



**UNIVERSITY OF NAIROBI  
POPULATION STUDIES AND RESEARCH INSTITUTE**

**ASSESSMENT OF M&E SYSTEMS OF LOCAL NGOs IN KENYA: A CASE STUDY OF  
FAMILY HEALTH OPTIONS KENYA**

A Research Project Report Submitted in Partial Fulfillment of the Requirements for the Award of  
A Degree of Master of Arts in Monitoring and Evaluation of Population and Development  
Programmes

**By**

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## DECLARATION

This project report is my original work and has not been presented for a degree in any university.

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## **DEDICATION**

I would like to dedicate this project to my dear wife, Nesther Karimi and my beautiful daughter, Hope Micere for their unwavering moral support and patience throughout my study period. I also dedicate this project to Family Health Options Kenya (FHOK) for the organization's moral and financial support throughout my study period. It is my sincere hope that this report will contribute to strengthening of FHOK M&E system. Last, but not least, I dedicate this project to Population Studies and Research Institute (PSRI), as one of the first projects by the first M&E postgraduate class. I hope that this work will contribute to the existing body of knowledge and that it will inform future similar assessments.

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## **LIST OF ACRONYMS AND ABBREVIATIONS**

|        |   |
|--------|---|
| AIDS   | Acquired Immune-Deficiency Syndrome                   |
| BPT    | Branch Performance Tool                               |
| CCS&PT | Cervical Cancer Screening and Preventive Therapy      |
| DANIDA | Danish International Development Agency               |
| DFID   | Department for International Development              |
| DQA    | Data Quality Audit                                    |
| FAO    | Food and Agriculture Organization                     |
| FHOK   | Family Health Options Kenya                           |
| HCT    | HIV Counseling and Testing                            |
| HIV    | Human Immunodeficiency Virus                          |
| IEG    | Independent Evaluation Group                          |
| IFC    | International Finance Corporation                     |
| IMF    | International Monetary Fund                           |
| IPPF   | International Planned Parenthood Federation           |
| M&E    | Monitoring and Evaluation                             |
| MA     | Member Association                                    |
| MIGA   | Multilateral Investment Guarantee Agency              |
| NGO    | Non-Governmental Organization                         |
| OECD   | Organization for Economic Cooperation and Development |
| PME    | Participatory Monitoring and Evaluation               |
| RBM    | Results-based Management                              |
| RDQA   | Routine Data Quality Assessment                       |
| SRHR   | Sexual and Reproductive Health and Rights             |
| SWAPs  | Sector-Wide Approaches                                |
| UNAIDS | Joint United Nations Programme on HIV/AIDS            |
| UNDP   | United Nations Development Programme                  |
| USAID  | United States Agency for International Development    |

## **ABSTRACT**

The overall objective of the assessment was to determine the status of the FHOK M&E system and its contribution to the improvements of the programme. Specifically, the assessment was aimed at: determining the extent to which the FHOK M&E system meets the established standards; identifying strengths and gaps of FHOK M&E system; and determining how the products of FHOK M&E system have been used to improve the programme.

The assessment employed descriptive research design which allowed for description of the current FHOK M&E system and helped to establish strengths and gaps which were fundamental to the realization of research objectives. The assessment adapted approaches used by Ogunbemi et al. (2012) in assessing Nigeria's HIV M&E system and Independent Evaluation Group (2013) in assessing International Finance Corporation and Multilateral Investment Guarantee Agency M&E systems. The assessment operationalized FHI 360's Participatory M&E System Assessment Tool that condenses the 12 components of an M&E system into 8 domains, programme-level use. The target population was 17 service delivery sites. 3 sites (Kisumu, Eldoret and Kakamega) and 17 respondents were purposively sampled to take part in the assessment. The head office was also involved in the study. Data was collected through document review, Key Informants' Interviews, discussions and observation. Data was analyzed both quantitatively and qualitatively to produce the results.

Overall, FHOK M&E system scored 148 out of 240 which is 62 percent. This is an aggregated score from all the 8 components. Scores vary from component to component with data analysis and use and evaluation (a tie) scoring the highest at 79 percent and documentation recording the lowest score at 43 percent. The assessment identified key strengths of FHOK M&E system to include: adequate resources allocated for M&E work (M&E budget was 8 percent of overall 2015 programme budget), alignment of indicators to donor and national indicators, use of standardized data collection tools, presence of M&E databases to track progress, continuous data analysis and use and use of evaluations to improve programme. Key gaps that were identified include: documentation of M&E procedures, inadequate evaluation and research capacity of M&E staff, corrections are not made after data quality assessments, evaluations are largely

donor-driven and no component of FHOK M&E system has been shared in a conference or published in a peer reviewed publication. In terms of contribution of FHOK M&E system to programme improvement, it was observed that FHOK M&E system has been vital in tracking progress against targets, accounting to donors and stakeholders, reviewing and improving programme implementation strategies, designing new innovations, ensuring that the right target group is reached and strengthening efficiency of FHOK programme.

The following components of FHOK M&E system were noted to be strong: resources and capacity building, data quality systems, data analysis and use and evaluation. However, documentation and data verification components presents opportunities for strengthening. The ongoing process of reviewing the M&E plan should directly address the documentation aspect as has been identified in the other two assessments that were conducted in 2014. With continuous management support, resource allocation and assessment for improvement, FHOK's M&E system can be an exemplary system for adoption by other NGOs.

The key recommendations that were made, basing on the findings include: the need to update the M&E Framework into an M&E Plan and align it to the new Strategic Plan, the need to document all aspects of FHOK M&E system in the updated M&E Plan, projects to draw clearer and more specific M&E budget lines, the M&E team to conduct more regular data verification exercises and make necessary corrections prior to sharing of data, and the need to build targeted and customized M&E capacity of field-level staff.

## CHAPTER ONE: INTRODUCTION

### 1.1. Background

Monitoring and Evaluation (M&E) systems provide institutions with a tool to enhance sound governance by providing information to support evidence-based policy decisions and evaluating effectiveness of projects/programmes. World Bank (2009) and International Monetary Fund (IMF) (2005) underscore the need for strong M&E systems for enhancing effectiveness of development initiatives, accountability and realization of Millennium Development Goals (MDGs). With increasing globalization, there are growing pressures on government and organizations around the world to be more responsive to the demands of internal and external stakeholders for good governance, accountability, transparency and greater development effectiveness (Hiller, 2002; Kusek and Rist, 2001; Levesque et al., 1996; World Bank, 2009; UNAIDS, 2009; Mackay, 2007; Mayne, 1997; Mayne and Goni, 1997; McCoy et al., 2005). Such growing demands calls for enhanced results-based monitoring and evaluation of policies, programmes and projects (Binnendijk, 1999). A functional M&E system is a powerful public and programme management approach that can be used to improve ways of governance and programme management (IMF, 2005).

Monitoring and evaluation has evolved over time due to the need for results-based management (RBM) as well as limited resources and involvement of non-state actors in development (Kusek and Rist, 2001). By 1980s, major donors such as United States Agency for International Development (USAID), Food and Agriculture Organization (FAO), Department for International Development (DFID) and Danish International Development Agency (DANIDA) had embraced Participatory Monitoring and Evaluation (PME) in programme management. However, the history of M&E systems goes back to the 1970s when M&E was essentially project-based. Essentially, M&E focused on inputs and outputs which were largely extracted from administrative records. From the 1970s, M&E has evolved through the 1980s when there was a shift to sector-wide approaches (SWAPs) as RBM gained popularity. This changed in the 1990s when M&E centered on conducting large scale national household surveys to track the living standards with a view to anticipating the direction in which they would likely move as a result of macroeconomic policy. When the Millennium Development Goals (MDGs) were developed in

the 2000s, project and sector-based M&E efforts merged with poverty monitoring efforts with the goal of monitoring poverty reduction initiatives. Presently, M&E continues to evolve as Non-Governmental Organizations (NGOs) are under pressure from funders (Liket et al., 2014) to develop systems to demonstrate performance of projects/programmes. In a few cases, NGOs have taken it upon themselves to develop M&E systems to measure results and account to donors and other stakeholders.

Family Health Options Kenya (FHOK) is a dynamic not for profit national Non-Governmental Organization with strong grassroots network. The organization provides sexual and reproductive health (SRH) information and services to all people, particularly women of reproductive age and young people. FHOK champions sexual and reproductive health and rights (SRHR) and the empowerment of Kenya's women of reproductive age and young people to exercise and enjoy these rights. The organization embraces gender sensitivity and collaboration in providing SRH information and services.

FHOK programme covers four core areas of operations, usually referred to as 5As: Access, Adolescents and Youth, HIV/AIDS, Abortion and Advocacy. The 5As are supported by six strategies namely: governance, institutional capacity building, partnerships, resource mobilization, knowledge management and institutional sustainability. In 2015, FHOK implemented 15 projects across the above five strategic areas. Sexual and Reproductive Health information and services are provided service delivery sites. FHOK runs 12 clinics referred to as FamilyCare Medical Centres (FCMCs) and 7 youth centres. Five of the seven youth centres are integrated in the FCMCs whereas two are stand alone youth centres. FHOK provides SRH services through static clinics (FCMCs), mobile outreaches, associated clinics and community based distribution of FP services and information. Annually, FHOK provides over 1,000,000 services to an average of about 300,000 clients.

FHOK M&E system is presented in the organization's M&E Framework. The specific year when FHOK M&E framework was developed is however not known. The goal of the M&E Framework is to guide coordinated and efficient collection, analysis, use and provision of

information that will enable tracking of the progress made and enhance informed and sound decision making. Specifically, the M&E framework of FHOK is meant to: ensure accurate and timely reporting to stakeholders; provide projects-related information; reinforce managerial capacities to regularly review and improve intervention strategies and decision making processes; ensure tracking of progress made by projects in achieving set targets; generate self-evaluation processes to ensure sustainability and effectiveness of projects; and lay the foundations for midterm and completion evaluations of projects.

In terms of data collection, data is collection in line with Service Delivery Points (SDPs) namely: static clinics, outreaches, community based distribution and associated clinics. At the static clinic, there is a clinic management information system usually referred to as SmartCare, Version 3.0 which allows for electronic and real time data collection and reporting. In other SDPs, manual data collection tools are used mainly the integrated client card, Daily Activity Register (DAR), and project specific tools such as participants' lists and events' logs.

Data collection is usually done in line with project indicators that are aligned to donor and government requirements. Project indicators are developed during project design in consultation with stakeholders such donors, programmes team and partners among others. Each project has a performance matrix for tracking the indicators.

Once data is collected, it is summarized in summary forms and reported to the head office on a monthly basis, by 10th of every month. Service statistics are reported by the service delivery sites to the Ministry of Health at the county level using MOH tools by 5th of the month. There are also project specific reporting frequencies and deadlines. Data reported at the head office is compiled for all sites and stored in relevant databases and shared with donors, partners, senior management team, project implementation teams, volunteers and other stakeholders.

Performance of projects is usually measured through baseline, mid-term and end evaluations, rapid assessments, outcome measurement, Branch Performance Tool (BPT), the vulnerability assessment, operations research and other assessments as desired.

FHOK M&E system ensures that data is used and disseminated for it to be meaningful. Data is usually used for target setting, tracking performance against targets, reviewing programme implementation strategies, proposal development and reporting to donors and stakeholders. Dissemination of M&E results to stakeholders is usually done on an ongoing and needs-basis through workshops, emails and conferences among others to encourage knowledge sharing.

Since its development, the M&E framework of FHOK has not been fully reviewed. However, two assessments have been conducted but focusing on the quality of data and data management systems. In August 2014, a Routine Data Quality Assessment (RDQA) was conducted by the International Planned Parenthood Federation (IPPF), Africa Region focusing on selected four key indicators of FHOK data using the same approach that was used by the Global Fund. That exercise involved assessments of the programme's data management systems as well as the accuracy, timeliness and completeness of reporting from sites to the head offices and to the donor. A similar assessment was conducted in late 2014 when Bill and Melinda Gates Foundation commissioned and conducted a Data Quality Audit (DQA) on Cervical Cancer Screening and Preventive Therapy (CCS&PT) project on the project's year 1 data (May 1, 2013 - April 30, 2014).

The assessments described above were project-based and they were focusing on the data component, hence leaving out the other key components of a functional M&E system such as evaluations, M&E advocacy and M&E partnerships among others. On this basis, it is clear that the M&E system of FHOK has not been comprehensively assessed which poses a challenge to the process of strengthening the system. It is important to note that currently, FHOK is reviewing her 2010-2015 Strategic Plan. At the same time, FHOK is reviewing the M&E framework to update it to an M&E plan and to align it to the revised Strategic Plan. The proposed assessment will inform the review of the M&E framework and provide practical recommendations that can be used to continuously strengthen the M&E system.



## **1.2. Problem Statement**

Great strides have been made towards strengthening monitoring and evaluation systems in local NGOs in Kenya (Karani et al., 2014). However, like in many developing countries, monitoring and evaluation in local Kenyan NGOs has not yet reached an acceptable level of operation (Odhiambo, 2000). This is largely attributed to weak monitoring and evaluation systems to guide the practice at the organizational level. It is important to note that a number of local NGOs have made attempts to institutionalize M&E practice. However, as Liket et al. (2014) notes, institutionalization of M&E by nonprofits is as a result of great pressure by funders who have an aim of demonstrating that programmes work or otherwise. AfrEA (2006); OECD (2003) and Phillips and Porter (2012) recognize the nature of M&E practice in Africa as donor-driven. As such, M&E components are outlined in projects/programmes and government plans, but in most cases, they are not operationalized, nor is M&E appreciated as a useful tool in development practice (Karani et al., 2014). Karani et al. (2014) goes on to observe that M&E is yet to be formalized in both public and private sectors.

For the above reasons, the need to pay specific attention to the nature and use of M&E systems to enhance project/programme efficiency, effectiveness and impact cannot be understated (Karani et al., 2014). As rightly put by Karani et al. (2014), “If you can’t measure how well you are doing against targets and indicators, you may go on using resources without changing the circumstances you have recognized.” In the context of development programmes, the measurement being referred to by Karani et al. (2014) cannot become a reality in the absence of strong M&E systems. Assessment of existing M&E systems is critical to ensure that they are continuously improved in response to the complex and rapidly changing development arena (FHI 360, 2013; World Bank, 2009; UNAIDS, 2009 and Global Fund et al., 2006).

In 2014, two assessments focusing on data quality and data management were conducted in FHOK. The assessments were project-based and they only focused on the component of data. Hence, the M&E system of FHOK has not been comprehensively assessed which poses a challenge to the process of strengthening the system. FHI 360 (2013); World Bank (2009); UNAIDS (2009) and Global Fund et al. (2006) identify components of a functional M&E system

to include other aspects other than data which include M&E capacities, M&E plan and evaluations among others. Conducting project-based data-focused assessments is vital to an M&E system but this leaves out other components that are critical to an M&E system. Hence, the proposed M&E research project will entail a comprehensive assessment of FHOK M&E system as recommended by FHI 360 (2013); World Bank (2009); UNAIDS (2009) and Global Fund et al. (2006).

### **1.3. Research Questions**

1. Does the M&E system of FHOK meet established M&E standards?
2. What are the strengths and gaps of the M&E system of FHOK?
3. How has the M&E system of FHOK contributed to improvement of the programme?

