Narok County
End Line Assessment of Monitoring and Evaluation Capacity

September 2017

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MEASURE Evaluation PIMA

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MEASURE Evaluation PIMA is funded by the United States Agency for International Development (USAID) through associate award AID-623-LA-12-00001 and is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in partnership with ICF International; Management Sciences for Health; Palladium; and Tulane University. The views expressed in this publication do not necessarily reflect the views of USAID or the United States government.
TR-17-206

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ACKNOWLEDGEMENTS

Our appreciation goes to the management and staff of the Narok County health management team for their time and dedication to this end line assessment and to the team at MEASURE Evaluation PIMA (funded by the United States Agency for International Development) for organizing the workshops and facilitating the end line assessment process. The following staff of MEASURE Evaluation PIMA, ICF, contributed to the work leading to this report: Geoffrey Lairumbi (technical direction and coordination of the end line assessment), Hellen Gatakaa (technical direction), Peter Nasokho (review of the Monitoring and Evaluation Capacity Assessment Tool), Erastus Marugu (coding), and Irene Okwara (logistical coordination). Liz Millar, of the USAID-funded MEASURE Evaluation, University of North Carolina at Chapel Hill, wrote the report. Project directors Judith Omumbo, Abdinasir Amin, and Edward Kunyanga provided technical and management input on the process and report. The USAID Kenya/East Africa team (Lize Ojowi and Washington Omwomo) provided technical input during the life of the project. Finally, we acknowledge Cindy Young-Turner, ICF creative services, for editing and MEASURE Evaluation's knowledge management team for editorial and production assistance.

CONTENTS

ABBREVIATIONS

CHMT	county health management team
DQA	data quality audit
M&E	monitoring and evaluation
MECAT	Monitoring and Evaluation Capacity Assessment Toolkit
MEval-PIMA	MEASURE Evaluation PIMA
MOH	Ministry of Health
MSC	most significant change
OCI	organizational capacity index
OM	outcome mapping
TWG	technical working group

1. INTRODUCTION

This report is a brief synthesis of an end line assessment undertaken to discern and document the capacity of the county health management team (CHMT) to perform monitoring and evaluation (M&E) functions in Narok County, as a means to understand the impact of MEASURE Evaluation PIMA (MEval-PIMA) in improving M&E systems at the county level and the changes in M&E capacity since the start of the project.

The MEval-PIMA project was implemented between December 2012 and June 2015.[1] As part of the project closeout, MEval-PIMA conducted an end-of-project assessment to document achievements and provide lessons learned toward strengthening capacity of the Ministry of Health (MOH) at the national and subnational levels to produce and use high-quality data for decision making and to communicate project results with stakeholders and beneficiaries. Specifically, the end line assessment aimed to achieve the following:

- Document changes in M&E capacity since the baseline assessments were conducted.
- Document the key drivers of changes in M&E capacity.
- Document MEval-PIMA's contribution to the changes in M&E capacity.
- Document lessons learned in terms of strengthening M&E capacity at individual and organizational levels.

The decision to include Narok County as part of the end line assessment was aimed at delineating the differences in M&E capacity between counties that benefited from financial and technical assistance from MEval-PIMA and those counties that did not benefit, for the period of the project.

2. BACKGROUND

MEval-PIMA is a five-year project funded by the United States Agency for International Development (USAID), with the aim of building the M&E capacity of the MOH to identify and respond to information needs at the national and subnational levels. To do this, MEval PIMA targeted selected national programs and counties to strengthen their M&E systems and their ability to contribute high-quality data to the national health system.

The MEval-PIMA project was awarded in 2012 and has been implemented in 5 national-level programs (National Malaria Control Programme, Reproductive and Maternal Health Services Unit, Community Health Services Unit, Disease Surveillance and Response Unit, and Civil Registration Services) and 24 counties, including Narok County.

As part of the startup, MEval-PIMA conducted a baseline assessment in 17 counties, including Narok, between March and June 2014 using MEASURE Evaluation's Monitoring and Evaluation Capacity Assessment Toolkit (MECAT).[2]

[1] MEval-PIMA support to Narok County was discontinued in Year 3, following USAID's geographical pivot to focus on HIV/AIDS priority counties.

