMA's contributions:

- Technical and financial assistance for establishing data review forums on the mining and use of service delivery data from DHIS 2

- Technical and financial assistance for launching the RMNCAH scorecard
- Roll out of the RMNCAH scorecard to selected counties
- Technical assistance for reviewing MPDSR guidelines and reporting tools
- Technical and financial assistance for convening MPDSR workshops to enhance mortality reporting

5.3.4 Domain 3: Promoting Data Use Practices

The MSC in this domain has been the use of data to advocate for more resources for reproductive, maternal, and newborn health. Before 2013, service delivery data was rarely used for decision making due to challenges with completeness and quality. The introduction of the RMNCAH scorecard as a management tool has enhanced how data are viewed and used. The scorecard has aided visualization of performance on priority indicators at the county level and is accessible to non-technical people. It has promoted the analysis and use of data and the quality of the data. The easy visualization of data provided by the scorecard and dashboards has resulted in local leaders increasing resources allocated to activities aimed at improving coverage and use. This change is important because with the devolution of health services, the counties became responsible for knowing their data and health concerns and advocating for resources to implement evidence-based programs. The use of data has also improved local commitment to health issues because there is an understanding of what information can do. Visual tools such as the scorecard and dashboards enable information products to reach a wider audience, including political leaders at the national and subnational levels, and encourage them to make decisions based on available data.

In addition, there has been a significant change in the interaction between the RMHSU and county health management teams, which was a challenge with devolution. The RMHSU has been able to convene data review meetings with county health management teams and to use these meetings as a forum to address any issues with the data and the supply of family planning services and commodities. The production of visually appealing policy briefs and fact sheets has also promoted data use for decision making at both national and county levels. M&E products such as the scorecard and dashboards have been useful to open channels of communication with the county teams and to enhance M&E activities, particularly in using data to improve service delivery within the counties.

MEval-PIMA's contributions:

- Technical and financial assistance in convening joint RMHSU and county data review meetings
- Technical assistance for developing and producing 16 EmONC county profiles
- Technical and financial assistance for designing, developing, and rolling out the RMNCAH scorecard to selected counties
- Technical assistance for developing and producing 16 maternal and newborn health county profiles

5.3.5 Domain 4: Building M&E Leadership Competencies

The MSC identified by the RMHSU in M&E leadership competencies is the ability to produce M&E products for information dissemination and advocacy. This is coupled with increased demand for these products by decision makers at the national and county levels and also among partners. The products have been embraced as sources of evidence for decision making. This is evidence that the capacity building

provided for the program M&E officers has strengthened the M&E capacity for performance monitoring of planned activities, use of evidence for advocacy and resource mobilization, data analysis and sharing, and the development of M&E-specific interventions. Continuing support to strengthen leadership will make the coordination function even stronger as all partners commit to work toward achieving the same results.

MEval-PIMA's contributions:

- Identification of gaps in M&E capacity through the 2013 MECAT assessment
- Financial support for capacity building of M&E officers
- Technical assistance for planning, implementing, and disseminating EmONC assessments

5.3.6 Domain 5: Building Capacity of MOH Staff

The MSC that has taken place since the beginning of the MEval-PIMA project has been the improved capacity for evidence-based decision making among RMHSU program officers at the national level and among county reproductive health focal persons. Previously, M&E functions at the MOH, particularly for reproductive health activities, were weak. Through MEval-PIMA, M&E officers at the national and county levels have received technical assistance and training on basic M&E concepts, analysis of relevant data and indicators, reporting and analysis of MPDSR data, and production and interpretation of the quarterly RMNCAH scorecard. This has resulted in a better understanding of the programmatic data elements and an increased ability of officers at the national level to produce M&E products. Staff at both the national and county levels can produce the RMNCAH scorecard and use it to advocate for funding for interventions to improve coverage and ultimately impact. After deployment of new M&E officers to the RMHSU, a needs assessment of training needs training was undertaken, and officers received appropriate training on essential M&E functions and data analysis. The officers also received mentorship on development of comprehensive M&E frameworks for the AWPs. The overall support to other units and county-level teams resulted in improved data quality and reporting rates for commodities. The MSC has been the improved quality of M&E reports and products coming from the program. The improved quality of reports makes it possible for technical officers and managers at the national and county levels to use information for planning and implementation of reproductive health activities, better reporting, and continuous improvement of data quality, enabling more precise interventions to be implemented.