### **1.4. Research Objectives**

The overall objective of the assessment was to determine the status of the FHOK M&E system and its contribution to the improvements of the programme. Specifically, the assessment will:

1. Determine whether the M&E system of FHOK meets the established standards.
2. Identify strengths and gaps of the M&E system of FHOK.
3. Determine how the products of the M&E system of FHOK have been used to improve the programme.

### **1.5. Justification**

According to Thomas (2010), M&E systems play key role in identifying and promoting development work that has the most positive outcomes and biggest impact on the lives of people in developing countries. Strong M&E systems can contribute to positive development outcomes as part of a system of good governance whereas weak M&E systems can lead to poor development outcomes (Thomas, 2010).

The importance of M&E function within institutions has been magnified by the rapidly growing voice of the civil society with questions of good governance and better administration being in the limelight (Odhiambo, 2000). Globally, there is a paradigm shift towards more transparent,

accountable and effective governments and this has bolstered the need for stronger M&E systems. Over the years, the importance of M&E has been elevated due to the stagnant and/or negative economic growth as more development actors question the usefulness and effectiveness of development efforts (Karani et al., 2014).

UNAIDS (2008) asserts that M&E systems provide programmes with integral management tools since they provide the programme management teams, funders, decision makers and other stakeholders with the opportunity to collect and analyze information on interventions and make decisions that can ultimately produce optimal (or better) results. Due to the central role of M&E systems in programme implementation, FHI 360 (2013); World Bank (2009); UNAIDS (2009) and Global Fund et al. (2006) emphasize the importance of periodically assessing the status of an organization's M&E system so as to establish how the system is working (or not) and identify areas of improvement.

#### **1.6. Limitations and Scope of the Study**

There is no literature on which score of an M&E system can be graded as 'good', 'excellent' or 'poor'. For instance, if a system scores 50 percent, there is no literature indicating whether this should be graded as 'good' or 'poor'. Literature on M&E system assessments focuses on how each component can be improved and areas to focus on during M&E system strengthening process. In addition, conducting data verification on all the indicators was not possible due to time constraints.

The study covered three sites i.e. Kisumu, Eldoret and Kakamega. It focused on assessing the M&E system of FHOK rather than other organizational level systems. The study assessed the M&E system of FHOK in line with the 8 domains that are recommended by FHI 360 (2013).

## **CHAPTER TWO: LITERATURE REVIEW**

### **2.1. Introduction**

This chapter reviews past literature on M&E systems. Specifically, the chapter focuses on the relevance of an M&E system, M&E system components and assessment of M&E systems. Additionally, the chapter provides the conceptual framework and the operational framework.

### **2.2. Relevance of an M&E System**

An M&E system is critical to carrying out a project/ programme effectively and efficiently and boosting accountability to beneficiaries, donors and other stakeholders (FHI, 2012). FHI 360 (2013); Hiller (2002); Kusek and Rist (2001); Levesque et al. (1996); World Bank (2009); UNAIDS (2009); Mackay (2007); Mayne (1997); Mayne and Goni (1997); McCoy et al. (2005); Nath (2007) and Global Fund et al. (2006) concur on the fact that an M&E system helps an organization to: determine if a project/programme is on-track, on-time and on-target; ensure that funds were used as intended and that the project/programme was implemented as planned; establish whether a difference was made by the project/programme.

World Bank (2009); AfrEA (2006); OECD (2003) and Liket et al. (2014) observe the constant and growing pressures on governments and organizations around the world to be more responsive to demands from internal and external stakeholders for good governance, accountability and transparency, greater development effectiveness and delivery of tangible results. World Bank (2009) and UNAIDS (2009) agree that governments, parliaments, citizens, the private sector, non-governmental organizations, civil society, international organizations and donors are all among stakeholders interested in better performance. As demands for greater accountability and results have grown, there is an accompanying need for useful and useable results-based monitoring and evaluation systems to support the management of policies, programmes and projects (World Bank, 2009; UNAIDS, 2009, Global Fund et al., 2006; Karani et al., 2014 and Odhiambo, 2000).

Development initiatives that yields most positive change on the lives of the people is identified and promoted by M&E systems (Thomas, 2010). For this reason, Thomas (2010) notes, positive development outcomes can be promoted by strong M&E systems and vice versa. Odhiambo

(2000) notes that the importance of M&E function within institutions has been magnified by the rapidly growing voice of the civil society with questions of good governance and better administration being in the limelight (Odhiambo, 2000). Odhiambo (2000); AfrEA (2006); Kusek and Rist (2001); Mackay (2007) and McCoy et al. (2005) observe that, globally, there is a paradigm shift towards more transparent, accountable and effective governments and this has bolstered the need for stronger M&E systems. Karani et al. (2014) adds that, over the years, the importance of M&E has been elevated due to the stagnant and/or negative economic growth as more and development actors question the usefulness and effectiveness of development efforts.

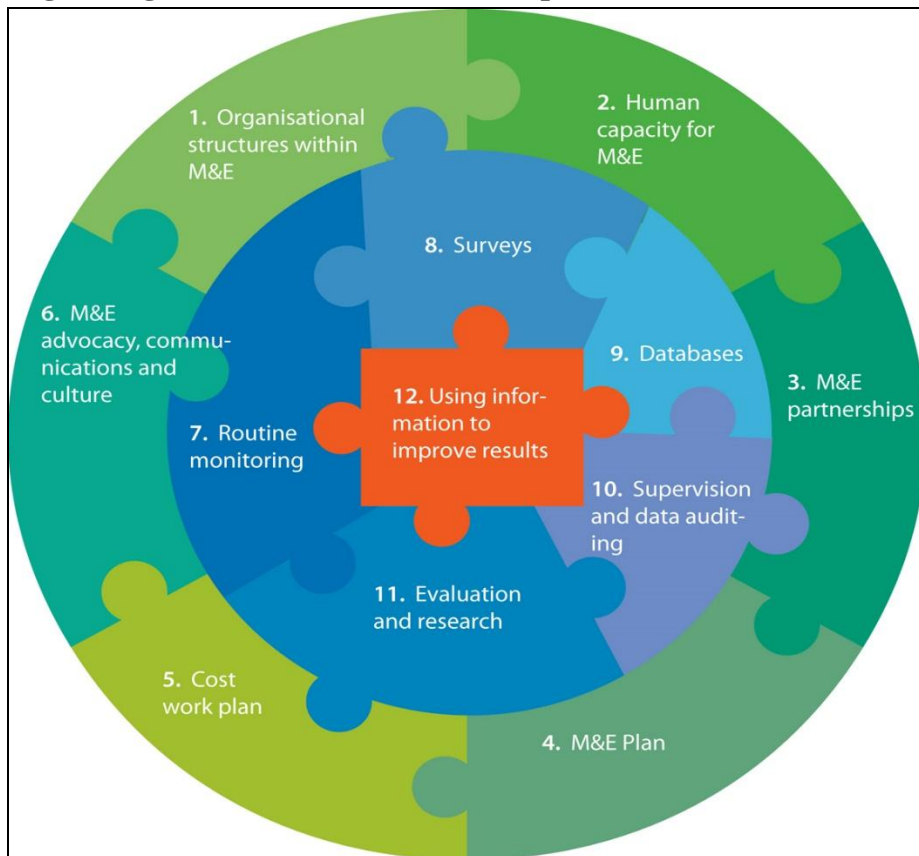
### **2.3. M&E System Components**

According to the Global Fund et al. (2006); UNAIDS (2008) and World Bank (2009), an M&E system is defined as a collection people, procedures, planning and data that interact to provide timely information that is integral in management of projects, programmes and policies. On the basis of this, an M&E system can be defined as an interaction of all indicators, tools and processes that are used to measure if a project/programme has been implemented according to plan and is achieving the desired results. Contrary to common understanding, setting up an M&E system is more than just building a spreadsheet or database. Setting up an M&E system entails having M&E staff, data collection tools, M&E capacity building plans, M&E plan, indicators, M&E database, advocacy and communication plan for M&E among other components as recommended by UNAIDS (2008) and World Bank (2009).

Applying the system's thinking, World Bank identified a total of eleven essential components of a functioning M&E system. A twelfth component was added following international peer review. World Bank (2009) adapted what UNAIDS (2008) refers to as 12 Components of a functional M&E System as shown in Figure 1 below. UNAIDS (2008) and World Bank (2009) categorize the 12 Components into three main areas: Components relating to people, partnerships and planning (Structure and organizational alignment for M&E systems; Human capacity for M&E systems; M&E partnerships; M&E plans; Costed M&E work plans; Advocacy, communication, and culture for M&E systems), Components relating to collecting, capturing and verifying data (Routine monitoring; Periodic surveys; Databases useful to M&E systems; Supportive

supervision and data auditing; Evaluation and research) and Component relating to data use in decision making (Using information to improve results).

**Figure 2.1: Organizing Framework for the 12 Components of a Functional M&E System**



Source: UNAIDS (2008)

According to UNAIDS (2008) and World Bank (2009), components at each level are strongly linked to form a sub-set. The 12 components have been categorized in three broad areas i.e. those related to people, planning and partnerships; components related to data and information and lastly, the twelfth component which is related to use of information.

***Components related to People, Partnerships and Planning***

Components in the outer ring represent the first sub-set that relates to people, partnerships and planning that support data production and data use constitute the enabling environment for M&E to function. World Bank (2009) sums it up as follows: People (Component 1) who are skilled

(Component 2) and work together (Component 3) to plan (Component 4), budget and cost (Component 5), motivate for and maintain a functional M&E system (Component 6). UNAIDS (2008) elaborates that the outer ring represents the human resources, partnerships and planning to support data collection and data use which includes individuals, organizations, functions/actions and the organizational culture that are fundamental to improving and sustaining M&E system performance.

### ***Components related to Data and Information***

UNAIDS (2008); World Bank (2009) and UNAIDS (2009) goes on to present the second sub-set that entails components in the middle ring which represent the next five linked components related to data management processes that involve M&E data collection, capture, and verification. This ring of components generates the data that are essential to the M&E system just as fuel is for an engine (World, 2009). An M&E system cannot be operational unless there is generation of data. The middle ring focuses on the mechanisms through which data are collected, verified and transformed into useful information (UNAIDS, 2008; UNAIDS, 2009).

### ***Components related to Use of Information***

The third, and last, sub-set can be traced in the inner ring which captures the system's central purpose of analyzing data in order to create information that is disseminated as a means to inform and empower decision making at all levels. This final component of the M&E system is red as it represents the bull's eye in making and keeping an M&E system functional (UNAIDS, 2008; World Bank, 2009). If we are not using data and information from M&E systems, we are not using these systems in the way they were designed. UNAIDS (2008) sums it up: the central purpose of an M&E system is to provide information and use it to improve our projects, policies and programmes.

According to UNAIDS (2009), the 12 components are not twelve implementation steps. They are not intended to be implemented sequentially; however, they should all be present and working to an acceptable standard in order for the M&E system to function effectively. Depending on resource availability, countries may need to focus on a few of the components at the outset and

phase-in M&E investments over time to get all of the system components operational (UNAIDS, 2008). UNAIDS (2008) and UNAIDS (2009) puts emphasis on the importance of building on what systems and capacity already exist and addressing the issues of human resources/capacity and functioning partnerships to support the collection of good quality data. Most importantly, it is crucial not to lose sight of the ultimate purpose of M&E which is: using data for decision-making. It is a waste of valuable resources to collect data that are not used.

#### **2.4. Assessment of M&E systems**

FHI 360 (2013); World Bank (2009); UNAIDS (2009) and Global Fund et al. (2006) reiterate the need to periodically assess M&E systems at national, organizational and/or programme/project level to enable stakeholders in M&E to identify strengths and weaknesses in the current system and recommend actions to maintain its strengths and improve its weaknesses. As noted by Karani et al. (2014), the importance of M&E is increasingly and rapidly being recognized as stakeholders in development question the usefulness and effectiveness of development efforts. As a result, most organizations have developed M&E systems to enable them measure performance of their development interventions.

FHI 360 (2013) recognizes the expected outcome of a functional M&E system as not only production of high quality data but also ensuring that the necessary human and financial resources, infrastructure, equipment and supplies and capacity of the underlying system are in place to support the production, analysis and use of data. As such, improving the quality and effectiveness of an M&E system is critical (FHI 360, 2013). With this in mind, organizations such as World Bank, UNAIDS, The Global Fund and FHI 360 have invested in M&E system assessment. Tools such as Monitoring and Evaluation Systems Strengthening Tool (Global Fund et al., 2006), Participatory Monitoring and Evaluation System Assessment Tool (FHI 360, 2013) and 12 Components Monitoring and Evaluation System Strengthening Tool (UNAIDS, 2009) have been developed to guide this important component.

The above M&E system assessment tools have been used to assess national and organizational M&E systems. In 2013, FHI 360 developed a Participatory Monitoring and Evaluation System



Assessment Tool through FHI 360's Technical Quality and Technical Assistance Initiative and Programme and Technical Quality Assessments (PTQAs) with input from a number of individuals within FHI 360 (FHI 360, 2013). FHI 360 M&E teams from programmes and projects from FHI 360 Ethiopia, FHI 360 Kenya, FHI 360 Mozambique and FHI 360 Ghana piloted the tool that is applied to the organization to continuously assess and improve her M&E system. The tool used by FHI 360 is based on the Organizing Framework for the 12 Components by UNAIDS (2008). It is a generic tool developed as a diagnostic exercise for programmes and projects to critically examine their M&E systems, identify areas performing well and critical gaps and develop a quality improvement plan to maintain strengths and overcome weaknesses in their M&E system (FHI 360, 2013).

Ogungbemi et al. (2012) assessed Nigeria's national HIV M&E system using 12 Components Monitoring and Evaluation System Strengthening Tool by UNAIDS (2009). The M&E assessment used a participatory and qualitative approach that allowed for discussion, reflection and consensus building. The main activity of the assessment process was the completion of the 12 components tool by stakeholders to serve as a springboard for discussion and strategic planning and help build commitment to improving M&E system performance. The assessment employed three critical steps: the pre-assessment desk review, consultation with key stakeholders and the stakeholders' M&E assessment workshop.

In 2013, World Bank's Independent Evaluation Group (IEG) assessed M&E systems of International Finance Corporation (IFC) and Multilateral Investment Guarantee Agency (MIGA). IEG used multiple instruments in this evaluation: desk reviews of policies and procedures, a sample of project-level M&E data, various internal databases, internal memos and strategic documents, and interviews and surveys of staff and management (IEG, 2013). IEG (2013) asserts that these sources meet the evaluative inquiries targeted to particular business segments and M&E characteristics. IEG compared existing M&E policies, procedures and practices with established standards such as the Good Practice Standards for private sector evaluation of the Evaluation Cooperation Group (ECG) for multilateral development banks (ECG, 2011).

