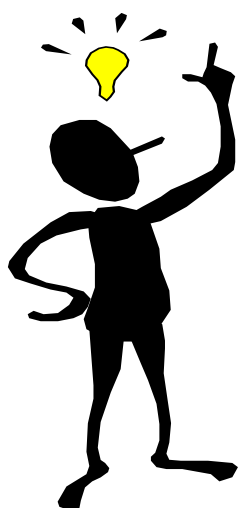


UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
BUREAU FOR GLOBAL HEALTH
OFFICE OF HEALTH, INFECTIOUS DISEASE, AND NUTRITION USAID/GH/HIDN

PVO CHILD SURVIVAL AND HEALTH GRANTS PROGRAM



**TECHNICAL
REFERENCE
MATERIALS**
Monitoring and
Evaluation

GH/HIDN is grateful for the many contributions to this document from public health specialists consulted through the ORC/Macro International Child Survival Technical Support Project plus (CSTS+), other USAID-funded contracts, offices of USAID, and PVOs.

2006

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Abbreviations and Acronyms

| | |
|-------|---|
| ACTs | Artemisinin-Based Combination Therapies |
| AFP | Acute Flaccid Paralysis |
| AI | Appreciative Inquiry |
| AIDS | Acquired Immuno-Deficiency Syndrome |
| AMTSL | Active Management of the Third Stage of Labor |
| ANC | Antenatal Clinic |
| ARI | Acute Respiratory Infection |
| ART | Antiretroviral therapy |
| ARVs | Antiretroviral drugs |
| BCG | Bacille Calmette-Guerin |
| BCI | Behavior Change Interventions |
| BHR | Bureau for Humanitarian Response |
| CA | Collaborating Agency |
| CBD | Community-Based Distributor |
| CDC | Centers for Disease Control |
| CDD | Control of Diarrheal Disease |
| CHW | Community Health Worker |
| CORE | Child Survival Collaborations and Resources Group |
| CORPS | Community Oriented Resource Persons |
| CQ | Chloroquine |
| CSHGP | Child Survival and Health Grant Program |
| CSTS+ | Child Survival Technical Support |
| CYP | Couple-Years of Protection |
| DHS | Demographic and Health Survey |
| DIP | Detailed Implementation Plan |
| DOSA | Discussion-Oriented Self-Assessment |
| DOT | Directly Observed Therapy/Direct Observation of Treatment or Therapy |
| DOTS | Internationally recommended strategy for TB control consisting of 5 components (originally Directly Observed Therapy, Short-course, although current DOTS strategy is much broader now than these two concepts) |
| DPT | Diphtheria-Pertussis-Tetanus |
| DST | Drug susceptibility testing |
| DTP | Diphtheria-Tetanus-Pertussis vaccine [N.B. International terminology has now shifted so that the convention is to use DTP rather than DPT.] |
| EBF | Exclusive Breastfeeding |
| EMNC | Essential Maternal and Newborn Care |
| EmOC | Emergency Obstetric Care |
| EOC | Essential Obstetric Care |
| EPI | Expanded Program on Immunization |
| FE | Final Evaluation |
| FP | Family Planning |
| GAVI | Global Alliance for Vaccines and Immunization |



Acronyms

| | |
|----------|--|
| GDF | Global Drug Facility |
| GEM | Global Excellence in Management |
| GFATM | Global Fund for AIDS, Tuberculosis, and Malaria |
| GIVS | Global Immunization Vision and Strategy |
| GLC | Green Light Committee |
| HB | Hepatitis B |
| HI | Hygiene Improvement |
| Hib | Haemophilus influenzae type b |
| HIF | Hygiene Improvement Framework |
| HFA | Health Facility Assessment |
| HIS | Health Information System |
| HIV | Human Immuno-deficiency Virus |
| HQ | Headquarters |
| HR | Human Resources |
| ID | Intravenous Drug |
| IEC | Information, Education and Communication |
| IMCI | Integrated Management of Childhood Illnesses |
| IMPAC | Integrated Management of Pregnancy and Childbirth |
| IPT | Intermittent Preventive Treatment |
| IPTp | Intermittent Preventive Treatment in pregnancy |
| IR | Intermediate Results |
| IRS | Indoor Residual Spraying |
| ISA | Institutional Strengths Assessment |
| ITM | Insecticide-Treated Material |
| ITN | Insecticide-Treated Nets |
| IUATLD | International Union Against Tuberculosis and Lung Diseases |
| IUD | Intrauterine Device |
| KPC | Knowledge, Practice, and Coverage Survey |
| LAM | Lactational Amenorrhea Method |
| LBW | Low Birth Weight |
| LQAS | Lot Quality Assurance Sampling |
| M&E | Monitoring and Evaluation |
| MCE | Multi-Country Evaluation |
| MCH | Mother and Child Health |
| MDR-TB | Multidrug-Resistant Tuberculosis (resistance to at least rifampin and isoniazid) |
| MIS | Management Information System |
| MNHP | The Maternal Neonatal Health Program |
| MOH | Ministry of Health |
| MPS | Making Pregnancy Safer |
| MTCT | Mother-to-Child Transmission |
| MTCT/HIV | Mother-to-Child Transmission of HIV |
| MTE | Mid-Term Evaluation |
| NACP | National AIDS Control Program |
| NGO | Non-Governmental Organization |
| NIDS | National Immunization Days |
| NMCP | National Malaria Control Programs |