[2] https://www.measureevaluation.org/pima/m-e-capacity/me-capacity

The baseline assessment in Narok County revealed gaps in capacity areas in terms of status and quality dimensions in human capacity for M&E, partnerships and governance, costed M&E plans, evaluation and research, and data demand and use. Both financial and technical dimensions were low, implying an overdependence on stakeholders for technical and financial support of M&E functions.

As part of the response to M&E gaps identified in Narok, MEval-PIMA provided both technical and financial support to develop a County Health Sector Strategic Plan. It also supported the initial stakeholder coordination meetings to raise awareness and resources for addressing the M&E gaps, in line with agreements made among U.S. Government implementing partners and the national MOH. Beyond this, however, the county had little further engagement with MEval-PIMA and did not benefit from continued support toward M&E systems strengthening, following the geographical and technical refocusing in 2015 by the United States President's Emergency Plan for AIDS Relief. After the baseline assessment, MEval-PIMA supported the development of an action plan to address the gaps identified and supported the dissemination of the findings to stakeholders in Narok County. The aim of including Narok County as one of the three counties in which the evaluation was undertaken was to provide learning on how the technical assistance provided as part of the baseline was used to address the identified gaps in the absence of financial support to the county.

3. METHODS

The end line assessment was conducted in a five-day workshop setting using three participatory data collection tools. Respondents for this exercise were program managers and program officers, including M&E officers and data managers from Narok County.

Data on the M&E capacity of the county department of health were collected using the group MECAT that had been administered at the baseline. This tool assesses 12 capacity areas that are necessary for sustainable M&E capacity of organizations. Data from the MECAT were used to compute the organizational capacity index (OCI), to demonstrate change in capacity.

In addition, an interview guide—based on two rapid evaluation methods: most significant change (MSC) and outcome mapping (OM)—was used to collect qualitative data, to explain the observed changes in capacity (if any), and to explore the set of conditions to be fulfilled in order to achieve the desired changes. The MSC approach[3] was used to identify significant changes in capacity, along five domains that formed the basis of MEval-PIMA's intervention to address gaps in M&E capacity that were identified at project inception. The outcome mapping method was used to map desired outcomes conditions for the sustainability the gains made in strengthening M&E capacity. The administration of both the MECAT and the qualitative tools was guided by facilitators of a series of plenary and group discussions. In addition, the individual competency-based assessment—also used during baseline—was administered for participants to self-assess their M&E competencies.

[3] MSC is a participatory monitoring approach that enables the identification of desired outcomes without using defined indicators. The MSC approach involves analyzing actual events to draw meaning out of them as a means of evaluating the impact of a project and to improve future planning and implementation. We used MSC to understand what program officers viewed as the most significant changes in the five domains listed in Section 3.1. Participants were guided through facilitated individual, group, and plenary sessions to identify and prioritize the most significant changes within the five domains since the baseline assessments were conducted.

3.1. Five MSC Domains

Five broad domains were selected to guide the discussion of changes in M&E capacity, based on the project's mandate and findings from the baseline assessment. Participants were asked to identify the significant changes towards strengthening M&E capacity under the following domains:

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

3.2. Data Analysis

Scores obtained from the MECAT were analyzed to compute an organizational capacity index score, and changes between baseline and end line were used to document achievements toward strengthening the M&E capacity of Narok County. The organizational capacity index was calculated by first summing the possible scores for the 12 M&E capacities for the status and quality dimensions. The financial and technical autonomy dimensions were excluded because the effect of these measures was not unidirectional, and the presence or absence of these dimensions could affect the performance of Narok County either positively or negatively. Technical and financial autonomy require long-term investment and depend on the status and quality dimensions. The organizational capacity index was then computed by dividing the actual score of the 12 M&E functions under the two dimensions of status and quality by the total maximum possible score. Individual assessment data were analyzed to understand changes in human capacity for M&E from baseline

to end line. The MSC data were analyzed to understand what the program found to be the MSCs resulting from the changes in the M&E system since baseline. The outcome mapping data were used to understand the threats to the changes made to the M&E system and to propose recommendations to mitigate these threats.