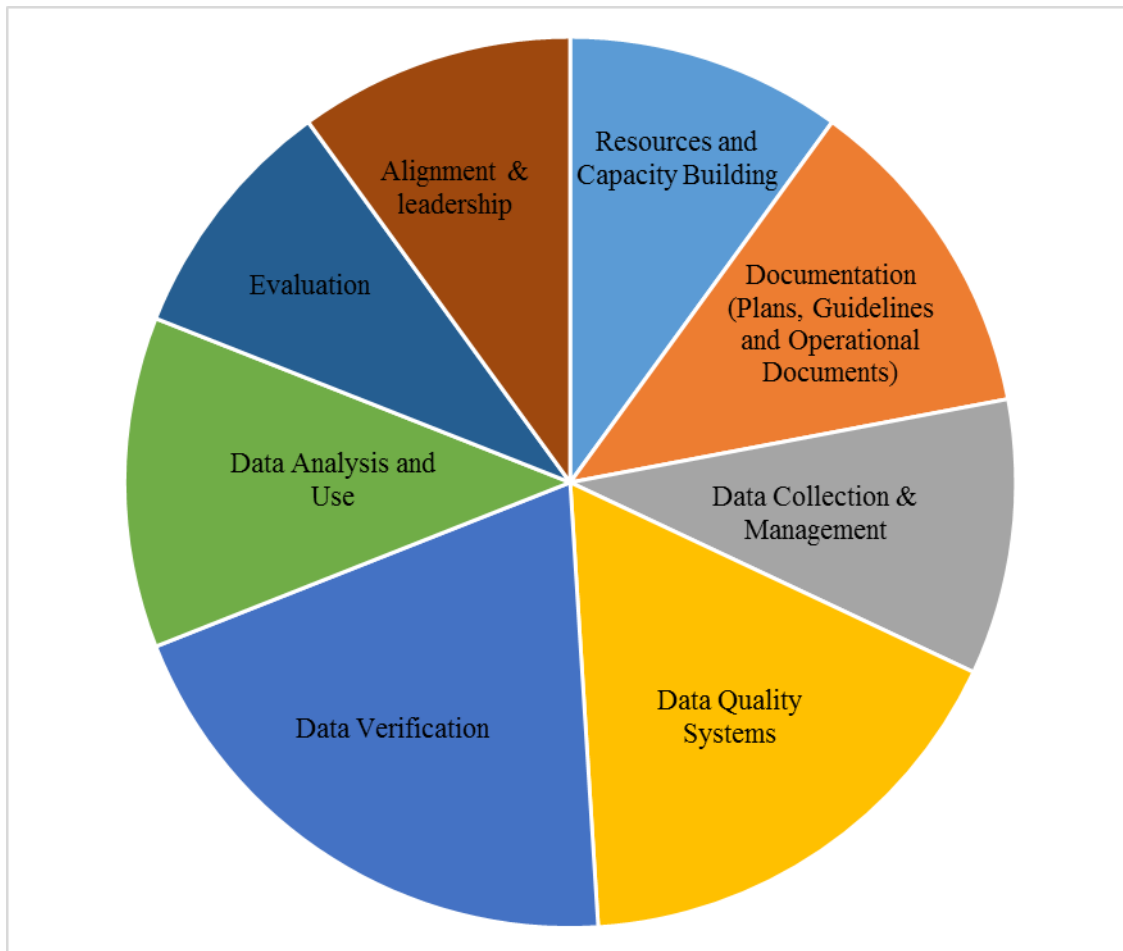
In August 2010, the United States Agency for International Development (USAID) assessed Kenya's national Monitoring and Evaluation and Health Management Information System (HMIS). The assessment entailed document review, site visits and interviews with over 100 people. The team evaluated the overall strengths and weaknesses of the national M&E system and HMIS as well as the multi-faceted challenges surrounding the two.

In June 2008, the Health Information System of Kenya was assessed by the Health Metrics Network (HMN). The assessment was based on the Health Metrics Network assessment tool which takes into account views of Health Information System (HIS) producers and users of health information. This entailed independent assessment of 6 different components of HIS in Kenya to include: resources, core indicators, data sources, data management, information products and dissemination and use of information. The steering committee identified 8 clusters from different organizations collecting and using health information. A team of at least three officers comprising of Health Records and Information Officers, Information Communication Technology (ICT), one doctor from Ministry of Health and Demographer/Statistician from Central Bureau of Statistics carried out the assessment in 7 out of 8 clusters selected. Focus Group Discussions were used with meetings organized by participants in their institutions. This was used as a learning process for both the participants and teams administering the tool. Each question was discussed in-depth and scored. The process was agreed by the teams and the scoring was given as one score for the group.

## **2.5. Conceptual Framework**

The study is informed by the 8 domains recommended by the Participatory M&E System Assessment Tool by FHI 360 (2013) which is based on the Organizing Framework for the 12 Components by UNAIDS (2008). Figure 2 below presents the conceptual framework.

**Figure 2.2: Conceptual Framework**



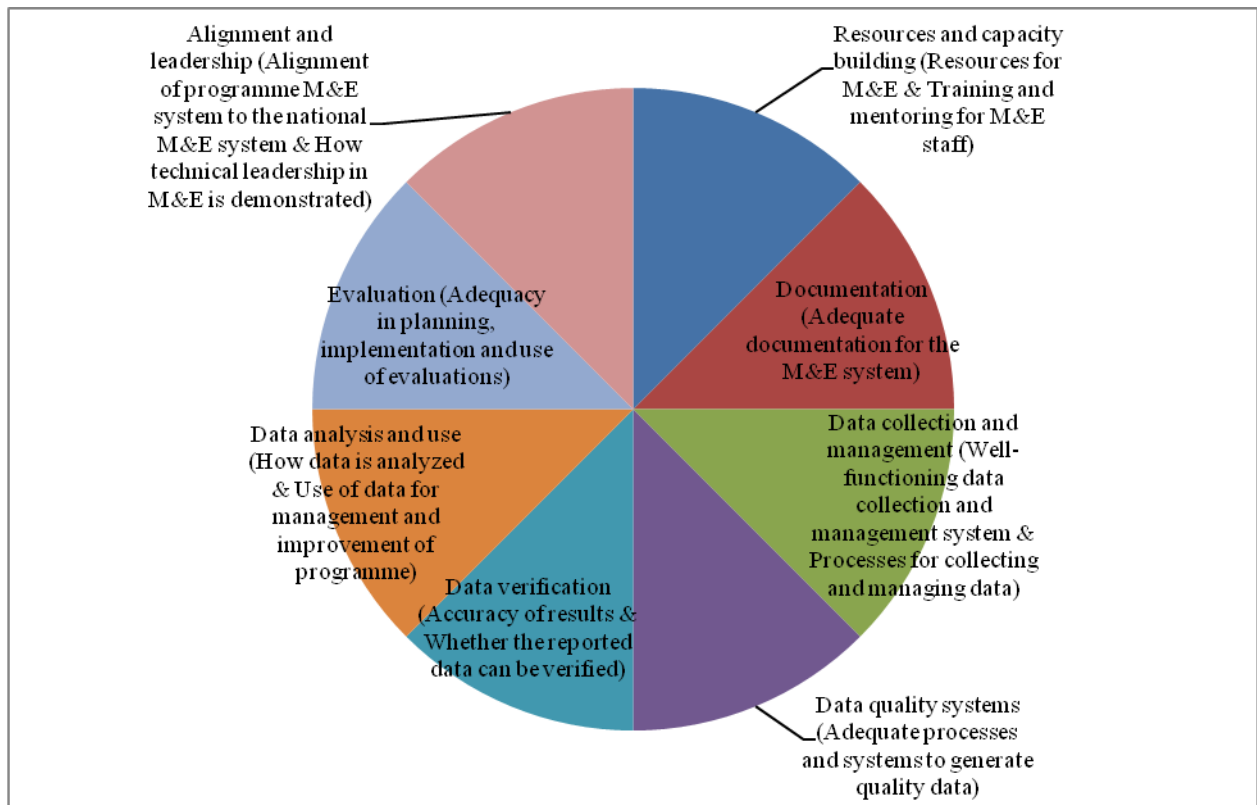
Source: FHI 360 (2013)

For programme-level use, FHI 360 (2013) condenses the 12 components into 8 domains which are applicable at an organizational and project/programme level: resources and capacity building; documentation (plans, guidelines and operational documents); data collection and management; data quality systems; data verification; data analysis and use; evaluation; and alignment and leadership. It is against the above framework that FHI 360 (2013) provides a generic tool developed as a diagnostic exercise for programmes and projects to critically examine their M&E systems, identify areas performing well and critical gaps and develop a quality improvement plan to maintain the strengths and overcome weaknesses in their M&E system.

## 2.6. Operational Framework

The operational framework of the study was adapted from FHI 360 (2013). Specifically, for each of the 8 domains, the assessment focused on a number of standards as shown in Figure 3 below. The assessment operationalized this operational framework focusing on specific standards for each of the 8 domains recommended by FHI 360 (2013).

**Figure 2.3: Operational Framework: Modified from FHI 360 (2013)**



## **CHAPTER THREE: DATA AND METHODS**

### **3.1. Introduction**

This chapter provides methods that were used to assess FHOK M&E system. Specifically, it covers data sources, research design, target population and study sites, sampling procedures, data collection methods and tools, operationalization of variables, data analysis methods and ethical considerations.

### **3.2. Sources of Data**

The assessment used data from both primary and secondary sources. Primary was collected from M&E Officers, Programme Managers and Coordinators, Centre Managers, service providers and field coordinators. Secondary data was collected from service statistics reports, project reports, FHOK Strategic Plan, internal reports and past literature.

### **3.3. Research Design**

The assessment employed descriptive research design. Descriptive research is used to obtain information concerning the current status of a phenomenon and to describe what exists with respect to conditions in a situation (Nath, 2007; Shamoo and Resnik, 2003). In other words, descriptive research design primarily describes what is going on or what exists (Luz, 2006; World Bank, 2009). Descriptive research design was used since it allowed for description of FHOK M&E system as it is and helped to establish strengths and gaps which was fundamental to the realization of research objectives.

According to World Bank (2009) the framework of the 12 Components can be used to assess the status of an organization's M&E system by assessing in a systematic way, the status of each of the 12 Components of the organization's M&E system. FHI 360 (2013) provides a Participatory M&E System Assessment Tool which is based on the Organizing Framework for the 12 Components by UNAIDS (2008). This is a generic tool developed as a diagnostic exercise for programmes and projects to critically examine their M&E systems, identify areas performing well and critical gaps and develop a quality improvement plan to maintain strengths and overcome weaknesses in their M&E system (FHI 360, 2013). For programme-level use, FHI 360 (2013) condenses the 12 components into 8 domains namely: resources and capacity building;

documentation (plans, guidelines and operational documents); data collection and management; data quality systems; data verification; data analysis and use; evaluation and alignment and leadership.

Ogungbemi et al. (2012) used a participatory and qualitative approach to assess Nigeria's national HIV M&E system in line with the 12 Components recommended by UNAIDS (2008). The assessment of FHOK M&E system adapted the same participatory approach used by Ogungbemi et al. (2012) which allowed for discussion, reflection and consensus building. The assessment also adapted the same approach used by World Bank's IEG to assess M&E systems of IFC and MIGA i.e. multiple instruments to include: desk reviews of policies and procedures, a sample of project-level M&E data, various internal databases, internal memos and strategic documents and interviews and surveys of staff and management. From a review of FHOK M&E system, it was evident that the 8 domains presented by FHI 360 (2013) are applicable to the former. For this reason, the diagnostic tool provided by FHI 360 (2013) was adapted since it provides 8 key domains which are applicable to FHOK programme-level M&E system.

### **3.4. Target Population and Study Sites**

The target population was FHOK programme-level M&E system that covers a total of 15 projects which are implemented through 17 service delivery sites. The service delivery sites are segregated into four service delivery points namely: static clinics, outreach sites, associated clinics and community based distribution of FP information and services. It is important to note that most of the projects are implemented in more than one service delivery site whereas some are implemented in only one site and hence there is a situation of overlaps in implementation and service provision. All projects contribute to the overall performance in service provision numbers.

Using sampling procedures presented in 3.4. below, three study sites were selected to include Kisumu, Eldoret and Kakamega. The study sites were purposively selected since about 70 percent of the projects are implemented in them and they produce more than 40 percent of service statistics. In addition, the head office was also involved in the study since this is the point

of convergence and policies and procedures are designed at the head office and the same communicated to the service delivery sites.

### **3.5. Sampling Procedures**

The assessment was based on data collected from three sites as recommended by FHI 360 (2013). The sites that were purposively sampled include Kisumu, Eldoret and Kakamega. FHI 360 (2013) recommends that the assessment sites should be sampled purposively on the basis of high volume data and priority. In addition, the assessment used 5 indicators as recommended by FHI 360 (2013) for the data verification component. The indicators include: 1.) number of women screened for cervical cancer using VIA/VILI, 2.) number of women aged 30-39 years screening for cervical cancer using VIA/VILI, 3.) number of VCT services provided to clients aged 10 to 24 years, 4.) number of counseling services provided to clients aged 10 to 24 years, and 5.) number of condoms distributed to clients aged 10 to 24 years. Indicators to focus on during data verification were sampled purposively depending on the service delivery channel and amount of data as evidenced in the service statistics reports. Purposive sampling was also used to select respondents from the programme implementation team to take part in the assessment. The respondents included: 1 M&E Manager, 2 M&E Officers, 4 Project Managers, 4 Field Coordinators, 3 Centre Managers and 3 service providers (17 respondents in total).

### **3.6. Data Collection Methods and Tools**

#### **3.6.1. Documents/Records Review**

A documents/records review process was employed to review the M&E framework, project indicator matrices, project reports, service statistics, data collection tools, minutes and electronic Clinic Management Information System (eCMIS) among others. A document/ record review guide (*See annex 1*) with guiding questions was used to guide the review process.

#### **3.6.2. Discussions with Key Informants**

Discussions were held with key informants such as M&E Officers, Programme Managers and Coordinators, Centre Managers, service providers and field coordinators. A discussion guide (*See annex 2*) with guiding questions was used to guide discussions with the above key

informants. Information from the key informants was used to score each of the eight components.

### **3.6.3. Observation**

Observation was also used to observe practical aspects of M&E such as the use of the eCMIS (also known as SmartCare system) and records keeping. An observation checklist with guiding questions (*See annex 3*) was used to guide this process.

### **3.7. Operationalization of Variables**

In the M&E System Assessment Tool provided by FHI 360 (2013), each of the 8 domains is broken down into a number of standards. Each standard was scored basing on information gathered from existing documents and key informants. Specifically, the scoring process entailed scoring each relevant standard on a scale of 0 to 2, where:

0 = standard is not met;

1 = standard is partially met; and

2 = standard is fully met.

Where the standard was not applicable or not available for review purposes, there was an option for indicated N/A (not applicable) and as such, the standard was not included in scoring the relevant domain.

The above enabled overall weighting of each of the 8 domains. The overall weighting was determined by the number of applicable standards within each of the 8 domains. The maximum score for the 8 domains was 240. Maximum scores for each of the 8 domains was 16 (resources and capacity building), 30 (documentation), 26 (data collection and management), 42 (data quality systems), 50 (data verification), 28 (data analysis and use), 24 (evaluation) and 24 (alignment and leadership).

Once each standard was scored, remarks were made in a separate column to provide basis for each score. This is where information gathered from the key informants, observation and documents was entered to provide the rationale for each of the score.



