Monitoring, Evaluation & Learning (MEL) Strategy

TCI's Monitoring, Evaluation & Learning (MEL) strategy focuses extensively on strengthening, monitoring and evaluating the effectiveness of TCI high-impact interventions (HIIs) by working hand-in-hand with the state team, which comprises of staff from the Department of Planning, Research and Statistics of State Ministry of Health (SMOH), Hospital Management Board (HMB) and Primary Health Care Management Board (PHCMB), state HMIS officer, FP statistician, HMB M&E officer, PHCMB M&E officer as well as LGA M&E officers. TCI MEL coach is embedded within the Department of Planning, Research, and Statistics of the three health arms of the state, i.e., SMOH, HMB and PHCMB.

TCI's MEL strategy takes a multi-phased approach to ensure learning and sharing related to the HIIs are incorporated into program design, implementation and evaluation. Additionally, MEL tracks and rapidly assesses program performance against output and outcome indicators. It uses this information to periodically review each project component, better understand what worked and why, refine implementation approaches and activities and inform decision-making throughout the life of not only engagement with TCI but also implementation of the HIIs. The three phases of TCI's MEL strategy include: Formative/Start-up Phase, Implementation Phase, and Evaluation Phase. The activities undertaken during each phase are listed in Table 1 below and described in detail throughout the rest of this document.

Table 1: Overview of TCI's MEL phase and activities

Formative/Start-up Phase	Implementation Phase	Evaluation Phase
• Secondary analysis of available data • Performance Improvement Assessment/Plan (PIA/PIP) • Baseline household survey • Baseline health facility survey • Data use to inform prioritization of HIIs	• MEL technical assistance & coaching support • Data quality assurance • Data review and feedback meetings • Production of briefs and infographics • Sharing at conferences and publications • Data use to inform adaptations of HIIs and course corrections	• Endline facility survey • Endline household surveys

I. FORMATIVE/START-UP PHASE

The formative and start-up phase involves activities that provide baseline information according to the geographical nuances. The evidence generated at this level is used to understand the target population, resources available and the health system structure. The activities implemented in this phase aid in gathering robust evidence for TCI and the state to make designs related to prioritizing and adapting the HIIs. They include:

a. Secondary analysis of available data

In a bid to understand the dynamics of state-specific family planning supply and demand barriers and provide evidence to plan for appropriate family planning interventions in all the TCI states, a secondary analysis of available data is conducted. The sources of data for the secondary analysis include NDHS and MICS, among others. The analysis covers relevant information about family planning programs among women of reproductive age. The outcome helps to give a guide to the implementation of TCI activities. Specifically, the secondary analysis provides answers to the following questions:

- What is the pattern of contraceptive use among women of reproductive age across states?
- What type of service outlets do contraceptive users patronize for contraceptive services across states?
- Is there an association between women's exposure to media and contraceptive use across states? What are the socio-demographic characteristics of FP users and non-users across states?

b. Performance Improvement Assessment/Performance Improvement Plan (PIA/PIP)

The PIA/PIP is one of the proven high-impact family planning interventions which TCI-supported states use to inform and target the other proven service delivery interventions with the goal of increasing contraceptive service uptake. The PIA provides a baseline assessment of infrastructure, staffing strength, service provision, training needs/gaps, equipment, consumables and supplies across supported facilities, prioritizing high-volume sites (HVS). Gaps identified are used to develop the PIP, which when implemented across the sites facilitates quality service delivery. Information gathered also provides a benchmark against which subsequent assessments are compared for measurement of programmatic impact.

c. Baseline household survey (Flexi-track omnibus survey)

The flexi-track omnibus survey is a cross-sectional assessment primarily used to generate data that guides the design and implementation of TCI mass media campaign and community mobilization activities. The survey also tracks program exposure and associated changes in ideation and intention to use

contraceptives. It is also used to track other program-related indicators at the household level throughout the lifespan of state's engagement with TCI. The specific objectives of the flexi-track omnibus survey are to:

- Monitor the reach of TCI multi-channeled communication approaches in target states, including listenership, viewership, etc.
- Track the effect of TCI demand generation activities at the population level. This includes the tracking of changes in norms, ideation and intention to use contraceptives among men and women of reproductive age.