| | |
|--------|--|
| NMR | Neonatal Mortality Rate |
| NTP | National Tuberculosis Program |
| OPV | Oral Polio Vaccine |
| OR | Operations Research |
| ORT | Oral Rehydration Therapy |
| PAHO | Pan American Health Organization |
| PEPFAR | President's Emergency Plan for Aids Relief |
| PHC | Primary Health Care |
| PLA | Participatory Learning and Action |
| PMTCT | Prevention of Mother-to-Child Transmission |
| PVC | Office of Private and Voluntary Cooperation |
| PVO | Private Voluntary Organization |
| QA | Quality Assurance |
| QI | Quality Improvement |
| RED | Reaching Every District |
| RBM | Roll Back Malaria |
| RDT | Rapid Diagnostic Test |
| RFA | Request for Applications |
| RTI | Reproductive Tract Infection |
| SBA | Skilled Birth Attendance |
| SCM | Standard Case Management |
| SDM | Standard Days Method |
| SIAs • | Supplementary Immunization Activities |
| SNL | Saving Newborn Lives Initiative |
| SP | Sulfadoxine-Pyrimethamine |
| STD | Sexually Transmitted Disease |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| TBA | Traditional Birth Attendant |
| Td | combination of Tetanus toxoid and a reduced dosage of diphtheria |
| TRM | Technical Reference Materials |
| TT | Tetanus Toxoid |
| USAID | United States Agency for International Development |
| VA | Vitamin A |
| VAD | Vitamin A Deficiency |
| VCT | Voluntary Counseling and Testing |
| VVM | Vaccine Vial Monitor |
| WHO | World Health Organization |
| WRA | Women of Reproductive Age |

Caretaker: An individual who has primary responsibility for the care of a child. Usually, it is the child's mother, but could also be his or her father, grandparent, older sibling, or other member of the community.

Introduction to the Technical Reference Materials

The Technical Reference Materials (TRMs) are a product of the Bureau for Global Health, Office of Health, Infectious Disease, and Nutrition USAID/GH/HIDN. This document is a guide (not an authority) to help you think through your ability and needs in choosing to implement any one technical area of the Child Survival and Health Grants Program. An attempt has been made to keep the language simple to encourage translation for use as a field document.

The TRMs are organized into modules that correspond to the primary technical areas and key cross-cutting areas that are central to the Child Survival and Health Grants Program. Each module is designed to reflect the essential elements to be considered when implementing the given intervention or strategy, important resources that grantees should consult when planning their interventions. Grantees are encouraged to download the specific modules that are most relevant to their proposed programs, or to download the entire package of TRM modules as a zipped file. The TRMs presently include the following modules:

Technical Areas

- Family Planning and Reproductive Health
- Maternal and Newborn Care
- Nutrition and Micronutrients
- Immunization
- Pneumonia
- Diarrheal Disease Prevention and Control
- Malaria
- Tuberculosis
- Childhood Injury and Prevention

Cross-cutting Areas

- Capacity Building
- Sustainability
- Program and Supply Management
- Behavior Change Interventions
- Quality Assurance
- Monitoring and Evaluation
- Integrated Management of Childhood Illness (IMCI)
- Health System Strengthening

The present TRMs are regularly reviewed and updated with input from technical specialists in the USAID Collaborating Agency (CA) community, CORE Working Groups, and USAID technical staff. The date of revision of each specific TRM module can be found at the bottom of each page of the module. The TRMs are updated regularly to ensure that they remain up to date and reflect current standards relevant, and useful to the PVO community. With this in mind, we ask that each user of this document over the next year please keep notes and inform us on the usefulness of these references, information that should be amended or changed, additions and subtractions, and general comments. This will help us keep this document alive and responsive to your needs throughout the life of your programs. Please share comments and any (electronic) translated copies with Michel Pacqué at CSTS+, michel.c.pacque@orcmacro.com.