### **3.8. Data Analysis**

Both quantitative and qualitative data analysis techniques were used in the assessment. Scores for each of the eight domains were entered into MS Excel 2013 (Microsoft Corporation, Redmond, USA) spreadsheet for analysis. Once the domains were scored, percentages, a table and charts were automatically generated by the tool to display the quantitative results of the analysis.

Qualitative data analysis was conducted using thematic analysis. Specifically, emerging themes were identified from qualitative data collected from discussions, observations and existing documents. This information was used to support each of the score for each standard that was assessed.

### **3.9. Ethical Considerations**

Ethical consideration is critical in ensuring credibility of and confidence in the study results. For this reason, ethical protocols and principles highlighted by Belmont (1979); FHI (2001); Bosnjak (2001); Pimpe (2002); Shamoo and Resnik (2003); Czech Republic (2006) and Resnik (2007) were employed to ensure that respondents were provided with: the choice to participate or not to participate in the study; an understanding of why the study was being carried out, the possible positive outcomes associated with the study, and the possible negative outcomes associated with the study; a clear understanding of the possibility that there will be no individual impact of the study; the knowledge that they were free to withdraw from the study at any point during the process; the knowledge that they were free to refuse to answer any questions they do not want to answer; and the reassurance that their answers would be strictly confidential and will not be attributed to any particular individual. It was determined that no approvals were needed from ethical clearance bodies due to the nature of the study.

## **CHAPTER FOUR: FINDINGS AND DISCUSSIONS**

### **4.1. Introduction**

This chapter provides a presentation of study results in line with the objectives. The results have also been discussed in this section. The chapter begins by providing the status of FHOK M&E system as assessed using Participatory M&E System Assessment Tool by FHI 360 (2013). The chapter then presents and discusses strengths and gaps of the M&E system of FHOK. Finally the chapter presents and discusses how the products of the M&E system of FHOK have been used to improve the programme.

### **4.2. Status of FHOK M&E System**

Table 1 below shows the summary of scores of the assessment. Overall, FHOK M&E system scored 148 out of 240 which is 62 percent. As shown in Table 1 below, the overall maximum score was 240. Scores vary from component to component with data analysis and use and evaluation (a tie) scoring the highest at 79 percent and documentation recording the lowest score at 43 percent. FHI 360 (2013) provides this tool for assessment of M&E systems to be used as a basis for continuous improvement of M&E systems. Hence, the assessment score should be used as a basis for improvement with a focus on specific areas that need to be addressed. Scores for each of the 8 domains are presented in the annexes and the supporting information that was gathered from the KIIs, documents review and observation are presented in Annex 4.

**Table 4.1: Summary Assessment Scores**

| Component  | Score        |               |            |
|--|--------------|---------------|------------|
|  | Actual Score | Maximum Score | Percentage |
| 1. Resources and capacity building                             | 11           | 16            | 69%        |
| 2. Documentation (Plans, guidelines and operational documents) | 13           | 30            | 43%        |
| 3. Data collection and management                              | 15           | 26            | 58%        |
| 4. Data quality systems  | 29           | 42            | 69%        |
| 5. Data verification   | 25           | 50            | 50%        |
| 6. Data analysis and use                                       | 22           | 28            | 79%        |
| 7. Evaluation  | 19           | 24            | 79%        |
| 8. Alignment and leadership                                    | 14           | 24            | 58%        |
| <b>TOTAL</b>   | <b>148</b>   | <b>240</b>    | <b>62%</b> |

### 4.3. Strengths and Gaps of FHOK M&E System

The assessment sought to identify the strengths and gaps of FHOK M&E system. Specifically, this was done in line with the 8 domains that the assessment focused on. Looking at the strengths and gaps of each domain will be critical in identifying strengths that can be capitalized on and gaps that need to be addressed to continuously strengthen FHOK M&E system.

#### 4.3.1. Resources and Capacity Building

As shown in the table above, out of the possible 16 points, this component scored 11 points which is 69 percent. In 2015 financial year, the overall M&E budget (Kshs. 14,039,761.22) accounted for 8 percent of the overall programme budget (Kshs. 184,923,773.25) which was an excellent case as it was within the recommended 5 to 10 percent. There are two M&E Officers

responsible for the projects. One of them is the Acting M&E Manager following resignation of the M&E Manager. Plans are underway to fill in the position of M&E Manager. Both M&E Officers are well versed in data analysis and management information systems. However, there is need to continuously strengthen the capacity of the team in the areas of evaluation and research.

Members of the M&E team have received initial orientation on the organization's M&E system. This is done during orientation on data collection, collation, analysis, supportive supervision and reporting among other things. However, a written procedure does not exist for orienting new staff on the M&E system in case of staff turnover.

It was worth observing that the two M&E Officers report to non-M&E staff and yet there is an M&E Manager who coordinates M&E work. At times, critical M&E work such as standardization of tools and harmonization of databases is not well coordinated and at times there are overlaps since the M&E Manager does not have the authority to detect and proactively address this.

Trainings and other capacity building initiatives on various components of FHOK M&E system takes place on a needs-basis and in most cases, this is facilitated by International Planned Parenthood Federation (IPPF) through review meetings, technical assistance missions, conferences and meetings.

Supervision of the M&E team is usually done by the Director of Resource Mobilization (DRM). This is done through review of reports, service statistics and workload among others. On the other hand, the M&E team conducts supportive supervision to clinics to conduct data verification, mentor field teams in data collection, data analysis and data use. The team also provides continuous training to field teams on data collection and reporting tools and guides them on how they can use data in decision making, particularly in improving their work and tracking targets.

#### **4.3.2. Documentation (Plans, Guidelines and Operational Documents)**

At 43 percent, documentation scored the lowest of all the 8 domains that the assessment focused on. FHOK has an M&E Framework that guides M&E practice in the organization. However, the M&E Framework is not updated. It is not clear when the M&E Framework was developed. Plans are underway to review the M&E Framework. However, this is pending finalization of the Strategic Plan which is currently being developed.

Guidelines on most of the reporting requirements are contained in the M&E Framework. However, FHOK projects and sites (including Programme Managers) do not have a copy of the M&E Framework. Instead, what they have are email communications on reporting requirements, specifically on what to report on, due dates, data sources, report recipients etc.

Whereas supervision takes place to projects and implementation sites, the procedures for the same are not documented. Specifically, supervision procedures are not documented in writing on how often supervision is done, what to look at, what happens next etc. Documentation of supervision procedures is critical in ensuring that knowledge is stored and that there is a common approach to the supervision.

It was important to observe that targets for key performance indicators are set on annual basis and regularly reviewed. Specifically, targets are set using a bottom-up approach for clinics. The clinics set their targets during Annual Programme and Budget (APB) which are then discussed and synthesized at the APB planning meetings. The APB is a document prepared by all IPPF Member Associations (MAs) on an annual basis presenting all projects (and their respective budgets) for the following year. Each project in the APB has a summary, a log frame with objectives and activities with corresponding results and process indicators and a budget. Project specific targets are set in negotiation with donors and then they are distributed to the project implementation sites. However, some service delivery sites do not have targets that they are working towards.

For each project, the APB provides a description of activities and respective key process indicators. It also presents key strategic objectives and respective results indicators for the same. The M&E Framework does not have key performance indicators that should be tracked. Specifically, the M&E Framework does not have a results framework linking programme goals to intermediate results and outcomes or outputs. This is necessary since it provides a clear link of results hence making it easier to track performance and adjust programmes where necessary.

The M&E Framework does not have an organogram describing the organization of the M&E unit in relation to the overall programme team. As a matter of fact, the M&E structure is not presented in the M&E Framework and only appears in the larger organizational organogram with only one position of the M&E Manager hence excluding project M&E officers from the organogram.

A matrix exists in the M&E Framework that has data sources, methods, reporting frequency and timelines, staff responsible and audience analysis. However, a number of important elements are missing, notably, indicators, annualized and cumulative targets. It is important to note that indicators and targets are contained in the APBs. However, key performance indicators and respective targets that are in line with the Strategic Plan objectives were missing.

During the assessment period, an up to date implementation timeline for M&E activities was available in the APB indicating persons responsible for each activity, including any M&E-related roles for the programme/technical staff. Key activities such as data verification exercises and supportive supervision were included in the annual work plan. However, specific documented monthly and quarterly work plans were not available.

All the implementing sites use a standard reporting template. In addition, the M&E Framework has a data flow chart that clearly demonstrates how data reaches the head office through to the donor and Ministry of Health (MOH). Feedback mechanisms have also been provided for in the data flow chart in the M&E Framework. However, there was no documented confidentiality protocol available for personal records.

### **4.3.3. Data Collection and Management**

The assessment noted that data collection tools include all required programme indicators hence enabling those collecting data to capture all the required information. In addition, there is minimal duplication in data collection requirements for staff, i.e. they are not required to report the same activity on more than one tool. This essentially reduces workload on the part of staff collecting data. However, data management and back up procedures were not documented to guide these critical aspects.

Historical data is properly stored, up to date and readily available. Specifically, historical information is stored in the library which is located at the head office whereas at the clinic level, clients records are well stored and easily retrievable. Records stored in SmartCare system are well protected since users have access restrictions. However, for hardcopy records, most of these are not stored under lock and key which presents possible risk of unauthorized access.

The programme has two main electronic M&E databases i.e. SmartCare and electronic Information Management System (eIMS). SmartCare is regularly updated with a provision to continuously include new indicators. However, the eIMS is only updated during reporting and APB periods. New projects are only entered into the eIMS during reporting and APB periods and at times, the reports are not fully updated. There is adequate in-house capacity for the programme database so that it can be modified by one or more staff. However, for SmartCare, most of the technical programming aspects are handled by Intersoft Technologies whereas IPPF Africa Region and Central Office handles technical aspects of the eIMS.

The number of data collection tools is sufficient for programme needs and not excessive. The data collection tools in SmartCare are aligned to MOH tools and donor needs. Where need arises, MOH tools are used, notably in the VCT rooms and the laboratories. Data from project implementation sites and clinics is disaggregated by sex and age to guide decision making at all levels.

The M&E team has provided a data entry database for summarizing data on a daily basis. In most cases field level data entry occurs immediately or shortly after service provision to limit recall bias. However, due to heavy work load, this is done at the end of the month.

Where client-level personal information is collected unique codes are used to protect the confidentiality of clients. As indicated earlier, access to client information is restricted in SmartCare where users have accounts with restriction to access client information. However, for hard copy records, most of the client records are stored in shelves at the reception and not under lock and key which presents a risk of possible unauthorized access.

In most cases, safeguards are place to guard against unauthorized changes to data. For SmartCare system, client data on services provided cannot be edited after midnight. For eIMS, changes to project data is not controlled but one can tell the user who last modified what project. For hardcopy data, there are clear safeguards on the same.

#### **4.3.4. Data Quality Systems**

Indicators are aligned to MOH, donor and IPPF indicator requirements. Definitions and interpretations of indicators are followed consistently when transferring data from front-line instruments to summary formats and reports. Specifically, this is the case for reports that are drawn from SmartCare. However, for outreach data, this is not fully the case. The outreach forms for IPPF data use inferences in reporting e.g. STI indicators are reported as just treatment but in the IPPF format, treatment is also translated into STI counseling and STI consultation. Precisely, mapping of FHOK services with IPPF services is encouraged so as to avoid increasing work load on the part of service providers.

Quality control largely takes the form of review of data and data verification exercises. Specifically, for IPPF reports, the Centre Managers review the data submitted by service providers before submission to head office. For project reports, data from the field is submitted directly to the project M&E Officer who reviews and submits to the project manager/coordinator. However, in some cases, project data is sent directly to the project manager/coordinator who



reviews the same. Once reviewed, data is compiled at head office and shared with DRM and/or DCS depending on the project and then submitted to the donor. From the field supervision reports, cases of data reviews not being conducted, notably at the clinic level were noted. This is largely attributed to workload and inadequate capacity by those concerned to do the same.

At the service delivery level, written guidance on filling in data collection tools is evident to some extent. Specifically, MOH registers and FHOK Daily Activity Register (DAR) have clear guidelines on data collection. However, most project data collection tools (including SmartCare forms) do not have guidelines to guide data capture.

Steps are taken to minimize calculation errors. In the SmartCare system, most reports are automated i.e. the system is programmed to compile the reports on a daily, monthly, quarterly, annually and custom basis hence minimizing the risk of calculation errors. There is database for IPPF reports and also individual project databases in Microsoft Excel where data is copied from field reports and merged into one single work sheet for all sites using automated functionality of MS Excel.

There is a clear link between fields on data entry forms and summary or compilation formats to reduce transcription error. For SmartCare data, this is taken care of since reports are generated automatically from the system. The same happens during transfer of outreach summary data to the IPPF formats and project reports. In addition, the number of transcription stages (manual transfer of data from one form to another) are minimized to limit transcription error.

There are systems in place to minimize and/or adjust for double counting. Specifically, SmartCare system identifies clients by unique codes. However, if a client goes to another site, they are captured afresh which brings the risk of being counted twice. For outreach data, there is no system for avoiding this to minimize double counting.

To some extent, systems are in place for detecting missing data. Reports from the SmartCare system have identifiers for missing data which is shown as 'default'. This is automatically

generated from the electronic system to help detect missing data. However, for data collected manually, there is no system for detecting missing data.

Standard forms and tools are used consistently within and between service delivery sites. However, the observation made during data verification and in field supervision reports was that there were cases of some sites using data collection forms and summary forms that are different from the approved versions.

At least once a year programme and/or technical staff (with or without M&E team) review completed tools at site level for completion, accuracy or service quality issues. However, this is not the case across sites as noted in field supervision reports.

A review of registers and reports, it emerged that data collection tools were not filled in completely and correctly. This had also been noted in internal field supervision reports and in the donor-commissioned DQA report by Khulisa Management Services Inc. on behalf of Bill and Melinda Gates Foundation for the CCS&PT programme.

In terms of timeliness, all donor reports are submitted on time to the donor and they correspond with donor-specified report periods. However, specific site reports are not always submitted on time which eats into time for review of the same before being submitted to the donor.

Feedback is provided to all service delivery points on the quality of their reporting in a timely manner. This is largely done via email but also during project review meetings, field supervision visits and during Annual Programme and Budget review and planning process.

There was no evidence that corrections have been made to historical data following data quality assessments. After data quality assessments, the focus is usually on improving future data collection and reporting efforts and not on revising data collected previously since the data would already have been submitted to the relevant offices.

It was noted that most of the implementation sites were reporting on all required indicators. However, some sites were reporting on critical indicators such as cryosurgery and counseling services and yet data on the same was being collected. This was due to oversight on the part of service providers. In some cases, data on some indicators was not being reported since it was not being captured.

There was evidence that supervisory site visits were made in the last 12 months preceding the assessment where data quality had been reviewed. The visits largely focused on CCS&PT project, Access, Services and Knowledge (ASK) project, Global Comprehensive Abortion Care Initiative (GCACI) project among others. As earlier noted, there was evidence that field-level supervisors review data from field workers before it is finalized and passed on to the head office. However, this was not the case for all the implementation sites with reasons of heavy work load carrying the day since the Centre Managers double up as service providers.