MEval-PIMA's contributions:

- Identification of gaps in M&E capacity through the 2013 MECAT assessment
- Provision of financing for capacity building of M&E officers
- Mentorship of M&E officers by MEval-PIMA technical staff
- Financial assistance for the training of 197 health workers from 5 counties on MPDSR guidelines and tools
- Orientation for 167 workers from 7 counties on EmONC assessments

5.3.7 Conclusions from MSCs

The MSC stories show that there were changes in the skills and practices of M&E at the RMHSU. Most important for the RMHSU was the ability to enhance coordination of partners, not only for M&E activities

but also for joint planning and implementation of interventions through the AWP and annual reviews. The MSC process provided some descriptive notes to the trends seen with the quantitative analysis of the MECAT group assessment, particularly for some of the impacts on the M&E officers, such as the ability to produce M&E products and use them for performance monitoring, advocacy, and resource mobilization. It also revealed challenges, such as high staff turnover and inadequate allocation of local financial resources for M&E activities. Although the MSC process is limited by its bias toward positive changes, no negative effects of the MEval-PIMA project were mentioned.

5.3.8 Results of the Outcome Mapping Process

Table 1 presents findings from individual and group discussions with participants to determine the future impact of the M&E capacity building provided by MEval-PIMA. The focus was how the RMHSU would use the knowledge and skills gained to address threats to the sustainability of existing M&E capacity-building initiatives and support provided.

Table 1. Mapping outcomes for sustainability of M&E practices at the RMHSU

Threat to sustainability	Expected behavior change	Partnerships to be developed	Illustrative activities
Dwindling external resources	• Increased transparency and mutual accountability on use of resources by MOH and partners • Provision of regular feedback on implementation of programs	• External donors and implementing partners (e.g., USAID, United Nations Population Fund [UNFPA], UK Department for International Development [DFID], UNICEF, Palladium) • Ministry departments and government agencies (e.g., health management information system [HMIS], National Council for Population and Development [NCPD], county governments)	• Hold joint planning and review meetings to identify funding gaps • Map and engage all relevant stakeholders • Develop binding memorandums of understanding with partners • Implement early budgeting and sharing of RMHSU work plans with partners
Inadequate domestic financing for M&E activities	• Innovative ways of information sharing and advocacy for resources • Adherence to the AWP • Commitment of local resources for data review and feedback meetings and DQA activities	• MOH • Ministry of Finance • County governments • NCPD • HMIS	• Present data through visuals and infographics that are simple and easily understood at all levels • Advocate with finance officers, treasury, and the leaders through M&E champions • Develop advocacy tools for resource mobilization • Share performance results (scorecard and policy briefs) with the all stakeholders • Establish county-level learning forums

Threat to sustainability	Expected behavior change	Partnerships to be developed	Illustrative activities
			• Conduct sensitization and advocacy meetings with county leaders
Lack of M&E champions	• Program officers strategically position M&E programs and continually advocate to strengthen M&E activities and functions	• County governments • County health teams • National government • Research and academic institutions • External donors and implementing partners (e.g., USAID, UNFPA, DFID, UNICEF, Global Fund)	• Identify champions using specified criteria • Train champions on the technical aspects of M&E • Recognize champions through awards • Implement mentorship programs for M&E champions
Lack of political good will and buy in	• Leaders accept the important role of M&E in implementation of health programs	• County governments • County health teams • NCPD • External donors and implementing partners (e.g., USAID, UNFPA, DFID, UNICEF, Global Fund)	• Present data through visuals, and infographics that are simple and easily understood at all levels • Share health data on performance with all stakeholders regularly • Advocate with and sensitize leaders to create awareness of the role of M&E • Engage in resource mobilization activities
Lack of consistent feedback and accountability	• Provision of regular feedback on implementation of programs • Adherence to set rules and regulations on accountability • Adherence to International Standards Organization (ISO) 9001:2007 standards	• County governments • County health teams • HMIS • External donors and implementing partners (e.g., USAID, UNFPA, DFID, UNICEF, Global Fund) • Research and academic institutions • ISO committee and Kenya Bureau of Standards	• Conduct regular data review meetings and DQAs • Convene research-sharing forums • Convene stakeholders' forums and regular TWG meetings • Develop and implement a data use plan
High staff turnover and attrition	• On-the-job training and mentorship to ensure that the knowledge and skills remain in the unit	• Intra-organizational partnerships	• Establish an environment that promotes skills transfer • Create time for skills sharing, on-the-job training, and mentorship sessions • Develop knowledge management practices within the unit