The 2006 edition was coordinated by Michel Pacqué, CSTS+, who is grateful for the many contributions and reviews by staff of the different Offices of the Bureau of Global Health, and many of their collaborating agencies, the CORE working groups and most of all to our PVO partners who continue to use this guide and provide valuable insight on how to improve it.

New Additions to the Monitoring and Evaluation Module:

The 2006 edition of Monitoring and Evaluation TRM module follows a six-step process to developing an M&E plan for Child Survival and Health projects. New sections include:

- Using Health Service Delivery Assessments
- Methodologies of Participatory Qualitative Assessments
- Including Organizational Capacity Assessments in situation analysis
- Utilizing a Results Framework to organize the project's goals and strategies

This edition of the manual also includes revised guidance on using secondary data sources in project planning, selecting appropriate indicators for the project, and linking to the existing Ministry of Health information system.

Monitoring and Evaluation

Introduction

Monitoring and Evaluation (M&E) is an important and essential component of any intervention, project or program. M&E is the process in which data are collected and analyzed in order to provide appropriate information for use in program planning and management



Essential Elements

- Six Step Development Process
- Linked to Program Design
- Participatory
- Data for Decisions
- Linked to existing HIS systems

What is monitoring? Monitoring is the regular observation and recording of ongoing activities in a project or program. Monitoring of a program involves the collection of information (data) on a regular basis to measure progress (or lack of progress) towards achieving specific program objectives. Monitoring allows program managers and stakeholders to make informed decisions regarding the effectiveness of programs and the efficient use of resources. Data from the monitoring process can be used to determine whether program/project activities need adjustment. Monitoring is sometimes called process evaluation because it focuses on the implementation process.

Monitoring is an integral part of every project, from start to finish: monitoring starts at the beginning of a project with the collection of baseline information and managers use project monitoring to determine how well the program is being implemented and at what cost.

What is evaluation? Evaluation is a process of judging on what a project or program has achieved particularly in relation to activities planned and overall objective. Evaluation involves the use and sometimes collection of information to determine how well program activities have met expected results and/or objectives.

Evaluations require data at the start of a program so that baselines can be established, data during the middle of a program (if a midterm evaluation is to be conducted) and data at the end of the program.

Impact evaluation gives us an idea of the extent to which changes in outcomes can be attributed to the program or intervention. In order to conduct an impact evaluation a control or comparison group is needed to measure whether changes in outcomes can be attributed to the program. However, for Child Survival and Health Grants, it is usually not practical to maintain a control group because these projects focus on implementing a broad range of activities with relatively small budgets and because they operate in areas where other public health interventions are present. Instead, evaluation of Child Survival and Health Grants focuses on demonstrating that projects contribute to results and/or objectives. This is done by reviewing baseline and final data and project activities that were implemented. From this information it is inferred that the results obtained are due to the project. Child Survival and Health Grants perform a final evaluation to

determine whether or not results and/or objectives have been met. Impact evaluation is not expected from Child Survival and Health Grants.

What are the links between monitoring and evaluation? While M&E are distinct functions, they are complementary. Information from monitoring systems should help assess whether the program is on track to meet its overall results and/or objectives. Data from monitoring may also be useful for explaining evaluation findings.

Monitoring is closer to day-to-day activities, and is carried out routinely by program managers and local stakeholders. Periodic evaluation may involve others in addition to local stakeholders, and is more concerned with the measurement of progress towards targets, objectives and health impacts, rather than to the details of implementation. Outside experts are commonly included as either the team facilitator of a participatory evaluation process or as an examiner or evaluator. Having a mid-term evaluation is a means for a program to track progress up-to-date and make any adjustments necessary in order to reach the specified results and/or objectives.