#### **4.3.5. Data Verification**

Data verification was conducted by going back to raw data and recounting the following indicators: 1.) number of women screened for cervical cancer using VIA/VILI, 2.) number of women aged 30-39 years screening for cervical cancer using VIA/VILI, 3.) number of VCT services provided to clients aged 10 to 24 years, 4.) number of counseling services provided to clients aged 10 to 24 years, and 5.) number of condoms distributed to clients aged 10 to 24 years. Overall, this component scored 25 out of 50 possible points which is 50 percent.

Two indicators (no. of women screened for cervical cancer using VIA/VILI and no. of women aged 30-39 years screening for cervical cancer using VIA/VILI) were found to be within 5 percent of reported data. No of VCT services provided to clients aged 10 to 24 years under ASK project was found to be between 5 to 10 percent of reported data. This acceptable if we give +/- 10 percent margin of error during reporting. However, two indicators (no. of counseling services provided to clients aged 10 to 24 years under ASK project and no. of condoms distributed to clients aged 10 to 24 years under ASK project) were above 10 percent of reported data which is

way outside the 10 percent acceptable margin of error. Specifically, this presents a situation of over-reported, with the main reason being lack of documentation and archiving of raw data.

#### **4.3.6. Data Analysis and Use**

Data analysis and use component scored the highest at 79 percent. This means that most of the standards were met. The majority of data that is collected is reported. In both SmartCare system and the manual registers, if client-level information is entered into a database then it is possible to analyze what services each person has received.

In the project reports, reasons for under- or over-performance (e.g. not achieving important targets) are documented. However, reasons for under- or over-performance are not documented for most IPPF reports. Performance issues (e.g. not meeting targets) are followed up with responsible sites/officers at project level and also during APB review meetings.

The assessment revealed that there were no written procedures to ensure regular (at least quarterly) review of M&E data by programme/project managers, M&E staff, other technical staff. However, such reviews take place but in an ad hoc manner since there are no documented procedures to guide the process. A data review and interpretation meeting took place in June 2015 at the national/programme level involving managers and M&E staff. In addition, a programme meeting takes place every quarter and one of the agendas is to review data and come up with ways of improving. The M&E team usually conducts regular analysis including trends in performance indicators over time to inform decision making at project and programme level.

In terms of data use, there is evidence that data analysis has led to improvements in programme design and/or implementation. Practical examples include the case of ASK project where the team realized that the number reached for 10 to 14 year olds was low and deliberate effort was made to conduct SRH sensitization meetings in primary schools. This saw the number of 10 to 14 year olds increase by over 30 percent. To increase access to Comprehensive Abortion Care (CAC) services, GCACI team made a deliberate effort to make use of pharmacists who would refer clients who came for over-the-counter abortion medication. This saw an increase in access

to CAC services by over 20 percent. The CCS&PT team adapted the Single Visit Approach where clients who tested positive for cervical cancer are treated on site. This was after realizing that most clients who tested positive were not going for treatment after being referred to the facilities. This reduced loss to follow up and increase treatment services by over 10 percent.

The assessment also observed that the project implementation teams understand all the relevant indicators concerning their projects and this was one of the reasons why the level of data use in implementation of projects was high. In addition, M&E data is made available to project implementation teams on a regular basis (mostly monthly) to guide and enable them make decisions.

Programme results are frequently shared with donors, the government, partners and volunteers. This is done through the periodic project reports, half year reports, annual reports, conferences and the Annual Delegates Conference which brings together volunteers. Prior to release of the results from the M&E unit and programme team, the Director of Resource Mobilization (DRM) and/or Director of Clinical Services (DCS) review the results for quality assurance.

#### **4.3.7. Evaluation**

As observed earlier, the evaluation component scored the highest at 79 percent. All the evaluation activities are explicitly outlined in the M&E Framework. Outcome evaluations are conducted, with the recent one being the Outcome Mapping under the ASK project. For projects whose life span is 3 years or more, mid-term evaluations are planned and executed. However, this is usually donor-driven and dependent on availability of resources. Where the respective donor does not avail resources, then a mid-term evaluation is not conducted. However, for all projects, baseline data is usually available within the first year of project inception. It is important to note that all the past evaluation reports are available.

It was critical to observe that findings from past evaluations have resulted in programme improvements. A good example is the youth peer provider strategy which was adapted by the ASK project since past assessments highlighted the need by young people to receive SRH

information and services by their fellow young people at the community. However, there is no clear mechanism of following up on evaluation recommendations and coming up with a clear action plans for implementation. This needs to be included in the M&E Plan that is being worked on.

Evaluation terms of reference usually include analysis plan, ethical provisions, budget and timeline. Also critical in the terms of reference is the evaluation design which guides the whole evaluation process. Dissemination of evaluation results is usually conducted to stakeholders. However, during dissemination, there is less of beneficiary involvement, mostly due to resource constraints. In most cases, beneficiary feedback is gathered through the actual evaluation data collection periods, project reviews, client exit interviews and suggestion boxes. However, this is not conducted systematically and by all service delivery sites due to time and resource constraints.

FHOK has made attempts to build local capacity in evaluation practice notably using Participatory Ethnographic Evaluation and Research (PEER) methodology which entails having direct beneficiaries being involved in the entire evaluation process. However, this has been done in a few projects i.e. DANIDA A+ project, Sexual and Gender Based Violence (SGBV) and Adolescents Count Today (ACT) projects. In most cases, the involvement of the local communities is in mobilization and data collection but not in data analysis and reporting.

#### **4.3.8. Alignment and Leadership**

Alignment and leadership component scored 58 percent. Under this component, the observation was that indicators collected in both electronic and manual systems included those earmarked for the national programme by the MOH. In addition, reports to MOH are usually sent by 5th of every month at the county level as prescribed by the ministry. Data reporting to the MOH is aggregated at the clinic level and submitted as one report (for each reporting area) to the Records and Information Officer to minimize double reporting. To enable FHOK report to MOH, the organization uses data collection tools by the ministry and in some cases, aligns her data collection tools to those of the ministry.

The County Health Management Teams (CHMT), donors and head office staff conducts regular supervision activities to ensure activities are aligned with national/international standards. These supervision visits focus on use of tools and the kind of data being collected and its quality. They are at times conducted jointly to give them more meaning, to gather government support and to avoid fatigue of facilities with external visits.

SmartCare has drawn a lot of attention to donors and government due to its efficiency and flexibility in data collection and reporting. As such, it has been recognized as a good practice by donors and government. For this reason, donors such IPPF and GCACI have used it as a learning example for electronic Clinic Management Information Systems in their countries of focus. However, SmartCare (or any other component of FHOK M&E system) has not been presented at national or international conferences or meetings or even published in peer-reviewed publications to demonstrate its strengths.

#### **4.4. Contribution of FHOK M&E System to Programme Improvement**

As noted earlier, products of FHOK M&E system have been used to improve the programme. Thomas (2010) observes that, development work that yields most positive change on the lives of the people is identified and promoted by M&E systems. Specifically, an M&E system is critical to carrying out a project/ programme effectively and efficiently and boosting accountability to beneficiaries, donors and other stakeholders (FHI, 2012). As a matter of fact, FHI 360 (2013); Hiller (2002); Kusek and Rist (2001); Levesque et al. (1996); World Bank (2009); UNAIDS (2009); Mackay (2007); Mayne (1997); Mayne and Goni (1997); McCoy et al. (2005); Nath (2007) and Global Fund et al. (2006) concur on the fact that an M&E system helps an organization to: determine if a project/programme is on-track, on-time and on-target; ensure that funds were used as intended and that the project/programme was implemented as planned; establish whether a difference was made by the project/programme.

Basing on the above literature, it was critical to look at how the products of FHOK M&E system have helped in informing and improving FHOK programme. Products of FHOK M&E system

(such as half year reports, annual reports, donor reports, periodic newsletters and service statistics) have been used to improve the programme in a number of ways as presented and discussed below:

***a.) Tracking progress against targets***

Every month, the results are compiled for every project to track performance against targets. This informs the project implementation teams whether they are on track in achieving targets that are set on a monthly basis. Performance is discussed during programme meetings and project review meetings. During these forums, areas that are behind targets are identified and strategies for achieving the targets are discussed. This move saw FHOK experience a 105 percent achievement of service statistics targets for year 2014.

***b.) Accountability to Donors and Stakeholders***

Accountability to donors is critical since they provide much-sought resources for programme work. AfrEA (2006); OECD (2003) and Phillips and Porter (2012) recognize the fact that donors have pushed organizations in Africa to institutionalize M&E systems for purposes of accountability and FHOK is not an exception. As such, FHOK M&E system produces vital information (both quantitative and qualitative) that feeds into donor reports. An observation was made that all the donor reports are prepared, reviewed and shared with donors on time. This has helped FHOK to be recognized as an accountable institution by donors.

AfrEA (2006) and OECD (2003) assert the importance of having internal accountability where the organization is not only accountable to donors but to themselves and other key stakeholders such as MOH and partner organizations. FHOK prepares half year and annual reports and periodic newsletters that are shared with volunteers, partners and MOH. These reports are vital in demonstrating the work that the organization is doing and keeping the key stakeholders informed on the same.



***c.) Reviewing and Improving Programme Implementation Strategies***

Data generated from project M&E databases has been used to make adjustment to programme implementation strategies. Practical examples include the case of ASK project where the team realized that the number reached for 10 to 14 year olds was low and deliberate effort was made to conduct SRH sensitization meetings in primary schools. This saw the number of 10 to 14 year olds increase by over 30 percent. Another example is that of GCACI project where to increase access to Comprehensive Abortion Care (CAC) services, an effort was made to make use of pharmacists who would refer clients who came for over-the-counter abortion medication. This saw an increase in access to CAC services by over 20 percent. The CCS&PT project team realized that a lot of clients who tested positive for cervical cancer during outreaches were not coming for cryotherapy when referred even after making follow up calls. As such, the team adapted the Single Visit Approach where clients who test positive are treated on site. This reduced loss to follow up and increased treatment services by over 10 percent.

***d.) Designing New Innovations***

M&E products have also resulted in new innovations being developed. A notable case in point is where past assessments highlighted the need by young people to receive SRH information and services by their fellow young people at the community. As such, the peer provider strategy was adapted in the design of ASK project where young people were trained as community based agents to provide SRH information and services such as counseling, condoms and pills and referrals for high level services. An abstract on this innovation was accepted for oral presentation at the 2015 International Conference on Family Planning (ICFP) in Nusa Dua, Indonesia.

***e.) Targeting: Ensuring the right Target Group is Reached***

Every year, the M&E team conducts the vulnerability assessment which is a rapid assessment that is geared towards estimating the proportion of clients who are poor and vulnerable. This is built on the premise that the mission of FHOK is to serve poor and vulnerable clients, hence the need to estimate the proportion of clients who fall in this category. In 2013, a vulnerability assessment conducted in sampled facilities estimated that 72 percent of clients that were served were poor and vulnerable. In 2014, measures were put in place to increase the proportion of

clients who were poor and vulnerable to include waivers, targeted outreaches and venturing into new geographical areas among others. At the end of 2014, the estimated proportion of clients who were poor and vulnerable was at 79 percent which was a tremendous improvement from the previous year.

*f.) Strengthening Efficiency*

FHOK M&E system has helped to identify areas that need cost cutting for efficient management. Karani et al. (2014) and UNAIDS (2008) underscore the integral role of M&E systems in establishing and strengthening the efficiency of programmes. As such, the Branch Performance Tool (BPT) was institutionalized by the M&E team at FHOK to guide the process of identifying key efficiency issues that needed to be replicated or strengthened. The BPT allows Member Associations (MAs) to visualize the operating performance of individual branches, compare across branches, and use the resulting information to guide performance improvements. To do this, the tool estimates relative efficiency, as well as key operational ratios, across a set of branches or clinics. Additionally, where data permit, a user can visualize more detailed statistics (e.g., cost and service mixes) to understand differences in branch performance. The goal is to use this data to facilitate a small number of performance improvements in specific branches that will significantly benefit the MA's ability to deliver quality sexual and reproductive health (SRH) services.

In 2012, data in the BPT indicated that 32 percent of total costs at Ribeiro FCMC were overheads with a significant portion (70 percent) going into rent for the facility. This confirmed previous fears that high rental costs were being incurred at the clinic. As such, in 2014, the Board made a decision to move the clinic from Ribeiro, along Luthuli Avenue, Nairobi to Kitengela which saw the proportion of overheads reduce by almost 50 percent.

In Eldoret clinic, Couple Years of Protection (CYP) in 2013 stood at 5,082 with a relatively high cost at \$50 per CYP. A decision was made to increase the number of CYP by 50 percent and reduce cost per CYP by 40 percent in the year 2014 by focusing on Long Acting and Permanent Methods (LAPMs). Previous data had indicated that more family planning clients were served

during integrated outreaches. Basing on this, the team scaled up integrated outreaches and conducted staff training and mentorship on contraceptive technology use. As a result, Eldoret clinic provided 10,786 CYP in the first semester of 2014 at a cost of \$15 per CYP representing a 112 percent increase in CYP and 70 percent reduction in cost per CYP.

## **CHAPTER FIVE: SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS**

### **5.1. Introduction**

This chapter summarizes the findings and basing on the same, presents conclusions and recommendations of the assessment. The chapter presents recommendations for each of the 8 domains so as to help identify specific areas for strengthening.

### **5.2. Summary of Findings**

The assessment aimed at: determining the extent to which the FHOK M&E system meets the established standards; identifying strengths and gaps of FHOK M&E system; and determining how the products of FHOK M&E system have been used to improve the programme. The assessment employed descriptive research design which allowed for description of FHOK M&E system as it is and helped to establish strengths and gaps which was fundamental to the realization of research objectives. Data was collected through documents review, Key Informants' Interviews, discussions and observation. Data was analyzed both quantitatively and qualitatively to produce the results.

Overall, FHOK M&E system scored 148 out of 240 which is 62 percent. Scores vary from component to component with data analysis and use and evaluation (a tie) scoring the highest at 79 percent and documentation recording the lowest score at 43 percent. Basing on grading criteria that was developed during the study by the author, FHOK system was rated as 'good' at 62 percent.

The key strengths of FHOK M&E system include: adequate resources allocated for M&E work (M&E budget was 8 percent of overall 2015 programme budget), alignment of indicators to donor and national indicators, use of standardized data collection tools, presence of M&E databases to track progress, continuous data analysis and use and use of evaluations to improve programme. Key gaps that were identified include: documentation of M&E procedures, inadequate evaluation and research capacity of M&E staff, M&E staff reporting to non-M&E staff, corrections are not made after data quality assessments, evaluations are largely donor-

driven and no component of FHOK M&E system has been shared in a conference or published in a peer reviewed publication.

In terms of contribution of FHOK M&E system to programme improvement, it was observed that FHOK M&E system has been vital in tracking progress against targets, accounting to donors and stakeholders, reviewing and improving programme implementation strategies, designing new innovations, ensuring that the right target group is reached and strengthening efficiency of FHOK programme.