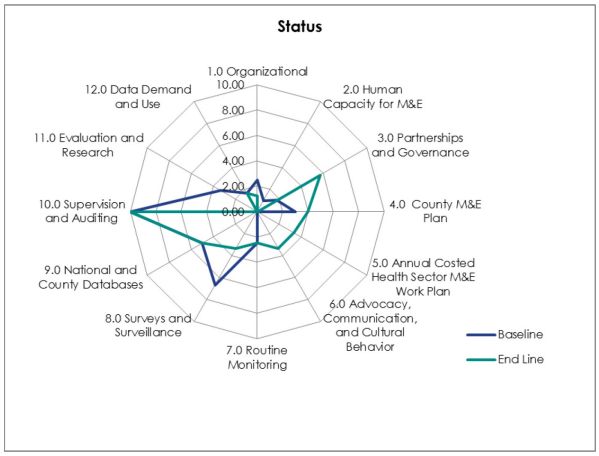
4. RESULTS

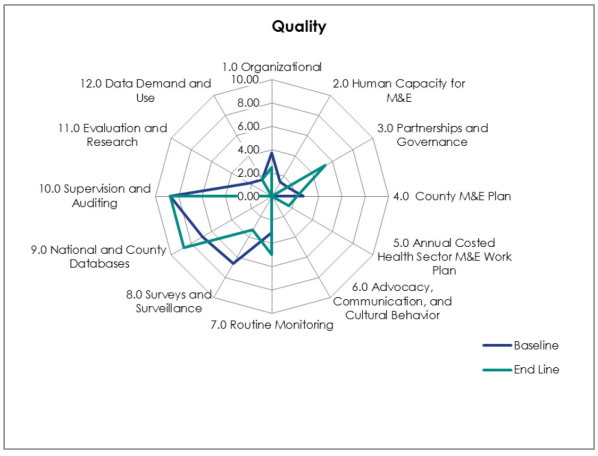
4.1. Overall Performance

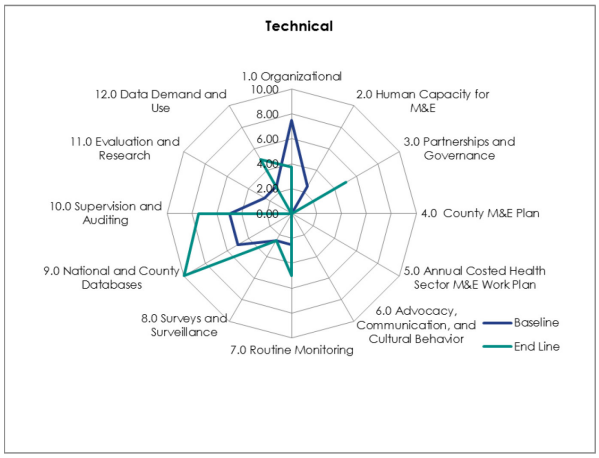
Figure 1 shows specific changes in the 12 capacity areas in the 2017 end line evaluation (blue), compared to the 2013 baseline evaluation (green), and by the MECAT group assessment's four dimensions. These dimensions are as follows:

- **Status:** Whether a given element exists, such as a county M&E plan
- **Quality:** Whether the element conforms to established quality norms
- **Technical autonomy:** The extent to which a program can develop and execute the element on its own
- **Financial autonomy:** The extent to which a program can develop and execute the element using its own resources

Figure 1. Overall dashboard depicting Narok County's scores in all the 12 capacity areas of M&E as measured by the MECAT group assessment at baseline and at end line