  Provide six-monthly data measures that can be used to plan and improve program implementation across all project states.

d. Health facility survey

The baseline facility survey generates information about the quality of family planning services at HVS and their readiness to provide integrated family planning services. Surveys look at client perceptions of family planning services as well as competency gaps among service providers to offer high-quality family planning services. Surveys are comprised of three components: facility audit, provider interviews and exit interviews.

e. Data use for decision-making

Data for decision-making is an important pillar of TCI's MEL strategy as it gives the program the nimbleness for course correction using near- to real-time data. It further ensures that the HIIs supported in the different states reflect the identified gaps and are adapted for the local nuances. Data for decision-making is carried out by:

- Assess the availability of data by assessing the FP tools in TCI-supported facilities to strengthen the reporting rates of the states for services provided in its health facilities,
- Establishing access to local data systems, such as the HMIS, and
- Assessing data quality and use to develop coaching plans to support improved data systems and use.

II. IMPLEMENTATION PHASE

The implementation phase encompasses all activities that aid in monitoring and tracking the key performance indicators (KPIs) related to TCI's results framework. This phase uses both quantitative and qualitative techniques in gathering relevant information to iterate the success of TCI. Additionally, the

MEL implementation phase focuses on measures that gauge the extent to which TCI HIIs and activities meet the state's targets. It further helps the project to refine strategies to fit the real needs of the communities served by the states, either by restating successful project streams with improvements or decommissioning project streams that do not provide tangible benefits at a reasonable cost. Some of the activities during the implementation phase include:

a. MEL Technical Assistance & Coaching Support to the States

TCI works with all the states to strengthen their health and family planning M&E systems by providing on-the-job coaching and mentoring. This simultaneously improves the quality and use of data by the states while improving the quality and reliability of data used to monitor and evaluate its interventions.

Coaching provided by TCI involves one-on-one practical sessions with the target audience using different approaches to build the skills of not only the individuals but teams on how to enhance their data collection, reporting and data use for decision-making to ensure quality service provision. TCI's coaching can be proactive, which is initiated by TCI based on observed needs, as well as on-demand, which is requested by the target audience. The coaching is provided to service providers, health information officers (HIOs), and M&E officers at the facility and local government area (LGA) levels monthly. Table below shows an example of a MEL coaching plan.

Table 2: MEL Coaching Plan

PERSONNEL FOR COACHING	GENERAL ISSUES	STRATEGIES	PLAN AND COACHING TYPE	TIME FRAME FOR COACHING	DESIRED OUTCOME
Service Providers (SP)	• Use of exercise book to capture data as well as use of old data tools • Missing values because of improper filling • No adequate feedback mechanism for SPs on service uptake • Common human error in data entry	• One-on-one coaching • Data visualization	Coach to coachee	Biweekly	• Improved feedback mechanism: SP should be able to determine and monitor trend in service uptake • Total elimination of exercise book in capturing data at the point of service delivery • Accurate data to be generated at facilities level

Health Information Officers (HIO)	• Computation error • Inconsistency in data harmonization at facility level • Low verification of data from the HMIS source documents	• One-on-one coaching • Group engagement	Coach to coachee (LGA M&E – HIO at facility level)	Monthly	• Improved data verification from source document • Consistency in data harmonization at facility level • Reduced human error because of computation
LGA M&E officers	• Extreme outliers • Frequent data update on DHIS 2 dashboard even up to 28th • Inadequate data feedback to decision making.	• Data Visualization • One-on-one coaching	Peer-to-peer WhatsApp	Monthly	• Improved data quality uploaded timely into the DHIS 2 dashboard • Regular data feedback to the policy maker
Medical Officers of Health	• Inadequate use of data for decision-making	• Data visualization • Regular feedback	Peer-to-peer WhatsApp	Quarterly	Regular use of data for decision-making

KEY

Coaching Style	Strategies to address identify issues	Coaching Type
• Mentor-to-Mentee/Coach-to-Coachee • Peer-to-peer • WhatsApp	• Data visualization • Regular update/feedback • Face-to-face, one-on-one	• Proactive • On demand

b. **Data Quality Assurance**

Routine service statistics data is only useful in making informed decisions if it is of high quality. More so, reliable and accurate health information is essential for improving service delivery, monitoring and evaluating health programs as well as demonstrating funding support for health programs, including family planning. As a result, TCI provides technical assistance to the state to measure data quality (in terms of accuracy, completeness, consistency and timeliness of data) and in addition identify gaps in reporting systems that inhibit the production of quality data. The DQA exercise also involves regular review of NHMIS performance as measured by the level of data quality and the use of data for decision-making.