Monitoring and evaluation together produce information that can be used in a number of ways. M&E is considered a means to both improve programs and to track progress towards improving health outcomes and impacts.

This document is intended for groups who are implementing 4 – 5 year community focused projects that are implemented through partnerships with local stakeholders. This guide provides details of steps and basic concepts to follow for developing a monitoring and evaluation system.

Characteristics of a Strong M&E System

There are **five points** to take into consideration for an M&E system to be useful.

The first point is that the system must be closely linked to the program design and the vision that stakeholders and implementers have about what is to be accomplished by the end of the project.

The second point is that the M&E system must be developed in a participatory manner. Developing the system in a participatory manner ensures that groups involved in collection and analysis of the information will understand what they are collecting and why it is important.

Third, the system must be developed with an emphasis on using information for making decisions. As much as possible groups that collect information should find the information useful for decisions that they make for their own work. As the system is being developed, it is important to think about decisions that will be made with each piece of information. If decisions are not obvious, do not collect the information.

Fourth, the system should be linked to existing M&E systems in the project area. If the project is working with the Ministry of Health, part of the project information should come from the regular MOH Health Information System (HIS), although the project may have activities to strengthen this system. Also, information should be coherent with national and international programs being implemented in the area such as Role Back Malaria, National Immunization

Program or the Global Fund for HIV/AIDS Tuberculosis and Malaria. Information collected does not need to be identical to what is used by these programs, but it should be similar.

The fifth point is that the development and implementation of the M&E system should follow a 6 step process:

1. Perform a situation analysis that gives basic information for developing the M&E system
2. Develop clearly defined goals and results (and/or objectives) that are organized into a conceptual framework
3. Develop clearly defined strategies and activities that are linked to the conceptual framework
4. Develop clearly defined indicators and targets that are linked to the results (and/or objectives) and activities
5. Develop a plan for data collection, analysis and use
6. Implement the M&E system, which is composed of:
 - a. Baseline and final assessments that measure progress toward achievement of results and/or objectives
 - b. Monitoring systems that let you know if project implementation is on track

The following sections of this document will provide further details about this 6 step process, keeping in mind the characteristics of a strong M&E system described above.

Developing an M&E Plan

An M&E plan is a document that details a program's results (and/or objectives) and interventions which are developed to achieve these results and describes how the results (and/or objectives) will be measured. The M&E plan demonstrates how the expected results of a program relate to its goal. It describes data needed; how it will be collected, analyzed and used; the resources needed to implement the M&E system; and how the system will be accountable to stakeholders. A framework or logic model, such as a Results Framework, is useful to organize the results and/or objectives and activities that will be carried out to improve the health of the target population.

A Monitoring and Evaluation plan provides information in the following areas:

- 1) Goals, results (and/or objectives) and indicators;
- 2) Definitions of each indicator;
- 3) Source, method, frequency and schedule of data collection;
- 4) Groups or individuals responsible for data collection; and
- 5) Description of how data will be analyzed, reported, reviewed, and used to inform program management.

The best way to develop an M&E plan is to follow the six step process which is described in detail in the following sections.

Step one - Perform a situation analysis that gives basic information for developing the M&E system.

Developing a monitoring and evaluation system is closely linked to the process of project design, which should begin with an analysis of the situation in the project area. This process gives an idea of the health situation in the area, access to and quality of health services, the policy environment, organizations that work in the area and existing health information systems. The situation analysis is a first step in identifying the most important health problems and the areas of greatest public health need. Information collected at this time serves two purposes. It is the first step in designing the project and it serves as the basis for designing the monitoring and evaluation system. The following methodologies are used to obtain information for this first step: Secondary Data Review; Participatory Qualitative Assessments; Health Service Delivery Assessments; and Organizational Capacity Assessments. These methodologies are described in more detail below.

Secondary Data Review

Secondary data is information that someone else has collected. This includes a broad array of information, reports and documents. It can include information about the health status of the population; knowledge and practice of community members; types and distribution of health facilities; existing health information systems; policies and protocols, quality of care and community perceptions of health. The advantage of secondary data is that they are available, inexpensive and a good source of information for a general overview of health problems, challenges and gaps in the health system including the health information system. Reviewing secondary data is a good starting place for understanding both the problems and opportunities in the project area. This review serves as the basis for both project design and for the development of the monitoring and evaluation system.