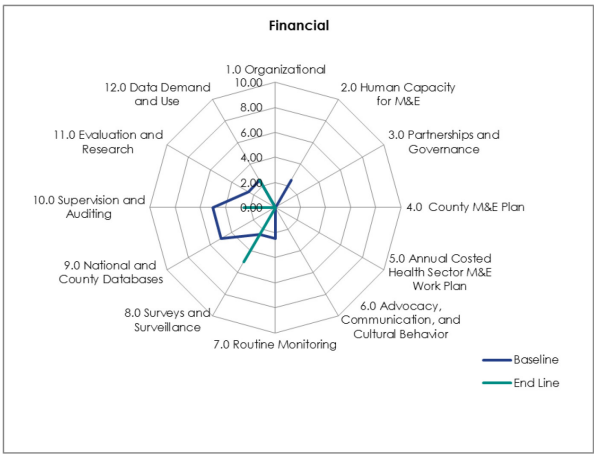
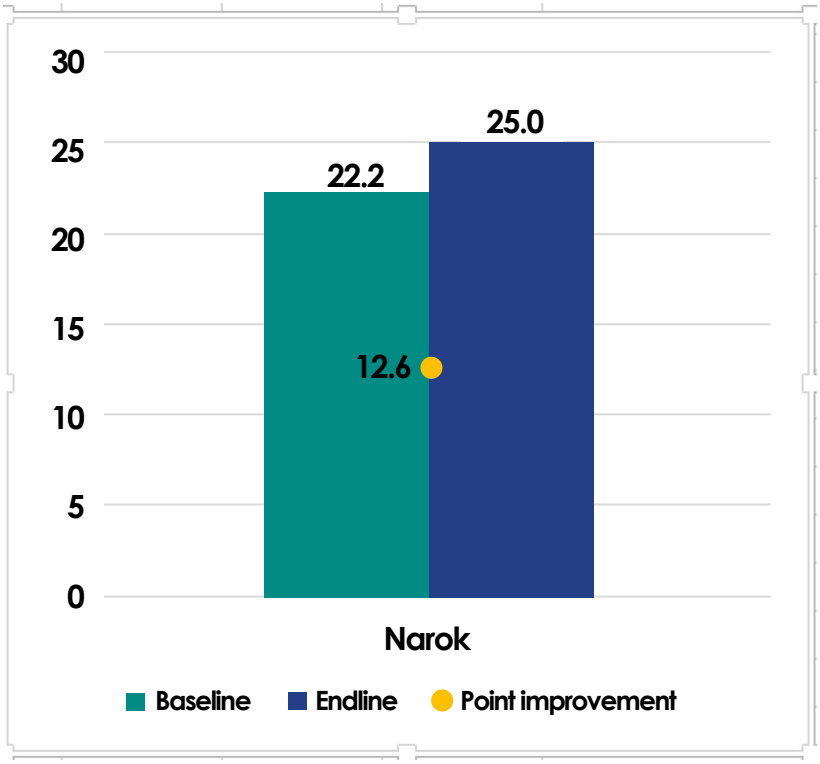


Figure 2. Narok County organizational capacity index at baseline and end line



Narok's organizational capacity index increased slightly, from 22 percent at baseline to 25 percent at end line. The MECAT scores for M&E capacity in Narok County display little change in overall status from baseline to end line. The baseline assessment in 2014 identified several gaps in status across the MECAT's 12 areas of M&E capacity. The status of organizational and human capacity areas, evaluation and research, and data demand and data use remained particularly low over the life of the project. This can primarily be attributed to the noted lack of M&E leadership and the absence of a strategic and work plan to guide M&E structures and capacity across the county. Narok also saw some decreases in surveys and surveillance, mainly due to heavy partner influence and a lack of county autonomy in this area. At baseline, Narok scored high in supervision and auditing, and the county remained strong in this area at end line, mainly due to the use of national-level guidelines for supportive supervision and review as well as disease-specific program support to conduct data quality audits (DQAs). Narok County did experience a notable increase in capacity for partnerships and governance, due to the formation of an M&E technical working group (TWG), established following the baseline assessment to oversee M&E structures and mechanisms across stakeholders.

Except for partnerships and governance, Narok County saw little to no improvement in quality across the 12 capacity areas. This increase in quality in partnerships and governance can be attributed to increased stakeholder coordination and information dissemination from the M&E TWG. The need for a county-level M&E TWG was identified during the baseline assessment, resulting in the creation of a stakeholder database, the creation of terms of reference for the group, and the establishment of mechanisms to support the sharing

of information and transmission of data across various county databases. Narok, however, still lacks standard operating procedures and clearly defined roles and responsibilities, making full operationalization of M&E practices a challenge.

Technical autonomy has increased in the areas of partnerships and governance, routine monitoring, national and county databases, and supervision and auditing. This is mainly due to the county's adoption of national-level supportive supervision guidelines and increased access to DHIS 2. Financial autonomy has lagged due to reliance on funding from partners and the lack of a work plan with costed M&E activities.