6. DISCUSSION

Of the M&E capacity areas assessed, organizational capacity, advocacy, communication and cultural change, and routine monitoring were the strongest for the RMHSU at both baseline and end line. At the end of the project, significant improvements were found in status and quality of organizational capacity and partnerships

and governance. The evaluation also found that there were also improvements in technical autonomy in these capacity areas. The MSCs were due to improvements in RMHSU's capacity in partnerships and governance, resulting in regular convening of TWGs that brought together stakeholders for joint planning and implementation of activities. Although the RMHSU strategic plan and M&E framework had come to an end during the project implementation period, MEval-PIMA supported the RMHSU in improving its AWPs to include M&E framework and indicators linked to the national health sector M&E plan and MTEF planning process. These processes strengthened the RMHSU's capacity to advocate for, mobilize, and efficiently allocate resources for activities in the AWP.

The performance of routine M&E and research capacities were well-established at the RMHSU at baseline, with average or above average scores. At end line, there were some improvements in the status and quality of all M&E practices, except for routine monitoring. Lack of a current M&E plan as well as a data demand and use plan were the key reason for the overall poor performance in these capacity areas. There was little or no change in the reliance on external technical and financial support for all M&E capacity areas, with technical support required for the development of key guidelines as well as for regular implementation of activities such as surveys and surveillance, evaluations, and research. The overall scores for technical autonomy remained below average at end line. Overall, significant improvements were seen in surveys and surveillance due to the regular production of MPDSR reports and supervision and auditing. The regular production of the RMNCAH scorecard has positively influenced data quality by having county teams review their performance on key indicators and ensuring accuracy and timeliness in data reporting through DHIS 2. Competencies of M&E officers improved at end line, compared with baseline, evidenced in part by their ability to plan, develop, and produce various M&E products despite the inadequate number of staff dedicated to M&E. The lack of a human resource capacity development plan for the RMHSU may need to be addressed.

The MSC discussions described changes in M&E skills and practices of RMHSU staff. Examples of significant changes were found in all five capacity domains explored using the MSC process. The improvement in governance, coordination, and leadership for M&E was further explained with MSCs being the ability of the program to mobilize resources and efficiently allocate resources to implement activities in the AWP, with all stakeholders working toward achieving the common objectives outlined in the AWP. This has resulted in improved performance in the attainment of targets outlined in the national reproductive health strategy. During the project period, production of the RMNCAH scorecard and family planning dashboards using available data led to increased interrogation of the data by end users at the county level and improvement in the quality of data reported in the routine system. The improved data quality encouraged evidence-based decision making and the analysis and use of data for planning and implementation. For example, data showing performance on various indicators were used to plan interventions and actions to improve performance in those indicators. As a result, health data have been used to advocate with county leaders for allocation of resources, both human and financial, for activities aimed at improving maternal and child health. The scorecard and dashboards are simple visual presentations of data that non-technical people at leadership and community levels can use to understand and appreciate the importance of health data. These visuals have also prompted health workers to appreciate the importance of analyzing service delivery data to support action planning at service delivery points.