### **5.3. Conclusions**

It is evident that FHOK M&E system is a strong case worth sharing. At 62 percent, the M&E system is was rated 'good', of course with areas for improvement. In terms of practice, a lot is taking place as far as M&E is concerned notably, in resources and capacity building, data quality systems, data analysis and use and evaluation. However, other components need strengthening with critical focus on documentation and data verification. The ongoing process of reviewing the M&E plan should directly address the documentation aspect as has been identified in the other two assessments that were conducted. With continuous management support, resource allocation and assessment for improvement, FHOK's M&E system can be an exemplary system for adoption by other NGOs.

### **5.4. Recommendations**

On the basis of the conclusions above, the following recommendations were made for each of the components that was assessed.

#### **a.) Resources and Capacity Building**

M&E budget lines should be specified in budgets so as to clear M&E activities in the budgets. It was observed that some project budgets have blanket budget lines stated as 'Monitoring and Evaluation'.

Evaluation and research capacity of the M&E team should be enhanced through training and mentorship so that their potential can be fully tapped into and utilized. Subsequently, an M&E

Consultancy Unit can be a good way of tapping into such capacity to provide M&E technical back stopping to SRH organizations.

For better coordination of M&E practice in FHOK, all the M&E Officers should directly report to the M&E Manager. It was observed that the two M&E Officers report to non-M&E staff and yet there is an M&E Manager who provides technical coordination of M&E work. This will ensure more coordinated M&E practice and approaches.

**b.) Documentation (Plans, Guidelines and Operational Documents)**

All M&E processes and procedures should be clearly defined in the M&E Plan. This entails updating of the current M&E Framework and aligning it to the new Strategic Plan and IPPF's M&E Plan. The M&E Plan should document all M&E procedures and processes to guide M&E practice at FHOK.

The M&E Framework (once reviewed, the M&E Plan) should be disseminated to all staff and copies of the same shared to keep provide a point of reference for M&E practice at FHOK. It was observed that most staff do not have a copy of the M&E Framework and yet they have a role in M&E practice in FHOK.

The M&E Framework (once reviewed, the M&E Plan) should contain key performance indicators that will be used to track the Strategic Plan. A results framework linking programme goals to intermediate results and outcomes or outputs should be provided. Clear targets for key performance indicators should also be provided.

The M&E Framework (once reviewed, the M&E Plan) should contain an M&E-specific organogram that clearly show the link to the larger organizational organogram.

### **c.) Data Collection and Management**

All hard copy client records should be stored under lock and key to restrict access. This will promote confidentiality of client information and should be aligned international information security protocols.

In-house programming capacity should be built by Intersoft Technologies to the CMIS team to equip with programming skills to be able to respond to programming queries that are raised from time to time by end users of SmartCare. This will reduce turn-around time and enhance sense of ownership of SmartCare at FHOK.

A single database should developed where all FHOK data (services, trainings, activities etc) is stored. This will ease access and make data retrieval faster and easier.

### **d.) Data Quality Systems**

All the data collection tools should have guidelines to guide the service providers when collecting data. FHOK should borrow from MOH registers and adapt the same.

With a Wide-Area-Network (WAN), the clinics should be interlinked so as to minimize the cost of maintaining SmartCare and also minimize the risk of double counting clients since a revisit FHOK client would not need to be registered when he/she goes to another clinic. Also critical to reducing double counting would be introducing a an outreach version of SmartCare which should be integrated into the static version.

Efforts should be made by the DRM and DCS to ensure that all sites use standard data collection forms so as to get the right information in the same format.

The Centre Managers should be mentored and incentivized to review data on a regular basis and before submitting reports to head office for quality assurance. This should include checking for correctness and completeness of data collection and reporting.

The DRM and DCS should ensure that reports are submitted on time by project sites and clinics to allow for adequate time for review and taking remedial actions.

The M&E team should ensure frequent data verification exercises are conducted and that remedial actions are taken in a timely manner by making the necessary corrections on historical data before submission to the donors.

The DRM and DCS should ensure that the service providers collect data on all the indicators so as to avoid cases of under-reporting which has a negative effect on performance.

#### **e.) Data Verification**

Data verification exercises should be conducted by the M&E team on a more frequent basis. The capacity of facility teams to conduct data verification should be built so as to enhance the culture of Routine Data Quality Assessments (RDQAs). As recommended earlier, corrections should be made on a timely manner before reports are shared with donors and other stakeholders.

#### **f.) Data Analysis and Use**

Procedures for regular reviews should be documented in the M&E Plan to ensure regular (at least quarterly) review of M&E data by programme/project managers, M&E staff, other technical staff.

Data analysis should be enhanced to move beyond project level to the whole programme and usage of results in decision making at the organizational level. This can be enhanced by more use of the Branch Performance Tools (BPT) to inform management decisions at higher organs.

#### **g.) Evaluation**

The M&E team should conduct rapid assessments on a regular basis focusing on outcomes to continuously document and demonstrate programme successes.



A clear mechanism of following up on recommendations made in evaluation reports should be included in the M&E Plan to strengthen use of evaluations in programme improvement.

Deliberate efforts should be made to involve the local communities more in evaluations so to build their capacity on the same. Hence, future evaluations should focus on not only involving local communities in mobilization and data collection but also in data analysis, reporting and use.

Dissemination of future evaluations should expand to include beneficiaries since they are directly affected by the interventions and evaluation results. However, the level of involvement should be carefully considered.

#### **h.) Alignment and Leadership**

FHOK should invest more in documenting strong areas in her M&E systems such as SmartCare. This can be done through abstracts, presentations in national and international forums and publishing in peer-reviewed journals. This will enhance knowledge sharing and cross-learning.

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## **ANNEXES: DATA COLLECTION TOOLS**

### **ANNEX 1: DOCUMENT/ RECORDS REVIEW GUIDE**

#### **Introduction**

This is a guide/ checklist that will help the assessor diagnose specific aspects of FHOK M&E system through review of available documents and records such as project reports, M&E plan/ framework, service statistics etc. The score should be along 4 possible parameters i.e. Fully meets; Partially meets; Does not meet; Not applicable. Explanation/ comments on the rating should be provided in the comments column of the MS Excel tool.

#### **A.) Resources and Capacity Building**

1. The M&E budget is between 5 percent-10 percent of the overall programme budget.
2. There is/are dedicated staff for M&E (*Confirm from the organogram*).
3. The number of M&E team staff is sufficient in relation to the programme size.
4. The M&E team (if >3 persons) has an appropriate skills mix (e.g. data analysis, evaluation/ research, HMIS).
5. Members of the M&E team have received initial orientation on the project M&E system.
6. Members of the M&E team have been trained at least once in the last two years.
7. Members of the M&E team have received a mentoring/supervision from their supervisor in the last 6 months.
8. Programme has had an M&E TA visit from HQ/region at least once in the last year.
9. Partner M&E staff (including those at site level) have all received initial training on the project M&E system.
10. A procedure exists for orienting new partner staff on the M&E system in case of staff turnover.
11. Partner programme management staff have received training or orientation on project M&E requirements.
12. Members of the M&E team have visited partners for capacity building/mentoring at least once in the past 6 months.
13. Members of partner M&E teams have visited all sites at least once in the past 1 year for capacity building/mentoring.

## **B.) Documentation (Plans, Guidelines and Operational Documents)**

1. There is an M&E plan (or PMP) which is up to date.
2. Implementing partner(s) have a copy of standard guidelines describing reporting requirements (what to report on, due dates, data sources, report recipients, etc.).
3. Supervision procedures are documented in writing (how often, what to look at, what happens next).
4. Targets have been set for key performance indicators.
5. PMP has a graphic results framework linking project/ programme goal, intermediate results and outcomes or outputs.
6. PMP/M&E plan or other project design document has an organogram describing the organization of the M&E unit in relation to the overall project team.
7. A PMP matrix exists that lists indicators, annualized and cumulative LOP targets, data sources, baselines, methods, reporting frequency, and responsible entities.
8. PMP includes indicators for measuring input, outputs, outcomes and where relevant, impact indicators, and the indicators are linked to the project objectives.
9. All PMP indicators have operational definitions e.g. performance indicator reference sheets.
10. An up-to-date implementation timeline for M&E activities is available.
11. M&E work plan includes regular internal DQA activities.
12. The up-to-date M&E work plan indicates persons responsible for each activity, including any M&E-related roles for the programme/technical staff and implementing partners.
13. Implementing partner(s) use a standard reporting template.
14. M&E plan/PMP has a dataflow chart that clearly demonstrates how data reaches programme managers and donors/government.
15. Documented confidentiality protocol is available (If personal records maintained).

## **C.) Data Collection & Management**

1. Training registers/documentation are available and meet donor and government standards.
2. Data collection tools include all required programme/project indicators.
3. There is no (or minimal) duplication in data collection requirements for staff/partners, i.e. they are not required to report the same activity on more than one tool.

4. Data management guidelines exist (e.g. filing systems for paper forms or back up procedures for electronic data).
5. Historical data is properly stored, up to date and readily available.
6. The project has one or more electronic M&E databases which are up to date.
7. Data from services is disaggregated by gender and age and training by gender.
8. The number of data collection tools is sufficient for programme needs and not excessive.
9. There is adequate documentation/in-house capacity for the programme database so that it can be modified by one or more staff.
10. There is management support for following up any persistent data gaps with partners.

#### **D.) Data Quality Systems**

1. Operational indicator definitions for national/global indicators are consistent w/existing standard guidelines (e.g. PEPFAR, PMI, UNGASS, etc.)
2. Definitions and interpretations of indicators are followed consistently when transferring data from front-line instruments to summary formats and reports.
3. Written guidance on filling in data collection tools is evident at the partner or service delivery level.
4. There is a clear link between fields on data entry forms and summary or compilation formats to reduce transcription error.
5. The number of transcription stages (manual transfer of data from one form to another) are minimized to limit transcription error).
6. Systems are in place to adjust for double-counting.
7. Systems are in place for detecting missing data.
8. Standard forms/tools are used consistently within and between partners.
9. At least once a year programme and/or technical staff (with or without M&E specialists) review completed tools at site or partner level for completion, accuracy or service quality issues.
10. Data collection tools/partner reports are filled in completely (take sample).
11. Data collection tools/partner reports are filled in correctly (take sample).
12. All expected partner reports have been received.



13. Donor reports are submitted on time.
14. Data reported corresponds with donor-specified report periods.
15. Feedback is provided to all service points on the quality of their reporting.
16. There is evidence that corrections have been made to historical data following data quality assessments.
17. All sites are reporting on all required indicators.
18. There is evidence that supervisory site visits have been made in the last 12 months where data quality has been reviewed.
19. There is evidence that field-level supervisors review data from field workers before it is finalized and passed on.

#### **E.) Data Verification**

1. Supporting documents are accurate for 5 sampled indicators (This is filled for each sampled indicator). The data verification is done by recounting the data from the source documents and comparing the same with reported data. A Verification Factor is calculated by dividing reported data by recounted data for each indicator. A Verification Factor of more than 100 percent depicts over-reporting and vice versa. A Verification Factor of 100 percent depicts accuracy. However, a 5 percent margin of error is allowed hence, a difference of +/- 5 percent is considered within the accuracy margin. In a situation of under-/over-reporting, then the indicator is scored as “Does not meet” whereas a situation of accuracy is scored as “Fully meets”.

#### **F.) Data Analysis and Use**

1. The majority of data collected is reported.
2. If client-level information is entered into a database then it is possible to analyze what services each person has received.
3. Reasons for under- or over-performance (e.g. not achieving important targets) are documented.
4. Performance issues (e.g. not meeting targets) are followed up with partners/others.

5. Written procedures are in place to ensure regular (at least quarterly) review of M&E data by programme/project managers and/or COP, M&E staff, other technical staff and partners.
6. At least one data review & interpretation meeting has taken place in the last quarter at the national/programme level involving managers and programme/technical staff.
7. At least one data review & interpretation meeting has taken place in the last quarter at the local/site level involving partner managers and programme/technical staff.
8. Regular analysis includes trends in performance indicators over time (e.g. monthly or quarterly).
9. There is evidence that data analysis has led to improvements in programme design or implementation.
10. Donors and/or government have received an analysis report or attended a meeting with results presented - over and above minimum reporting requirements - within the last 12 months.
11. A gender analysis has been conducted to help programmes understand and integrate gender issues.

### **G.) Evaluation**

1. Evaluation activities are explicitly outlined in the M&E plan.
2. An outcome or impact evaluation is planned for the programme (especially unique and large-scale programmes).
3. A process evaluation or mid-term review has been conducted for projects which are >3 years into implementation.
4. Baseline data is available within the first 2 years of project.
5. Reports of any past evaluations are available.
6. Findings from past evaluations have resulted in programme improvements.
7. Evaluation designs are adequately outlined in a protocol.
8. Evaluation protocols include analysis plan, ethical provisions, budget and timeline.
9. Relevant personal data are maintained according to national or international confidentiality guidelines.
10. Evaluation results have been disseminated to all stakeholders.

11. When evaluations have been conducted, local capacity has been built as part of the process
12. There is a mechanism in place for obtaining periodic feedback on service acceptability from beneficiaries/ target group members.

#### **H.) Alignment & leadership**

1. Indicators collected include those earmarked for the national programme (government).
2. Reports have been submitted to the relevant government departments according to schedule.
3. Data collection tools are aligned with those of the Government.
4. Regular supervision activities are conducted to ensure activities are aligned with national/international standards.
5. Programme participates in national M&E TWG or other fora.
6. Programme participates in donor M&E TWG or other fora.
7. Programme has been used as a best practice/learning site for one or more M&E practices by donor or government.
8. Programme has been used as a best practice/learning site for one or more M&E practices by other (not supported) NGOs/CBOs/FBOs.
9. Programme has presented components of its M&E system at national conferences or other meetings in the last 2 years.
10. Programme has presented components of its M&E system at international conferences or other meetings in the last 2 years.
11. One or more elements of Programme's M&E system have been published in peer review publications in the last 2-3 years.

## **ANNEX 2: DISCUSSION GUIDE**

### **Introduction**

Hello. My name is Stephen Njoka. I am assessing the M&E system of Family Health Options Kenya (FHOK) which is the focus of my project for M.A. in Monitoring and Evaluation of Population and Development Programmes from the University of Nairobi, Population Studies and Research Institute (PSRI). I would like to have a discussion with you on matters pertaining the M&E system of FHOK. I would like to assure you that the information you provide will remain confidential and will only be used for analysis and reporting purposes and that your name(s) will not be quoted and/or mentioned. Please note that this assessment will not have any direct benefit to you and that the results will be used to improve the system to make better. You may choose not to answer any of my questions and you may terminate the discussion at any point. The discussion will take approximately 45 minutes.

Do you agree to participate? *(If no, move to the next sample. If yes, take the identifier of the respondent(s) and position and after warming up the discussion e.g. by asking about what they do and the period they have been in the organization, begin the discussion.)*

### **A.) Resources and Capacity Building**

1. The M&E budget is between 5 percent-10 percent of the overall programme budget.
2. There is/are dedicated staff for M&E *(Confirm from the organogram)*.
3. The number of M&E team staff is sufficient in relation to the programme size.
4. The M&E team (if >3 persons) has an appropriate skills mix (e.g. data analysis, evaluation/research, HMIS).
5. Members of the M&E team have received initial orientation on the project M&E system.
6. Members of the M&E team have been trained at least once in the last two years.
7. Members of the M&E team have received a mentoring/supervision from their supervisor in the last 6 months.
8. Programme has had an M&E TA visit from HQ/region at least once in the last year.
9. Partner M&E staff (including those at site level) have all received initial training on the project M&E system.