4.2. Findings from the Qualitative Data on Most Significant Changes

This section describes the key findings from the qualitative data across the five capacity-building domains.

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

The capacity area of strengthening structures and mechanisms for M&E coordination relates to building and supporting M&E processes, policies, guidelines, M&E TWGs, and resource allocation methods. The participants involved in the end line assessment workshop noted that there was better stakeholder coordination for M&E through mechanisms such as the TWG and implementation of M&E activities such as supportive supervision, performance review meetings, and DQAs. Narok County's M&E TWG was established in 2014, and baseline scores showed little in the way of regular stakeholder coordination. Following the baseline workshop, an inventory of county stakeholders was created to identify relevant stakeholders, most of whom now participate in the TWG. In addition, terms of reference have been established to support the TWG, and M&E is a standing agenda item for group meetings. The group meets biannually and circulates meeting information with stakeholders in a timely fashion.

Establishment of the TWG has contributed to improved coordination in county resources and successful implementation of M&E processes such as supportive supervision and data quality assurance practices. However, the county continues to lack a unified county health sector strategic plan and instead maintains numerous joint work plans with partners. The county has adopted a donor-generated work plan with costed M&E activities specific to certain programs, but not all county M&E activities are covered under these work plans. Most M&E activities are done on an ad hoc basis, as requested by partners. The TWG has provided a forum for M&E discussion and information sharing across county sectors such as malaria and HIV-focused programming, but the county continues to face challenges due to lack of financing and overall guidance for the group, and the group is not able to meet as frequently as had been planned. The county has no written mandate to execute its M&E functions and continues to rely on external support from partners to fulfill routine M&E tasks.

An additional significant change identified in this domain was evidence-based planning. The baseline assessment allowed the CHMT to identify its strengths and weaknesses and develop a corresponding action plan. The assessment and the dissemination of the results were made possible through technical and financial support from MEval-PIMA. However, operationalization of the plan has continued to be a challenge due to the lack of technical and financial support. The CHMT now has better awareness of the need for strengthened M&E mechanisms but lacks the capacity and the support to act. Instead their activities are

driven mainly by partner requests. Joint work plans with partners identify M&E costed activities, responsible implementers, and timeframes, but for areas with no direct partner support, such as reproductive health, this does not exist.

Additional improvements under this domain, as identified by the MECAT group assessment, included clear descriptions of M&E job responsibilities, especially for county health records officers. In addition, in partnership with stakeholders, the county has established structures, mechanisms, procedures, and a timeframe for transmitting, entering, extracting, merging, and transferring data among databases used by the county and other existing MOH databases. Data are routinely captured in program- or disease-specific databases, and the same information is transferred to DHIS 2.

4.2.2. Domain 2: Availability of quality data

Capacity building in this domain focuses on improving, availability of quality data through strategies such as developing data collection and reporting tools; training on proper coding for International Classification of Diseases-10; strengthening surveillance systems; and supporting the research agenda. The MSC for data quality has been the availability of complete and timely data, supported by improved collection and reporting rates in the national database. This has been supported by the availability of standard data collection tools (from the national level) and improved skills in DQA practices, as well as mentoring and on-the-job training provided by partner organizations.

Although still inadequate, the county reported better availability of standardized data collection tools and improved DQA skills, achievements that remained threatened by the lack of financial commitment by the county to print and disseminate tools and by the lack of critical mass to undertake DQA. All tiers of county health services now use standardized data collection forms and tools to capture essential indicators for routine performance monitoring. County personnel have been able to identify and correct gaps in reporting forms. A customized checklist for DQAs has been implemented, but DQAs continue to be conducted with technical and financial support from external partners.

Another significant change in the county has been the increased desire to improve data quality. This can be attributed to a better understanding of data indicators and use of data in performance reviews. The county is now able to use data for monitoring successes and to identify gaps. Although this has been widely recognized as an important practice, non-routine data are not commonly shared because the county continues to lack mechanisms and standard practices for information sharing. Surveys and surveillance activities continue to be characterized by a lack of county ownership. Surveys and surveillance have been implemented solely by individual partners, and CHMTs are not aware when surveys are conducted. Relevant stakeholders from the M&E TWG are occasionally involved in survey or surveillance implementation, but there is no standing mechanism to coordinate efforts for information sharing across county initiatives.