c. **Data Review and Feedback Meetings**

The overall goal of the data review and feedback meeting is to provide feedback to stakeholders at the state and LGA level to enable them to appreciate the status of reproductive health/family planning indices across facilities, LGAs and states. This is with a view towards also providing a scorecard for measuring improvements and developing an actionable plan, capable of improving family planning services. Additionally, the review and feedback meetings help the state to:

- Review service statistics trends across TCI-supported or demonstration health facilities
- Share feedback from supportive supervision visits, discuss general and peculiar identified gaps and propose solutions
- Identify issues that impact family planning service uptake and client visits more generally.
- Discuss the development of a realistic plan for the next quarter per LGA and HVS

The organization further supports this process through quarterly RH/FP data review meetings and M&E technical working group health meetings facilitated by the state M&E leadership.

d. **Production of Briefs and Infographics**

The electronic health management information system for family planning data reporting in Nigeria has undoubtedly made data more available for use by decision-makers at national and state levels of the health system. However, its use at the LGA and health facility level has remained grossly limited due to obvious challenges with internet connectivity, computer systems, electricity, skilled manpower and information technology support. Therefore, strategies to improve the uptake of family planning services at the facility level must take into consideration what simple and effective approaches work in visualizing and using data to identify areas requiring attention or improvement, determine factors influencing family planning service uptake and forecast clients' in-flow to the health facility. The state with support from TCI uses the run chart, a simple form of data visualization to transform data into information for improvement.

Thus, the run chart is a simple and easy-to-use process improvement tool that graphically represents a set of data plotted against a period. When data is collected and charted over time, it shows trends or patterns. The data displayed describes an output, performance or important changes that may have occurred over time. It is requisite to note that health workers are most likely to understand, explain and use data collected and charted themselves more than that collected and charted by others.

e. **Conferences and Publications**

TCI shares data through program review and data review meetings, briefs and infographics, and publications and presentations. During the last few years, the MEL team has presented several oral and poster presentations at international and national conferences and meetings.

f. **Data Use**

TCI supports state in conducting further analysis of the HMIS data from DHIS2. The HMIS analysis is used to monitor near- to real-time changes in the state's health system before national level surveys, like the MICS and NDHS, are carried out. TCI's client volume estimation methodology is based on modeling of service statistics data from HMIS. The methodology tracks the number of FP clients served in each TCI city since implementation began, aggregates this number by method type (short-acting, long-acting, or permanent). As part of this analysis, the data is adjusted for seasonality, short-acting methods and revisits. The mc-mcpr estimates the modeled change or modeled growth in mcpr across the LGAs/states. Also, while annualized client volume presented looks at the baseline versus latest reporting period by using only the facility-based data for its estimation, the mc-mcpr puts the population served into consideration and this shows growth per implementation year. This has helped states see if there is a progression in the mc-mcpr across the years since they have been engaged with implementing TCI's HIIs. Furthermore, this estimation helps to give a near accurate picture of how TCI's HIIs are impacting FP uptake, especially at TCI demonstration LGAs. In addition, the estimation is expanded to non-TCI demonstration LGAs and statewide, thereby providing evidence to monitor the diffusion effect of HIIs in neighboring LGAs. The results from client volume and mc-mcpr also form part of the framework used to assess the readiness of the states for graduation.

At the facility and LGA levels, challenges with reporting correct data are identified and addressed through various coaching channels to improve the quality of the data being reported. On-the-job coaching and peer-to-peer mentoring are some of the modalities employed to implement the coaching strategy modified from place to place, depending on the coaching need and local context. Where nonexistent, feedback loops are set up to enable the facility record officers and service providers to identify areas where they have challenges and places for improvement.

III. EVALUATION

During this phase, TCI collects and analyzes data from multiple sources to measure program and population-level outcomes associated with TCI's HII implementation. TCI uses both secondary and primary data sources to measure and document key outcomes. The data comes primarily from the following sources:

Endline facility survey	•Final evalution survey measuring service delivery outcome indicators Eg. percent of service providers who report approval of service provision without bias, percent of women who would return to their provider and refer a friend or family member, etc.
Endline household surveys	• Final evalutions measuring population level outcomes, and impact indicators Eg. contraceptive prevalence rate, percent of women who have heard religious leaders speak about family planning, percent of women who believe that most of their peers are using family planning, etc.
Secondary analysis and need-based Ad-hoc surveys	• Ad hoc surveys are done without any plan for repetition. They are implemented as needed E.g the Coaching study conducted to understand coaching methodology, best practices and lesssons learned to inform future programming for TCI and others who desire to use coaching as an approach to technical assistance.