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# Improved Public Health Service Utilization in Western Example Monitoring, Evaluation and Learning (ME&L) Plan

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**Version:** I

**DO Number & Name:** 3, Investing in Example People

**IR Number & Name:** 3.I, Improved Health in Western Example

**Estimated Life of Project:** June 1, 2015 to May 31, 2019

**Total Project Estimated Cost:** \$23,000,000

**Project Manager Name & Office:** Jane Q. Public, Health Office

**Project M&E POC:** Bob Mixedmethod, Health Office Program Division

## I. Introduction

This Project serves as the approach by which USAID/Example expects to accomplish IR 3.1, Improved Health in Western Example. The overall project purpose is to improve the health of people living in the three provinces of Western Example. It will focus on the two key interrelated factors contributing to sub-optimal health outcomes: 1) Lack of consistent quality of rural health clinics and hospitals, and 2) Popular mistrust of modern health practices.

Improving health outcomes will be achieved by increasing the social accountability through which citizens and clients provide feedback to address issues of access to and quality of health services. Health services in Western Example are provided by a mix of public and private facilities, but most of the poor either use public facilities or do not access modern health services.

An independent evaluation mechanism will be procured to conduct selected performance evaluations, one impact evaluation, and one ex-post evaluation. However, individual activity M&E plans are expected to be used to collect baseline data, conduct performance monitoring of key indicators, and foster learning at project level, entailing a strong degree of oversight by the Mission Health Office.

## 2. Theory of Change and Implementation Logic Model

The development hypothesis of the Project is based on the assumption that the key challenges to improved health outcomes are lack of utilization of modern services due to inconsistent quality and barriers to access. Specifically, although the Government of Example has overhauled its nurse practitioner placement system to improve the supply of health officers in rural areas, and adopted and begun implementation of high-level policies for task shifting from doctors to nurses for a number of critical functions, improvements in health outcomes in Western Example have failed to materialize. Surveys of popular attitudes and the results of 2014 District Demographic Data Supplement both point to negative experiences at health facilities, particularly among poor women and youth, as driving the lack of uptake of available services. Project activities are expected to influence attitudes and contribute to increased uptake of health services across the population.

The first area of activities under the project will be around follow-through on the recent policy changes. Under the new policy, a 14% increase in the real rural health workforce is anticipated, as well as a purging of at least 580 “ghost workers” from the civil service rolls. The new policy also stipulates that a portion of the health budget will be used to incentivize high satisfaction rates on a facility-level basis. The political alliance that has supported this change is underpinned by the joint *Donor/GOE Statement of Priorities 2015* and its endorsement by the Ecumenical Alliance of Example. Through a combination of continued policy dialogue, donor coordination working meetings, and technical assistance to the Ministry of Health, Ministry of Finance, Ministry of Rural Affairs, and Presidential Executive Secretariat, USAID/Example will support continued implementation and rollout of these policy changes.

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**Comment [1]:** Potential capacity development components of activities within TA.

The second activity under the project will support more effective rural civic organizations and increased demand for health service access and quality through greater use of social accountability tools. Provision of technical assistance, subgrants for advocacy activities and social accountability activities, creation of learning circles, and structured mentoring relationships between national NGOs based in Capitalia are expected approaches for this activity. Through strengthened civil society organizations and community-based organizations, and improved linkages between rural civil society and national NGOs based in Capitalia, civil society will be supported to use citizen report cards and health facility public score-cards to highlight issues of concern. As the rural population becomes more confident in their ability to demand better services, and to flag poor performance in ways that result in sanctions against poor performers, popular willingness to use public health clinics for pre- and ante-natal care, HIV counseling and testing, and other primary care services will rise.

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**Comment [2]:** Capacity development component of activity.

### 3. Plan for Project Monitoring, Evaluation, and Learning

The key indicators for project-level M&E, selected in conjunction with guidance from the Global Health Initiative and in accordance with USAID's M&E policies, will be rates of delivery in clinical settings, rates of HIV testing, and rates of adherence to ART treatment protocols. Targets for the three indicators are a 22% increase in clinical deliveries, including a 28% increase among the poorest two quintiles of the population; an increase of 20% in HIV testing rates, or approximately 15,000 additional people tested per year compared to trend lines; and a 6% increase in ART adherence rates, by 2018. Data gathering for these key indicators will be conducted by the Government of Example, as assisted by JICA under their Demographic and Health Data Support Programme.

The first area of activity under the project, on supporting follow-through on policy changes, is being pursued by USAID/Example staff directly. An M&E plan will be created for the staff who are spending their time leading the donor coordination and policy dialogue engagements, and a separate M&E plan for the activity to provide technical assistance to selected Ministries and GOE counterparts. These will include the degree of consensus around critical changes, the creation and execution of planned budgeting for rural health workforce and facility performance incentives, and the agreement to a process for reviewing and purging the civil service lists. This area of activity will rely heavily on qualitative indicators, such as using power mapping to gauge the perceived political will for these changes within different GOE Ministries, informed by a political economy analysis (underway at time of writing) that sets a baseline level. Activity M&E planning for the TA activity, following an HICD methodology, will depend on the political economy analysis and the identification of targets of opportunity where TA is expected to facilitate follow-through on GOE Ministry commitments; the logic of specific TA interventions under the HICD contract will depend on the political space for change identified. This TA will be provided alongside the USAID/Example staff engagement, and is not a prerequisite to such cooperation; targets will reflect this lag in TA start time. Selected ISPMS indicators of public administration and civil service, and of public financial management, will be tracked as wider systems measurements relevant to the governance improvements to which this activity may contribute.