4.2.3. Domain 3: Promoting use of data

The capacity-building domain of promoting data use focused on interventions to improve data use plans and data analysis tools, hold data review meetings and other data-sharing forums, and develop information products. The MSC in this domain has been the use of data for decision making, made possible by data

review meetings with the CHMT and sub-CHMT to monitor progress in performance of indicators, identify gaps, and take corrective measures. This has also been possible by improvements in the availability of high-quality data and mentorship to support the use of data. Despite this improvement, the county does not have a data use plan or data analysis and dissemination guidelines, so data use for decision making does not happen on a regular basis, and information from non-routine sources is not regularly available. The county also disseminates information to stakeholders on a non-routine basis, mainly when partners request it. However, when information products have been disseminated, they have contributed to influencing county policy and practice, especially in resource allocation. For example, the county was able to successfully advocate increasing staff and resources in facilities in which immunization coverage was found to be low in a 2013 Standardized Monitoring & Assessment of Relief and Transition survey.

An additional significant change has been increased ownership of data at all levels of the health system. This has been made possible by feedback mechanisms, improvement in analysis abilities at the facility level, and the ability to present data in simple bar graphs for easy interpretation. Despite these improvements and recognition of the importance of data ownership and data use practices, the lack of structures to support regular information sharing and data use for decision making continue to represent a major challenge in coordination of partners and resources.

4.2.4. Domain 4: Development of M&E leadership competencies

The capacity-building domain of development of M&E leadership competencies focused on ownership, involvement, partnerships, and coordination for M&E as well as advocacy for the resources needed to support programs using M&E data. The MSC in this domain has been improved M&E knowledge and skills, driven by the recognition of the need for effective M&E leadership skills. However, the county lacks a health sector communication strategy and people who strongly advocate for and support M&E for the county. There is some disconnect here, because the CHMT supports funding for and coordination of M&E activities, but this is not recognized by the county assembly in terms of funding.

The county provides leadership in supportive supervision and in reviewing tools for data collection, but it lacks the skills to advocate for funding and establish county-wide practices for information sharing and resource coordination. An HIV communication strategy exists, but this is specific to one partner and does not address all county health sector activities. As a theme, the county continues to lack important coordination and communication among sectors and partners working in the county. Although health records information officers are adequately trained in analyzing and presenting data in easy-to-interpret visuals, they continue to lack the skills to effectively advocate for resources and dedicated funding streams from the county government.

4.2.5. Domain 5: Building capacity of staff in M&E

The capacity-building domain for building capacity of MOH staff in M&E focused on developing training curricula, conducting trainings, and mentoring county staff. The MSC in this area has been improved M&E skills and competencies as a result of M&E fundamentals training.

The county lacked a standard curriculum for organizational and technical capacity building in M&E and also lacked a costed capacity-building plan. However, the county had improved efforts in facilitating M&E fundamentals training and providing mentorship and continuing medical education, which reportedly improved M&E skills and competencies. Mentorship during support supervision also resulted in improved reporting rates, although the county continued to rely on external finical and technical assistance for such capacity-building activities. The county continues to lack a complete and dedicated M&E unit, missing key roles such as an epidemiologist and a statistician. There is also a need to improve analysis skills at all levels in the county.

4. DISCUSSION

The end line assessment revealed improvements in a few M&E capacity areas in Narok County, particularly in skills related to supportive supervision, data quality reviews, and promotion of M&E information materials. Organizational and human capacity for M&E remained low, as did capacity for data demand and use, evaluation and research, and advocacy and communication. The county saw improvement in partnerships and governance, primarily as a result of the formation of an M&E TWG, which held biannual meetings and included M&E as part of other programmatic TWGs' standing agendas, improving the county's ability to leverage resources and communicate M&E information among stakeholders. However, the county was constrained in terms of ensuring that the meetings were regular because there were often inadequate resources for arranging the meetings. This led the county to rely on external financial support from other partners, which further threated the ownership of the M&E activities by the county. The lack of an approved strategic and costed M&E work plan has meant that most M&E functions are driven by donor requests and support. The county does not have countywide M&E policies, practices, guidelines, and plans in place. Resource allocation has improved, due to some information sharing and use for decision making, but this has not been consistent since baseline.