Although the RMHSU has faced challenges with deployment of adequate personnel to support M&E activities, there was an improvement in the technical capacity of existing M&E staff during the MEval-PIMA

project. At end line, staff reported that they had improved the quality of M&E reports and products produced by the program. The improved quality of reports resulted in an increased demand for these products among stakeholders at national and county levels for use in planning and implementation of reproductive health activities. Current staff have planned to strengthen on-the-job training and mentorship for newly deployed staff and any staff engaged in M&E activities to sustain gains made during the MEval-PIMA project.

7. ACHIEVEMENTS AND LESSONS LEARNED

7.1 Achievements

The strongest capacity areas at baseline—routine monitoring; partnerships and governance; and advocacy, communication, and cultural behavior—improved and remained strong at end line. The weakest performing areas—supervision and auditing, national and subnational databases, and surveys and surveillance—significantly improved at end line, with the exception of human capacity for M&E, which was hampered by inadequate staff dedicated to M&E functions. The successes in terms of M&E capacity were as follows:

- Stronger leadership and coordination of health stakeholder activities through convening of regular technical working group meetings.
- Improved program planning and implementation through engagement of all stakeholders for joint planning, implementation, and performance monitoring.
- Resource mobilization and equitable allocation to activities in the AWP, improving implementation.
- Improved reporting and data quality, enabling better forecasting and quantification for family planning commodities.
- Improved data analysis and presentation in various M&E products, including surveillance reports, program briefs, and reports used for planning.
- At the county level, improved service delivery by program and improved referral practices for services not available at lower-level facilities.
- Increased interest and ownership of M&E programs by county leadership and health teams.
- Increased participation in M&E activities by non-health records program officers at both national and county levels.
- Increased competence of designated M&E officers, evidenced by their ability to develop M&E products (e.g., quarterly bulletins, quarterly RMNCAH scorecard, and monthly reports), in addition to less reliance on external technical assistance for work plan development.
- Improved documentation and reporting of service delivery data using International Classification of Diseases-10 classification and improved linkages with integrated programs, including HIV, sexually transmitted infections, tuberculosis, and malaria programs.
- Improved technical competency in performance monitoring and less need for external technical assistance in this area.

7.2 Lessons Learned

Lessons learned from MEval-PIMA in its support of the RMHSU are as follows:

- Insufficient financial resources for M&E activities and reliance on external financing hamper the sustainability of efforts to strengthen M&E systems. Reliable financing is essential for building capacity, performing routine monitoring, and ensuring the availability of high-quality data and supportive supervision.
- The lack of an M&E strategy and plan is a challenge to the institutionalization of M&E functions. Documentation is essential for the definition of roles and responsibilities of various stakeholders with respect to implementation of programs and M&E functions, including the terms of reference for coordination mechanisms such as TWGs.
- Regular updating of stakeholder inventories ensures that all stakeholders are continually engaged in program planning, implementation, and performance reviews, even though their roles may vary from year to year.
- Human resources are key to sustaining M&E capacities within national and county programs.
    - It is essential that program staff, in addition to existing health information officers, engage in M&E activities beyond collation and reporting of data so that analyses and use of data for decision making can be culturally entrenched.
    - Ensuring availability of staff with the right skill set for M&E will enable scalability of capacity building, especially at the county level, where a limited number of people have critical M&E skills.
- Lack of awareness of the importance of M&E for planning and implementation of programs among key decision makers results in inadequate allocation of local resources for M&E activities. Visual presentations of data, such as the RMNCAH scorecard and family planning dashboards showing performance of priority indicators, are a useful tool for advocating for both human and financial resources to improve program implementation.

8. RECOMMENDATIONS

Overall, the RMHSU demonstrated a significant increase in organizational capacity for M&E with the support of MEval-PIMA and other partners. To further strengthen the M&E system, the MOH, the RMHSU, and their partners must strive to sustain these changes while continuing to make improvements in areas flagged for additional action. The following is a summary of identified threats to sustaining the MSCs identified in Section 5.3 and some recommendations as proposed by the participants.