The following are examples of secondary data sources:

- National Surveys such as the DHS (Demographic Health Surveys) and MICS (Multi-Indicator Cluster Surveys)
- National health information systems or district health information systems
- Previous and other project studies
- Special studies (focus groups, anthropological research)
- Descriptive studies, surveys or monitoring information for specific diseases
- Ministry of Health policy and protocol documents
- Ministry of Health strategic plan and organizational chart
- Description of MOH structures (service map)
- Health facilities records, registers and reports
- Data from routine health surveillance systems and health information systems including morbidity and mortality data
- Administrative data on population size
- Maps (indicating target communities, roads, Health facilities and natural obstacles such as rivers...)

Secondary information provides crucial information needed for the development of the M&E system. Close attention should be paid to the following information from secondary data: (1) basic figures on the health situation that can be used to set initial targets; (2) basic figures about the health situation that can be used to judge whether information collected by the monitoring and evaluation system is logical; (3) information that is important to the country, that should be included in the M&E system; (4) policy and protocols that affect indicators used in the M&E system; and (5) Policy and protocol documents that describe national and district health information systems. The following are three examples of secondary data that is relevant to M&E plans:

1. The DHS results for exclusive breast feeding may be 40% at the national level and 20% in the region where the project is located. In the early stages of development of the monitoring and evaluation system a target of 40% may be proposed based on the national figure. The project baseline may find a level of 25%. Because the level is close to the regional level found by the DHS, the quality of the survey was probably good. Because the level is lower than the national average, exclusive breastfeeding should be addressed in the project area and included in the monitoring and evaluation system.
2. The national strategic health plan may stress improving measles coverage in order to address the Millennium Development Goal of Reduced child mortality, which includes an indicator on one year old children who have been immunized against measles. Because this information is important to the national MOH, it is good for the project to collect this information as part of the monitoring and evaluation system.
3. The national immunization protocol may specify that pentavalent vaccine is to be used instead of DPT. Pentavalent contains DPT, Hib and HepB and is given on the same schedule as DPT. In this case if the project wants to track DPT dropout rates between DPT1 and DPT3, the M&E system will have to track coverage rates of pentavalent vaccine.

Some projects plan on influencing national policies. If indicators or benchmarks are to be established to track this progress in this area, policy documents should be reviewed at the beginning of the development of the M&E system in order to establish baseline information and should be consulted in the future to see if changes occur.

It is also important to review policy and protocol documents because they will describe national and district level health information systems. Project M&E systems should link to these systems, use information produced by these systems and where possible work to improve these systems.

Secondary information has limits. It may not be specific to the project area or to the exact interventions or target groups that the project plans to work with. The information may be outdated and it may be incomplete. It may not reflect perspectives of stakeholders in the project area. For these reasons use of secondary information is only the first step in understanding the situation in the project area and in developing the monitoring and evaluation system.

Participatory Qualitative Assessments

Participatory Qualitative Assessments are methodologies that use qualitative techniques to obtain information and that involve the participation of local stakeholders in the process. Information obtained through participatory qualitative assessments provides important information for the development of the M&E system. Qualitative information from communities helps ensure that language used in questionnaires is culturally appropriate and helps to anticipate possible answers to questions. Qualitative information especially from In-depth interviews of critical people in the Ministry of Health can give insight into how the national or district health information functions and can draw attention to problems with these systems.

Qualitative research captures information and produces findings that are not reached by means of quantitative procedures. These techniques focus on answering questions of why, how, when and who. They are useful for probing for explanations and exploring underlying causes for health problems and health behaviors. They compliment quantitative information by providing more in-depth understanding of situations. However, they cannot be used to describe frequencies, rates, averages or numbers of knowledge, practice or coverage in a population. Qualitative information has limits. It is highly susceptible to subjective bias of the questions asked by the interviewers and by the interpretation of responses.

Participatory Qualitative Assessments use the following basic techniques: Observation, In-depth interviews, Focus group discussions, and visual techniques.

Observation is the collection of information through visual or auditory experience of behavior. It can be structured or unstructured. For example a checklist might be used to observe the feeding practices of a mother.