Although the county made some effort in ensuring that the M&E information materials were shared through quarterly dissemination meetings, the county did not have an explicit advocacy strategy for M&E. In particular, the county lacked M&E champions to advocate for attention to gender in analysis, reporting, and use of sex-disaggregated and gender-sensitive data and mainly relied on the committed leadership of the CHMT in promoting data review meetings to monitor progress on performance of indicators, identify gaps, and make timely corrective measures. MEval-PIMA's initial provision of technical assistance through mentorship and its role in building networks among counties and relevant partners enabled it to be part of the TWG at its formative stages. This enabled significant stakeholder identification and coordination, resulting in better dissemination of information products to stakeholders without technical assistance.

The availability of better-quality data has improved due to the county's adoption of national data collection tools and guidelines, including supportive supervision and DQAs. Promotion of data use practices has mainly been the result of program-specific county partners. When data have been reviewed and information shared, the county has seen the benefits of better resource allocation and stakeholder communication. M&E leadership has remained low due to the lack county ownership over M&E functions and information products. The capacity of individual staff to perform M&E functions has improved, but the county continues to lack a complete M&E unit.

The continued poor performance in human capacity was a result of low prioritization of M&E in the county's budgeting agenda and the lack of a standardized M&E training curriculum, meaning that staff did not have clearly defined or adequate M&E skills. The lack of fully developed M&E units in the county meant that the M&E TWG guided M&E functions and emerged as the local leadership for M&E. A significant finding across all three counties in the end line assessment was the limited understanding of the role and importance of gender in M&E; this needs to be addressed to strengthen overall M&E performance.

The results of the MSC exercise reveal increased recognition of important practices, structures, and mechanisms necessary to support effective M&E at the county level. The baseline assessment supported by MEval-PIMA has sensitized county health personnel to what those structures and practices are. Although the county now recognizes important components and has succeeded in some important first steps, such as mapping stakeholders and creating an M&E TWG, several important coordination and communication structures are still lacking. The main drivers of change were the identification of M&E needs, such as the need for better stakeholder coordination and the need for capacity building to support effective leadership. Specific improvements in capacity beyond the creation of the M&E TWG have mainly been supported by national initiatives, such as the rollout of DHIS 2 and corresponding data collection tools as well as partner-supported initiatives, highlighting the importance of technical and financial support. The initial MEval-PIMA-supported baseline assessment has been an important step toward improving capacity for M&E in Narok; however, the lack of technical and financial assistance to better support partner coordination and planning has impacted the county's growth in the status and quality of M&E capacities.

5. RECOMMENDATIONS

Although the county did not receive explicit support from MEval-PIMA on M&E activities over the four years the project was implemented, Narok showed some improvement, compared to performance at baseline. The biggest threat to the sustainability of these gains is the lack of financial autonomy to undertake M&E activities, which is linked to poor prioritization of M&E in county budgets. Other threats include inadequate M&E skills, staff turnover, erratic supply of data collection tools, competing priorities by other partners, and potential change of leadership (political and health management). Recommendations are as follows:

- Develop innovative resource mobilization strategies to reduce dependence on funding from partners, by working with the county health leadership, other line ministries, the private sector, and other players in health within the county. The county can enlist the support of M&E champions to engage the legislative and the executive arms of the county government and involve the civil society.
- Promote ownership of the M&E agenda by the county government and development partners at the county level by working with the Council of Governors and by developing and signing binding memoranda of understanding with stakeholders. This will promote accountability among partners and ensure transparency in the implementation of the development support. In addition, the department of health should promote joint planning by involving county departments and other stakeholders in order to align priorities and leverage resources.
- Invest in human resources development through the CHMT by developing a staff capacity development plan with a clear career trajectory and scheme of service for M&E staff, training plans, clear job descriptions, and clear deployment plans. In addition, there is need to develop a database of skills relevant to M&E that exist in the county to facilitate deployment and assignment of duties.

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