10. A procedure exists for orienting new partner staff on the M&E system in case of staff turnover.
11. Partner programme management staff have received training or orientation on project M&E requirements.
12. Members of the M&E team have visited partners for capacity building/mentoring at least once in the past 6 months.
13. Members of partner M&E teams have visited all sites at least once in the past 1 year for capacity building/mentoring.

**B.) Documentation (Plans, Guidelines and Operational Documents)**

This will be assessed using the Review Guide in Annex 1.

**C.) Data Collection & Management**

1. There is no (or minimal) duplication in data collection requirements for staff/partners, i.e. they are not required to report the same activity on more than one tool.
2. If client-level personal information is collected then IDs are used to protect the confidentiality of clients, and access is restricted to this information.
3. Field level data entry (filling in forms) occurs immediately or shortly after service provision to limit recall bias.
4. There is adequate documentation/in-house capacity for the programme database so that it can be modified by one or more staff.
5. There is management support for following up any persistent data gaps with partners.

**D.) Data Quality Systems**

1. Steps are taken to limit calculation errors, including automation where possible.
2. Systems are in place for detecting missing data.
3. At least once a year programme and/or technical staff (with or without M&E specialists) review completed tools at site or partner level for completion, accuracy or service quality issues.
4. All expected partner reports have been received.

5. Donor reports are submitted on time.
6. Data reported corresponds with donor-specified report periods.
7. Feedback is provided to all service points on the quality of their reporting.
8. There is evidence that corrections have been made to historical data following data quality assessments.
9. All sites are reporting on all required indicators.
10. There is evidence that supervisory site visits have been made in the last 12 months where data quality has been reviewed.
11. There is evidence that field-level supervisors review data from field workers before it is finalized and passed on.

#### **E.) Data Verification**

Following actual data verification (as described in the Records Review Tool – Annex 1), establish reasons why recorded data does not tally with reported data (If this is realized for any of the 5 sampled indicators).

#### **F.) Data Analysis and Use**

1. The majority of data collected is reported.
2. If client-level information is entered into a database then it is possible to analyze what services each person has received.
3. Reasons for under- or over-performance (e.g. not achieving important targets) are documented.
4. Performance issues (e.g. not meeting targets) are followed up with partners/others.
5. Written procedures are in place to ensure regular (at least quarterly) review of M&E data by programme/project managers and/or COP, M&E staff, other technical staff and partners.
6. At least one data review & interpretation meeting has taken place in the last quarter at the national/programme level involving managers and programme/technical staff.
7. At least one data review & interpretation meeting has taken place in the last quarter at the local/site level involving partner managers and programme/technical staff.

8. Regular analysis includes trends in performance indicators over time (e.g. monthly or quarterly).
9. There is evidence that data analysis has led to improvements in programme design or implementation.
10. Donors and/or government have received an analysis report or attended a meeting with results presented - over and above minimum reporting requirements - within the last 12 months.
11. A gender analysis has been conducted to help programmes understand and integrate gender issues.
12. Programme/technical staff are familiar with key indicators and results pertaining to their programme/technical area.
13. A senior staff member (e.g. Programme Manager) is responsible for reviewing aggregated data prior to release of reports from M&E unit.
14. Monitoring data is accessible to relevant technical staff and manager(s).

### **G.) Evaluation**

1. Findings from past evaluations have resulted in programme improvements.
2. Evaluation results have been disseminated to all stakeholders.
3. When evaluations have been conducted, local capacity has been built as part of the process.
4. There is a mechanism in place for obtaining periodic feedback on service acceptability from beneficiaries/ target group members.

### **H.) Alignment & leadership**

1. Reports have been submitted to the relevant government departments according to schedule.
2. If applicable data have been reported through a single channel of the national system to prevent double-counting of programme results.
3. Regular supervision activities are conducted to ensure activities are aligned with national/international standards.
4. Programme participates in national M&E TWG or other fora.
5. Programme participates in donor M&E TWG or other fora.

6. Programme has been used as a best practice/learning site for one or more M&E practices by donor or government.
7. Programme has been used as a best practice/learning site for one or more M&E practices by other (not supported) NGOs/CBOs/FBOs.
8. Programme has presented components of its M&E system at national conferences or other meetings in the last 2 years.
9. Programme has presented components of its M&E system at international conferences or other meetings in the last 2 years.
10. One or more elements of Programme's M&E system have been published in peer review publications in the last 2-3 years.



## **ANNEX 3: OBSERVATION CHECKLIST**

### **Introduction**

This is an observe guide/ checklist that will help the assessor observe specific aspects of FHOK M&E system. The score should be along 4 possible parameters i.e. Fully meets; Partially meets; Does not meet; Not applicable. Explanation/ comments on the rating should be provided in the comments column of the MS Excel tool.

### **C.) Data Collection & Management**

1. The project has one or more electronic M&E databases which are up to date.
2. Data from services is disaggregated by gender and age and training by gender.
3. Safeguards are in place to prevent unauthorized changes to data.

### **D.) Data Quality Systems**

1. Quality controls are implemented to minimize errors when data are entered into computer/PDA (e.g. double entry, post-entry verification, etc.).
2. Steps are taken to limit calculation errors, including automation where possible.
3. Systems are in place for detecting missing data

## ANNEX 4: DETAILED ASSESSMENT RESULTS

### A.) Resources and capacity building

| Detailed Checklist/Standard |  | Rating/Score           | Observations, rationale for rating, comment and recommendations  |
|-----------------------------|--|------------------------|--|
| 1.                          | The M&E budget is between 5%-10% of the overall programme budget   | <b>Fully meets</b>     | M&E budget is 8% of the overall 2015 budget i.e. Ksh14M out of Ksh184M   |
| 2.                          | There is/are dedicated staff for M&E   | <b>Fully meets</b>     | M&E Manager and 2 M&E Officers. M&E Manager position is vacant but it is already advertised for replacement  |
| 3.                          | The number of M&E team staff is sufficient in relation to the programme size                             | <b>Partially meets</b> | 3 staff providing M&E of 15 projects. 2 more would be enough so that atleast each M&E staff can have 5 projects  |
| 4.                          | The M&E team has an appropriate skills mix (e.g. data analysis, evaluation/ research, HMIS)              | <b>Partially meets</b> | Both M&E Officers are well versed in data analysis and management information systems. However, there is need to continuously strengthen the capacity of the team in the areas of evaluation and research.   |
| 5.                          | Members of the M&E team have received initial orientation on the project M&E system                      | <b>Partially meets</b> | Yes. This is done during orientation on data collection, collation, analysis, supportive supervision and reporting among other things. How orientation is done is not documented   |
| 6.                          | Members of the M&E team have been trained at least once in the last two years                            | <b>Partially meets</b> | On a needs-basis, mostly by IPPF. No structured training of M&E staff  |
| 7.                          | Members of the M&E team have received a mentoring/supervision from their supervisor in the last 6 months | <b>Partially meets</b> | Supervision of the M&E team is usually done by the Director of Resource Mobilization (DRM). This is done through review of reports, service statistics and workload among others.  |
| 8.                          | Programme has had an M&E TA visit from HQ/Region at least once in the last year                          | <b>n/a</b>             |  |
| 9.                          | Staff (including those at site level) have all received initial training on the project M&E system       | <b>Fully meets</b>     | M&E team conducts supportive supervision to clinics to conduct data verification, mentor field teams in data collection, data analysis and data use. The team also provides continuous training to field teams on data collection and reporting tools and guides them on how they can use data in decision making, |

|     |  |            |  |
|-----|--|------------|--|
|     |  |            | particularly in improving their work and tracking targets. |
| 10. | A procedure exists for orienting new partner staff on the M&E system in case of staff turnover                       | <b>n/a</b> |  |
| 11. | Partner programme management staff have received training or orientation on project M&E requirements                 | <b>n/a</b> |  |
| 12. | Members of the M&E team have visited partners for capacity building/mentoring at least once in the past 6 months     | <b>n/a</b> |  |
| 13. | Members of partner M&E teams have visited all sites at least once in the past 1 year for capacity building/mentoring | <b>n/a</b> |  |

**B.) Documentation (Plans, guidelines and operational documents)**

| <b>Detailed Checklist/Standard</b> |   | <b>Rating/ Score</b>   | <b>Observations, rationale for rating, comment and recommendations</b>   |
|------------------------------------|---|------------------------|--|
| 1.                                 | There is an M&E plan (or PMP) which is up to date   | <b>Partially meets</b> | FHOK has an M&E Framework that guides M&E practice in the organization. However, the M&E Framework is not updated. It is not clear when the M&E Framework was developed. It has never been updated   |
| 2.                                 | Implementing sites have a copy of standard guidelines describing reporting requirements (what to report on, due dates, data sources, report recipients, etc.) | <b>Does not meet</b>   | No. What they have are email communications on reporting requirements, specifically on what to report on, due dates, data sources, report recipients etc.  |
| 3.                                 | Supervision procedures are documented in writing (how often, what to look at, what happens next)  | <b>Does not meet</b>   | Whereas supervision takes place to projects and implementation sites, the procedures for the same are not documented.  |
| 4.                                 | Targets have been set for key performance indicators  | <b>Partially meets</b> | Targets are set using a bottom-up approach for clinics. During APB. Project specific targets are set in negotiation with donors and then they are distributed to the project implementation sites. However, some service delivery sites do not have targets that they are working towards. |
| 5.                                 | PMP has a graphic results framework linking project/ programme goal, intermediate results and outcomes or outputs   | <b>Partially meets</b> | For each project, the APB provides a description of activities and respective key process indicators. It also presents key strategic objectives and respective results indicators for the same. The M&E Framework does not have key performance indicators that should be tracked.         |
| 6.                                 | PMP/M&E plan or other project design document has an organogram describing the organization of the M&E unit in relation to the overall project team           | <b>Does not meet</b>   |  |
| 7.                                 | A PMP matrix exists that lists indicators, annualized and cumulative LOP targets, data sources, baselines, methods, reporting frequency,                      | <b>Partially meets</b> | A matrix exists in the M&E Framework that has data sources, methods, reporting frequency and timelines, staff responsible and audience analysis. However, a number of important  |

|     |   |                        |   |
|-----|---|------------------------|---|
|     | and responsible entities  |                        | elements are missing, notably, indicators, annualized and cumulative targets. It is important to note that indicators and targets are contained in the APBs. However, key performance indicators and respective targets that are in line with the Strategic Plan objectives were missing.   |
| 8.  | PMP includes indicators for measuring input, outputs, outcomes and where relevant, impact indicators, and the indicators are linked to the project objectives             | <b>Does not meet</b>   |   |
| 9.  | All PMP indicators have operational definitions e.g. performance indicator reference sheets   | <b>Partially meets</b> | Most of them have definitions esp those from IPPF. However, some do not have definitions  |
| 10. | An up-to-date implementation timeline for M&E activities is available   | <b>Partially meets</b> | an up to date implementation timeline for M&E activities was available in the APB indicating persons responsible for each activity, including any M&E-related roles for the programme/technical staff. Key activities such as data verification exercises and supportive supervision were included in the annual work plan. However, specific documented monthly and quarterly work plans were not available. |
| 11. | M&E work plan includes regular internal DQA activities  | <b>Fully meets</b>     | In the APB  |
| 12. | The up-to-date M&E work plan indicates persons responsible for each activity, including any M&E-related roles for the programme/technical staff and implementing partners | <b>Partially meets</b> | Only annual work plan. Quaterly and monthly work plans do not exist   |
| 13. | Implementing sites use a standard reporting template  | <b>Fully meets</b>     |   |
| 14. | M&E plan/PMP has a dataflow chart that clearly demonstrates how data reaches programme managers and donors/government   | <b>Fully meets</b>     | In the M&E Framework  |
| 15. | Documented confidentiality protocol is available (If personal records maintained)   | <b>Does not meet</b>   |   |

### C.) Data collection and management

| Detailed Checklist/Standard |  | Rating/Score           | Observations, rationale for rating, comment and recommendations  |
|-----------------------------|--|------------------------|--|
| 1.                          | Training registers/documentation are available and meet donor standards  | <b>Does not meet</b>   | No training plans  |
| 2.                          | Data collection tools include all required programme/project indicators  | <b>Fully meets</b>     | Data collection tools include all required programme indicators hence enabling those collecting data to capture all the required information.  |
| 3.                          | There is no duplication in data collection requirements for staff/partners, i.e. they are not required to report the same activity on more than one tool | <b>Partially meets</b> | There is minimal duplication in data collection requirements for staff   |
| 4.                          | Data management guidelines exist (e.g. filing systems for paper forms or back up procedures for electronic data)   | <b>Does not meet</b>   | Data management and back up procedures were not documented to guide these critical aspects.  |
| 5.                          | Historical data is properly stored, up to date and readily available   | <b>Partially meets</b> | Historical information is stored in the library which is located at the head office whereas at the clinic level, clients records are well stored and easily retrievable. Records stored in SmartCare system are well protected since users have access restrictions. However, for hardcopy records, most of these are not stored under lock and key which presents possible risk of unauthorized access. |
| 6.                          | The project has one or more electronic M&E databases which are up to date  | <b>Partially meets</b> | SmartCare is regularly updated with a provision to continuously include new indicators. However, the eIMS is only updated during reporting and APB periods. New projects are only entered into the eIMS during reporting and APB periods and at times, the reports are not fully updated.  |
| 7.                          | Data from services is disaggregated by gender and age and training by gender   | <b>Fully meets</b>     | Yes. The data collection tools in SmartCare are aligned to MOH tools and donor needs. Where need arises, MOH tools are used, notably in the VCT rooms and the laboratories.  |

|     |   |                        |   |
|-----|---|------------------------|---|
| 8.  | If client-level personal information is collected then IDs are used to protect the confidentiality of clients, and access is restricted to this information | <b>Partially meets</b> | Where client-level personal information is collected unique codes are used to protect the confidentiality of clients. Access to client information is restricted in SmartCare where users have accounts with restriction to access client information. However, for hard copy records, most of the client records are stored in shelves at the reception and not under lock and key which presents a risk of possible unauthorized access |
| 9.  | Field level data entry (filling in forms) occurs immediately or shortly after service provision to limit recall bias  | <b>Partially meets</b> | The M&E team has provided a data entry database for summarizing data on a daily basis. In most cases field level data entry occurs immediately or shortly after service provision to limit recall bias. However, due to heavy work load, this is done at the end of the month.  |
| 10. | The number of data collection tools is sufficient for programme needs and not excessive   | <b>Fully meets</b>     |   |
| 11. | There is adequate documentation/in-house capacity for the programme database so that it can be modified by one or more staff                                | <b>Partially meets</b> | There is adequate in-house capacity for the programme database so that it can be modified by one or more staff. However, for SmartCare, most of the technical programming aspects are handled by Intersoft Technologies whereas IPPF Africa Region and Central Office handles technical aspects of the eIMS.  |
| 12. | Safeguards are in place to prevent unauthorized changes to data   | <b>Partially meets</b> | In most cases, safeguards are place to guard against unauthorized changes to data. For SmartCare system, client data on services provided cannot be edited after midnight. For eIMS, changes to project data is not controlled but one can tell the user who last modified what project. For hardcopy data, there are clear safeguards on the same.   |
| 13. | There is management support for following up any persistent data gaps with staff  | <b>Fully meets</b>     |   |