In-depth interviews are conversations during which the informant provides information in an area that he or she knows well, such as how the health information system functions. This is used when the subject matter is complex and respondents are highly knowledgeable; when the information is highly sensitive; or when respondents are geographically dispersed. Like observation, In-depth interviews can be either structured or not structured. This technique makes use of both open and closed questions and is flexible enough to follow the lead of the informant, keeping in mind the main themes to be covered.

Focus group discussion is a group discussion that allows exchange of ideas among participants in order to: (1) discover trends and patterns in perceptions; (2) explore the range and variety of attitudes and practices; (3) explore the variety of barriers and motivations; (4) learn about social norms. It is important to remember that the emphasis in a focus group discussion is the dialogue generated among participants. The aim of the moderator is to generate and facilitate this discussion. Focus group discussions use guides, open questions and probing questions.

Visual techniques include techniques such as village mapping, ranking priorities, social networks and body mapping. Village mapping involves asking community members to draw a map of their village and to highlight pertinent elements such as the location of health services and important leaders. Ranking involves asking people to decide on the relative importance of items, such as different diseases in the area. Social networks is similar to village mapping. For this

technique community members are asked to draw circles of how people interact and where networks overlap. These might include schools, people at a water source, and the health center. Body mapping is used in reproductive health to gain an understanding of how people view their reproductive health system. People take an outline of a woman's or man's body and draw in and name (in local language) the body parts that are important for reproduction. The researcher thus gains insight into the use of local terms and the local understanding of reproduction.

Health Service Delivery Assessments

Health Service Delivery Assessments (HSDAs) use both quantitative and qualitative techniques to answer questions about the quality, access and availability of health services. These assessments can be complex, so projects usually focus on specific areas for data collection.

Those involved in research on health systems often divide health service delivery at the local level into a hierarchy that uses terms that are similar to those for project planning: health systems inputs, processes, and outputs. Inputs include domains like medical supplies and finances, processes include such domains as supervision and training, and outputs includes domains such as preventive or curative services provided. Of course, there are health outcomes (population service coverage) and ultimately impact (morbidity and mortality), but these are best measured through population-based surveys, rather than HSDAs.

There are four basic techniques used in HSDAs: Inventories, Observations, Interviews, and Record Reviews. Inventories can be taken of infrastructure, equipment, supplies, and personnel. Observations can be used to assess client reception and patient flow; patient – provider interaction; hygiene and infection control; and quality of patient care during clinical encounters. Interviews can be performed with both providers and clients. Providers can be interviewed about their job satisfaction, the amount and quality of training they have received, the amount and quality of supervision they have received, etc. It is during the provider interview that record review is often incorporated in order to increase the validity of the responses. Stock records can be reviewed to determine if there have been any stock outs of essential medications or supplies; patient registers can be reviewed for completeness and/or for adherence to established protocols. Clients can also be interviewed, usually after they have received care. In these so-called “exit interviews” satisfaction can be measured, as well as the client's or caretaker's understanding of the instructions they have received about treatment or follow-up

It should be obvious from the discussion that a single domain (like health worker performance) can be examined through more than one HSDA technique. As an example, we may want to know if the health worker gave proper instructions on follow-up. One could choose to directly observe the patient-provider interaction during the clinical encounter. Alternatively, one could ask the client about the instructions received in an exit interview. The various tools that are commonly used for HSDAs generally cover the same domains (i.e. areas of health system performance) and use the same techniques but they divide the assessment tasks differently among the different techniques. Additionally, there are differences among the tools depending on the health area of interest – for instance, laboratory services are crucial for tuberculosis, and counseling services central for family planning. Consequently, HSDAs for these health areas place more emphasis on these domains and services than a child health HSDA tool might.

Analysis of the HSDA data provides a project with information about problems that ought to be addressed. Based on the results of an assessment, specific results (and/or objectives), indicators and targets can be developed to measure progress in addressing these problems. For instance, if a project is encouraging better health seeking behavior among caretakers in a malarial area so that more mothers take their children with fever to the health post, then it is crucial that any problems with the quality and availability of malaria treatment be addressed in the health facilities. This might mean addressing difficulties with the provision of drugs, adherence to standard malaria treatment protocols by health workers, etc. Information from the initial health service delivery assessment serves as baseline information. Information that corresponds to specific results and objectives can be incorporated into monitoring systems and into mid-term and final evaluations. Because initial health service delivery assessments are often time consuming, subsequent information collected should be limited to information specifically needed to measure project results and/or objectives.