Insufficient financial resources to fully implement the M&E activities in the M&E plan

Recommendations for mitigating this threat:

- Advocate with the Government of Kenya, national and county treasuries, and county governments for more funding using a resource mobilization plan. The RMHSU can use findings from the MECAT group assessment to identify gaps in capacity and areas in which the program lacks financial autonomy. The RMHSU should partner with the County Chief Executive in charge of health, the

County Director of Health, and local leaders to allocate required resources to implement M&E activities for health.

- Develop a current strategic plan, cost it, and use it as an advocacy tool for resource mobilization. The RMHSU should also adopt program-based budgeting for its AWPs. This will ensure more accurate budgets that reflect actual program needs.

High attrition and turnover of skilled M&E staff

Recommendations for mitigating this threat:

- Develop a human capacity needs plan for RMHSU, and specifically for M&E.
- Designate adequate personnel with the appropriate skills mix to support M&E activities for the entire program. Adequate human resources will enable more efficient and sustainable use of capacity-strengthening resources and less reliance on external technical assistance for M&E.
- Ensure that a critical mass of staff is trained with the appropriate analysis and leadership skills.
- Continue to use cascade training so that staff who can build capacity of others are embedded in the program.
- Develop succession plans and implement them to ensure that knowledge and procedures are transferred appropriately when staff transition from the program.

Need to strengthen program planning, implementation and M&E practices

- Prioritize the review and development of the national reproductive health strategy and include an objective for strengthening M&E practices for reproductive, maternal, and newborn health services countrywide. The RMHSU should also develop a comprehensive M&E plan, including a data demand and use section and plan to guide M&E practices at national and county levels.

Other recommendations to strengthen M&E practices include the following:

- **Strengthen coordination of stakeholders.** Institute regular meetings of TWGs, including the M&E TWG, and regularly update stakeholder maps to ensure that all stakeholders are engaged in the coordination processes.
- **Develop a costed human capacity-building plan.** Develop and use a costed human capacity-building plan to anticipate training needs and the resources needed to support the trainings. The plan can be used to advocate for funding allocations from the Government of Kenya and other partners for trainings to keep staff up-to-date on the latest methods and skills in M&E for reproductive health programs.
- **Roll out M&E best practices in RMNCAH to all counties.** Set up or strengthen existing county M&E TWGs and provide support for the use of visuals such as the RMNCAH scorecard and county maternal and newborn health profiles to track performance and progress of key indicators.

9. REFERENCES

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APPENDIX A. BASELINE AND END LINE ASSESSMENT METHODS

Table A1. Baseline assessment methods

Tool	Method	Target	Questions addressed
Excel-based Monitoring and Evaluation Capacity Assessment (MECAT) group assessment workbook	Participatory group assessment	Reproductive and Maternal Health Services Unit (RMHSU) staff, including program managers and program officers, monitoring and evaluation (M&E) officers, and data managers	• What is the status of M&E activities? • What is the capability in M&E capacity areas?
Excel-based MECAT individual assessment workbook	Individual self-assessment	M&E staff	
Desk review guidance	Desk review	Organizational documentation (policy and strategic documents and reports on health and measurements)	• What are the objectives and expectations for the organization's M&E? • What is the organization's capacity for M&E? • How well is the organization performing against its objectives and expectations for M&E?
Key informant interview guide	Key informant interviews	M&E stakeholders and program and other technical staff	

Table A2. End line assessment methods

Tool	Method	Target	Questions addressed
Excel-based MECAT group assessment workbook	Participatory group assessment	RMHSU staff, including program managers and program officers, M&E officers, and data managers	• What is the status of M&E activities? • What is the capability in M&E capacity areas?
Excel-based MECAT individual assessment workbook	Individual self-assessment	M&E staff	
Most significant change guide	Focus group discussion	RMHSU program managers and program officers, including M&E officers and data managers	• What are the most significant changes in the M&E system since baseline? • What were the drivers of these changes? • What role, if any, did MEval-PIMA have in these changes?
Outcome mapping	Focus group discussion	RMHSU program managers and program officers, including M&E officers and data managers	• What are the threats to sustainability of the most significant changes identified? • What are recommendations to mitigate these threats to sustainability?

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