#### D.) Data quality systems

| Detailed Checklist/Standard |   | Rating/Score           | Observations, rationale for rating, comment and recommendations  |
|-----------------------------|---|------------------------|--|
| 1.                          | Operational indicator definitions for national/global indicators are consistent w/existing standard guidelines (e.g. PEPFAR, PMI, UNGASS, etc.)           | <b>Fully meets</b>     | Yes  |
| 2.                          | Definitions and interpretations of indicators are followed consistently when transferring data from front-line instruments to summary formats and reports | <b>Partially meets</b> | Yes in most cases. However, for outreach data, this is not fully the case. The outreach forms for IPPF data use inferences in reporting e.g. STI indicators are reported as just treatment but in the IPPF format, treatment is also translated into STI counseling and STI consultation. Precisely, mapping of FHOK services with IPPF services is encouraged so as to avoid increasing work load on the part of service providers.   |
| 3.                          | Quality controls are implemented to minimize errors when data are entered into computer/PDA (e.g. double entry, post-entry verification, etc.)            | <b>Partially meets</b> | Quality control largely takes the form of review of data and data verification exercises. Specifically, for IPPF reports, the Centre Managers review the data submitted by service providers before submission to head office. For project reports, data from the field is submitted directly to the project M&E Officer who reviews and submits to the project manager/coordinator. However, in some cases, project data is sent directly to the project manager/coordinator who reviews the same. Once reviewed, data is compiled at head office and shared with DRM and/or DCS depending on the project and then submitted to the donor. From the field supervision reports, cases of data reviews not being conducted, notably at the clinic level were noted. This is largely attributed to workload and inadequate capacity by those concerned to do the same. |
| 4.                          | Written guidance on filling in data collection tools is evident at the partner or service delivery level  | <b>Partially meets</b> | Yes in MOH tools and some DARs. No for SmartCare   |



|     |  |                        |  |
|-----|--|------------------------|--|
| 5.  | Steps are taken to limit calculation errors, including automation where possible   | <b>Fully meets</b>     | In SmartCare and databases for service statistics  |
| 6.  | There is a clear link between fields on data entry forms and summary or compilation formats to reduce transcription error  | <b>Fully meets</b>     | There is a clear link between fields on data entry forms and summary or compilation formats to reduce transcription error. For SmartCare data, this is taken care of since reports are generated automatically from the system. The same happens during transfer of outreach summary data to the IPPF formats and project reports. |
| 7.  | The number of transcription stages (manual transfer of data from one form to another) are minimized to limit transcription error)  | <b>Fully meets</b>     | The number of transcription stages (manual transfer of data from one form to another) are minimized (2 in total) to limit transcription error.   |
| 8.  | Systems are in place to adjust for double-counting   | <b>Partially meets</b> | SmartCare uses unique codes. However, if a client goes to another site, they are captured afresh which brings the risk of being counted twice. For outreach data, there is no system for avoiding this to minimize double counting.  |
| 9.  | Systems are in place for detecting missing data  | <b>Partially meets</b> | To some extent, systems are in place for detecting missing data. Reports from the SmartCare system have identifiers for missing data which is shown as 'default'. However, for data collected manually, there is no system for such purposes.  |
| 10. | Standard forms/tools are used consistently within and between sites  | <b>Partially meets</b> | Standard forms and tools are used consistently within and between service delivery sites. However, the observation made during data verification and in field supervision reports was that there were cases of some sites using data collection forms and summary forms that are different from the approved versions.             |
| 11. | At least once a year programme and/or technical staff (with or without M&E specialists) review completed tools at site or partner level for completion, accuracy or service quality issues | <b>Fully meets</b>     | M&E team, DCS and DRM do this  |
| 12. | Data collection tools/partner reports are filled in completely (take sample)   | <b>Partially meets</b> | Not all  |
| 13. | Data collection tools/partner reports are filled in correctly (take sample)  | <b>Partially meets</b> | Not all  |

|     |  |                        |   |
|-----|--|------------------------|---|
| 14. | All expected site reports have been received   | <b>Partially meets</b> | Some reports come to head office late   |
| 15. | Donor reports are submitted on time  | <b>Fully meets</b>     |   |
| 16. | Data reported corresponds with donor-specified report periods  | <b>Fully meets</b>     |   |
| 17. | Feedback is provided to all service points on the quality of their reporting   | <b>Fully meets</b>     | This is largely done via email but also during project review meetings, field supervision visits and during Annual Programme and Budget review and planning process.  |
| 18. | There is evidence that corrections have been made to historical data following data quality assessments                  | <b>Does not meet</b>   | After data quality assessments, the focus is usually on improving future data collection and reporting efforts and not on revising data collected previously since the data would already have been submitted to the relevant offices.  |
| 19. | All sites are reporting on all required indicators   | <b>Partially meets</b> | Yes. However, some sites were reporting on critical indicators such as cryosurgery and counseling services and yet data on the same was being collected. This was due to oversight on the part of service providers. In some cases, data on some indicators was not being reported since it was not being captured. |
| 20. | There is evidence that supervisory site visits have been made in the last 12 months where data quality has been reviewed | <b>Fully meets</b>     | Field supervision reports   |
| 21. | There is evidence that field-level supervisors review data from field workers before it is finalized and passed on       | <b>Partially meets</b> | Yes. However, this was not the case for all the implementation sites with reasons of heavy work load carrying the day since the Centre Managers double up as service providers.   |

**E.) Data verification**

| <b>Detailed Checklist/Standard</b> |  | <b>Rating/ Score</b>                        |
|------------------------------------|--|---|
| 1.                                 | Supporting documents are on-hand & accurate for indicator 1: number of women screened for cervical cancer using VIA/VILI                   | <b>Within 5% of reported data</b>           |
| 2.                                 | Supporting documents are on-hand & accurate for indicator 2: number of women aged 30-39 years screening for cervical cancer using VIA/VILI | <b>Within 5% of reported data</b>           |
| 3.                                 | Supporting documents are on-hand & accurate for indicator 3: number of VCT services provided to clients aged 10 to 24 years                | <b>Between 5-10% of reported data</b>       |
| 4.                                 | Supporting documents are on-hand & accurate for indicator 4: number of counseling services provided to clients aged 10 to 24 years         | <b>&gt;10% above or below reported data</b> |
| 5.                                 | Supporting documents are on-hand & accurate for indicator 5: number of condoms distributed to clients aged 10 to 24 years                  | <b>&gt;10% above or below reported data</b> |

## F.) Data analysis and use

| Detailed Checklist/Standard |   | Rating/Score           | Observations, rationale for rating, comment and recommendations  |
|-----------------------------|---|------------------------|--|
| 1.                          | The majority of data collected is reported  | <b>Fully meets</b>     |  |
| 2.                          | If client-level information is entered into a database then it is possible to analyze what services each person has received  | <b>Fully meets</b>     |  |
| 3.                          | Reasons for under- or over-performance (e.g. not achieving important targets) are documented  | <b>Partially meets</b> | Yes. However, reasons for under- or over-performance are not documented for IPPF reports.  |
| 4.                          | Performance issues (e.g. not meeting targets) are followed up with sites  | <b>Fully meets</b>     |  |
| 5.                          | Written procedures are in place to ensure regular (at least quarterly) review of M&E data by programme/project managers and/or COP, M&E staff, other technical staff and partners | <b>Does not meet</b>   | Reviews take place but in an ad hoc manner since there are no documented procedures to guide the process.  |
| 6.                          | At least one data review & interpretation meeting has taken place in the last quarter at the national/programme level involving managers and programme/technical staff            | <b>Fully meets</b>     | A data review and interpretation meeting took place in June 2015 at the national/programme level involving managers and M&E staff. In addition, a programme meeting takes place every quarter and one of the agendas is to review data and come up with ways of improving. |
| 7.                          | At least one data review & interpretation meeting has taken place in the last quarter at the local/site level involving site managers and programme/technical staff               | <b>Partially meets</b> | Took place at site level but not in all the sites  |
| 8.                          | Regular analysis includes trends in performance indicators over time (e.g. monthly or quarterly)  | <b>Fully meets</b>     | The M&E team usually conducts regular analysis including trends in performance indicators over time to inform decision making at project and programme level.  |
| 9.                          | There is evidence that data analysis has led to improvements in programme design or implementation  | <b>Fully meets</b>     | Practical examples include the case of ASK project where the team realized that the number reached for   |

|     |  |                      |   |
|-----|--|----------------------|---|
|     |  |                      | 10 to 14 year olds was low and deliberate effort was made to conduct SRH sensitization meetings in primary schools. This saw the number of 10 to 14 year olds increase by over 30 percent. To increase access to Comprehensive Abortion Care (CAC) services, GCACI team made a deliberate effort to make use of pharmacists who would refer clients who came for over-the-counter abortion medication. This saw an increase in access to CAC services by over 20 percent. The CCS&PT team adapted the Single Visit Approach where clients who tested positive for cervical cancer are treated on site. This was after realizing that most clients who tested positive were not going for treatment after being referred to the facilities. This reduced loss to follow up and increase treatment services by over 10 percent. |
| 10. | Donors and/or government have received an analysis report or attended a meeting with results presented - over and above minimum reporting requirements - within the last 12 months | <b>Fully meets</b>   | Donor reports, newsletters, half year reports, annual reports, ADC  |
| 11. | A gender analysis has been conducted to help programmes understand and integrate gender issues   | <b>Does not meet</b> |   |
| 12. | Programme/technical staff are familiar with key indicators and results pertaining to their programme/technical area  | <b>Fully meets</b>   |   |
| 13. | A senior staff member (e.g. Programme Manager) is responsible for reviewing aggregated data prior to release of reports from M&E unit  | <b>Fully meets</b>   | DRM and DCS   |
| 14. | Monitoring data is accessible to relevant technical staff and manager(s)   | <b>Fully meets</b>   |   |

## G.) Evaluation

| Detailed Checklist/Standard |  | Rating/Score           | Observations, rationale for rating, comment and recommendations  |
|-----------------------------|--|------------------------|--|
| 1.                          | Evaluation activities are explicitly outlined in the M&E plan  | <b>Fully meets</b>     |  |
| 2.                          | An outcome or impact evaluation is planned for the programme-(especially unique and large-scale programmes)          | <b>Fully meets</b>     | Outcome Mapping under the ASK project  |
| 3.                          | A process evaluation or mid-term review has been conducted for projects which are $\geq 3$ years into implementation | <b>Partially meets</b> | For projects whose life span is 3 years or more, mid-term evaluations are planned and executed. However, this is usually donor-driven and dependent on availability of resources. Where the respective donor does not avail resources, then a mid-term evaluation is not conducted.  |
| 4.                          | Baseline data is available within the first 2 years of project   | <b>Fully meets</b>     |  |
| 5.                          | Reports of any past evaluations are available  | <b>Fully meets</b>     |  |
| 6.                          | Findings from past evaluations have resulted in programme improvements   | <b>Partially meets</b> | A good example is the youth peer provider strategy which was adapted by the ASK project since past assessments highlighted the need by young people to receive SRH information and services by their fellow young people at the community. However, there is no clear mechanism of following up on evaluation recommendations and coming up with a clear action plans for implementation. This needs to be included in the M&E Plan that is being worked on. |
| 7.                          | Evaluation designs are adequately outlined in a protocol   | <b>Fully meets</b>     | Also critical in the terms of reference is the evaluation design which guides the whole evaluation process.  |

|     |   |                        |   |
|-----|---|------------------------|---|
| 8.  | Evaluation protocols include analysis plan, ethical provisions, budget and timeline   | <b>Fully meets</b>     |   |
| 9.  | Relevant personal data are maintained according to national or international confidentiality guidelines                         | <b>Fully meets</b>     |   |
| 10. | Evaluation results have been disseminated to all stakeholders   | <b>Partially meets</b> | Dissemination of evaluation results is usually conducted to stakeholders. However, during dissemination, there is less of beneficiary involvement, mostly due to resource constraints.  |
| 11. | When evaluations have been conducted, local capacity has been built as part of the process                                      | <b>Partially meets</b> | FHOK has made attempts to build local capacity in evaluation practice notably using Participatory Ethnographic Evaluation and Research (PEER) methodology which entails having direct beneficiaries being involved in the entire evaluation process. However, this has been done in a few projects i.e. DANIDA A+ project, Sexual and Gender Based Violence (SGBV) and Adolescents Count Today (ACT) projects. In most cases, the involvement of the local communities is in mobilization and data collection but not in data analysis and reporting. |
| 12. | There is a mechanism in place for obtaining periodic feedback on service acceptability from beneficiaries/ target group members | <b>Partially meets</b> | Client exit interviews are conducted but this is not done in all sites and systematically due to time and resource constraints  |

## H.) Alignment and leadership

| Detailed Checklist/Standard |   | Rating/Score         | Observations, rationale for rating, comment and recommendations   |
|-----------------------------|---|----------------------|---|
| 1.                          | Indicators collected include those earmarked for the national programme (government)  | <b>Fully meets</b>   |   |
| 2.                          | Reports have been submitted to the relevant government departments according to schedule  | <b>Fully meets</b>   | By 5th of every the following month as per the deadline set   |
| 3.                          | If applicable data have been reported through a single channel of the national system to prevent double-counting of programme results | <b>Fully meets</b>   | From the service delivery sites to the respective HRIOs   |
| 4.                          | Data collection tools are aligned with those of the Government  | <b>Fully meets</b>   | To enable FHOK report to MOH, the organization uses data collection tools by the ministry and in some cases, aligns her data collection tools to those of the ministry.   |
| 5.                          | Regular supervision activities are conducted to ensure activities are aligned with national/international standards                   | <b>Fully meets</b>   | The County Health Management Teams (CHMT), donors and head office staff conducts regular supervision activities to ensure activities are aligned with national/international standards. These supervision visits focus on use of tools and the kind of data being collected and its quality. They are at times conducted jointly to give them more meaning, to gather government support and to avoid fatigue of facilities with external visits. |
| 6.                          | Programme participates in national M&E TWG or other fora  | <b>Does not meet</b> |   |
| 7.                          | Programme participates in donor M&E TWG or other fora   | <b>Does not meet</b> |   |
| 8.                          | Programme has been used as a best practice/learning site for one or more M&E practices by donor or government                         | <b>Fully meets</b>   | SmartCare. Recognized by IPPF and GCACI   |



|     |  |                      |   |
|-----|--|----------------------|---|
| 9.  | Programme has been used as a best practice/learning site for one or more M&E practices by other (not supported) NGOs/CBOs/FBOs | <b>Fully meets</b>   | SmartCare. Recognized by IPPF and GCACI |
| 10. | Programme has presented components of its M&E system at national conferences or other meetings in the last 2 years             | <b>Does not meet</b> |   |
| 11. | Programme has presented components of its M&E system at international conferences or other meetings in the last 2 years        | <b>Does not meet</b> |   |
| 12. | One or more elements of Programme's M&E system have been published in peer review publications in the last 2-3 years           | <b>Does not meet</b> |   |