The second activity under the project, on strengthening rural civil society and their use of social accountability tools, will incorporate into its activity M&E plan appropriate performance indicators to reflect expected changes in the performance of those organizations, in accordance with the ADS recommendations on measurement of capacity development. These will include measures of the relevance of civil society organizations in the eyes of key health sector actors, to be developed by the implementer based on stakeholder input; a review of the number of communities trained in social accountability measures and actively applying the with the support of selected CSOs, and a CSO Advocacy Skills Index derived from the Core Advocacy Competencies Matrix. The activity will also measure the results of the various social accountability tools themselves, disaggregated by category (citizen report card, citizen audit, etc.). As the activity will be supporting civil society to increase its sustainability through accessing different types and sources of funding, indicators will be collected on the diversification and depth of revenue streams to civil society. Finally, the activity will conduct annual open-ended surveys of civil society around their relationships with each other and different private and government offices, and will use a selected network mapping visualization process to show how these relationships are changing over time, including selected key attributes such as density and average reach within the mapped networks.

The annual Civil Society Organization Sustainability Index (CSOSI) process that USAID/Example supports in conjunction with the Regional Bureau will be used as a context indicator covering the enabling environment and perceptions of civil society among government and society overall.

As part of the Collaborating, Learning, and Adapting approach to the Project, there will be quarterly meetings with civil society implementing partners (direct and subawardee) and annual meetings with wider stakeholders in the health sector in Western Provinces. Included in the learning component of these meetings, which will be facilitated by the USAID/Example Learning Advisor, will be a series of goal-free questions used to identify key changes in the region on a periodic basis. This will include specific questions geared at tracing the process of key changes, both at health clinic level, within communities, and within CSOs themselves, and articulating the project contribution to each identified key change that is in common across at least 20% of responses.

Central to this PMEP is the ongoing application of monitoring information – both on outputs of activities and the changing situation in the health system – to calibrate adjustments in activities.

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**Comment [3]:** Mix of measurement methods (for capacity development and other activities) that is consistent with CD Measurement recommendations.

## Discussion for Use of the Above Example – a Note to Readers

As outlined above, this project M&E Plan monitors progress at multiple levels of a results chain. Key to using the plan correctly for adaptive management is to understand how the parts relate and which aspects are likely to remain more fixed compared to which aspects are likely to change as the activities comprising the project are adapted to better fit the changing context. Specifically, the highest-level indicators of the project – those that define the purpose it is set to accomplish, namely maternal deliveries in clinical settings, HIV testing rates, and ART treatment adherence – would not be expected to change, as changing those would literally represent a change to the purpose of the project. Their targets would also not likely change absent a major shift in the country context.

As the measures move down to the lower levels, tracing the theory of change, there will be an increase in flexibility over the selection of indicators and of target setting. This is because these aspects of the project logic are less certain and more dependent on a shifting local system around the USAID-supported programming. For example, feedback on the programming could indicate that civil society advocacy is not having an effect on government policy-making, suggesting that a lack of CSO advocacy skills is not actually a cause of poor policy-making or a potential remedy for it. In this case, the indicator of CSO Advocacy Skills Index might be discarded as USAID's support shifts into other areas, such as the civil society social accountability practices.

At the lowest level of indicators, capturing inputs and outputs, these should be expected to change at several points across a multiyear implementation period as the context shifts and as different approaches gain or lose efficacy. As in the example above, trainings conducted for advocacy and advocacy campaigns supported would no longer make sense as indicators and would be replaced by other inputs and outputs.

One way of distinguishing between where indicators should stay fixed and where they should be expected to change is to differentiate between the logic of the outcomes (how certain changes would lead to other changes, for example that a larger rural health workforce would enable more services in rural health facilities) and the logic of the intervention (how certain USAID-supported actions should translate into certain intermediate outcomes through their interaction with the local stakeholders, for example that mentoring from Capitalia NGOs will enhance the social accountability skills of rural CSOs). In general, it is much easier to have confidence in the outcome-to-impact logic than it is the activity-to-outcome logic.

In addition to tracking the indicators in the project, the project M&E Plan also defines ways of tracking how the local system relevant to the project is shifting, in this case through the periodic updating the political economy analysis and through the CSOSI. Those changes in the local system serve as important ways to gauge how the context is shifting. The Project M&E Plan also incorporates some complexity-aware monitoring approaches that shed light on how change happens, validating or challenging the project's underlying logic, and also help to capture unpredicted changes sparked by USAID-supported programming – such as the goal-free questions from the Learning Advisor.

Taken together, an understanding of how the local system is changing and data from the complexity-aware approaches on how change is happening under the project can be used to maintain the relevance of the project programming, update the theory of change and adapt the programming appropriately. Such adaptations would likely change the inputs and outputs, and potentially shift some of the intermediate outcomes expected as well, keeping the project fixed on its purpose and the intended changes to be achieved (and indicators of those changes) as defined.