CSHGP has been developing a list of core indicators for HSDAs that will be available for use by grantees by the end of 2006, along with the instruments and instructions for collecting and analyzing the information. There are a number of more comprehensive HSDA tools. They may be shortened by only using the parts that are relevant to the areas of interest in the project. They also may need to be adapted to specific project needs and contexts. Among the tools in most common use by PVOs are the following:

- Service Provision Assessment (SPA) of the Demographic and Health Survey (DHS) for all health services: <http://www.cpc.unc.edu/measure/publications/html/ms-02-09-tool06.html>
- BASICS Integrated Health Facilities Assessment for child health services: http://www.basics.org/publications/pubs/hfa/hfa_toc.htm
- World Health Organization (WHO) Health Facilities Survey for child health services: <http://www.who.int/child-adolescent-health/publications/IMCI/HFS.htm>
- WHO Safe Motherhood Needs Assessment for Maternal-Neonatal Care: http://www.who.int/reproductive-health/MNBH/smna_index.en.html
- Quick Investigation of Quality (QIQ) for family planning services: <http://www.cpc.unc.edu/measure/publications/pdf/ms-01-02.pdf>

Organizational Capacity Assessments

Most projects work with local partner organizations and often include organizational strengthening activities in the project design. Organizational capacity assessments can serve two purposes in this process. They provide baseline information about strengths and problems and at the same time may serve as methodologies by which organizations themselves can work to solve problems. Projects that work toward strengthening local organizations must develop a plan to measure progress that includes definition of expected results (and/or objectives), indicators and targets. Often baseline assessments are performed, but no follow up assessments are performed either for monitoring or for evaluation. This situation can be avoided by including capacity building indicators as part of the project M&E system.

Organizational capacity can be defined as the ability of an organization to meet its objectives so that it can perform better. For example, a health center can improve quality of care or a local

NGO can improve its project design process. There are three important areas of organizational capacity that can be assessed: Institutional Resources, Institutional Performance and Institutional Viability/ Sustainability. Institutional resources refer to: Legal structure and governance; Human resources; Management system and practices; and Financial resources. Institutional performance refers to how effectively the organization uses its institutional and technical resources to deliver programs, services or other impacts. Institutional viability/sustainability includes attributes such as: Organizational autonomy, Leadership, and Organizational learning.

Organizational assessments can be self evaluations or external audits. The self evaluation methodologies can be entirely internal or can have outside facilitation. COPE, developed by EngenderHealth, is an example of a self evaluation methodology. Both self evaluations and external audits are useful. The advantage of self evaluation is that organizations and their personnel are often more accepting of the results and willing to work toward improvements. The disadvantage is subjectivity of the results. Indicators and targets can be developed from self evaluation methodologies. Because these methodologies are implemented by the organizations themselves, they can incorporate them into their own monitoring systems to track indicators and progress toward targets. External audits provide more reliable measurements and can also be used to develop indicators and targets, although these may not be as readily accepted by the organizations. Indicators developed from either methodology can be incorporated into supervision systems or evaluations so progress toward targets can be assessed. It is best to work with the local organization in the development of these indicators.

Step two - Develop clearly defined goals and results (and/or objectives) that are organized into a conceptual framework.

Once the situation analysis has been performed and information has been analyzed a framework of the project should be developed. This step should be performed with participation of local stakeholders so they gain ownership of the project design and because they provide a realistic check on the design. Different frameworks are used by different organizations to represent program designs. This section concentrates on one framework, which is the Results Framework. The end of the document provides brief descriptions of two other models (log frame and logic model). Organizations can choose one model or a combination of models that they are comfortable with. Use of a framework ensures a coherent project design that leads to clear results or outcomes and avoids a design that is just a list of activities that are not clearly connected.

The Results Framework is a schematic representation of the project design and is the starting point for the development of the M&E system. It represents the whole view of the project including the big goal and the ideas about what has to be in place in order to achieve success. There are advantages to using a results framework. The results framework helps project managers focus on the key results required (i.e. that are necessary and sufficient) for achieving the higher goal. Results frameworks also help ensure logical links between results and the strategic objective and lower level results and strategies that contribute to them. A good framework shows a chain of results which clearly identifies what a project is doing to affect change. This framework links the strategic objective backwards to intermediate results at different levels, which in turn link to strategies, activities and inputs.

The following key terms are used in results frameworks:

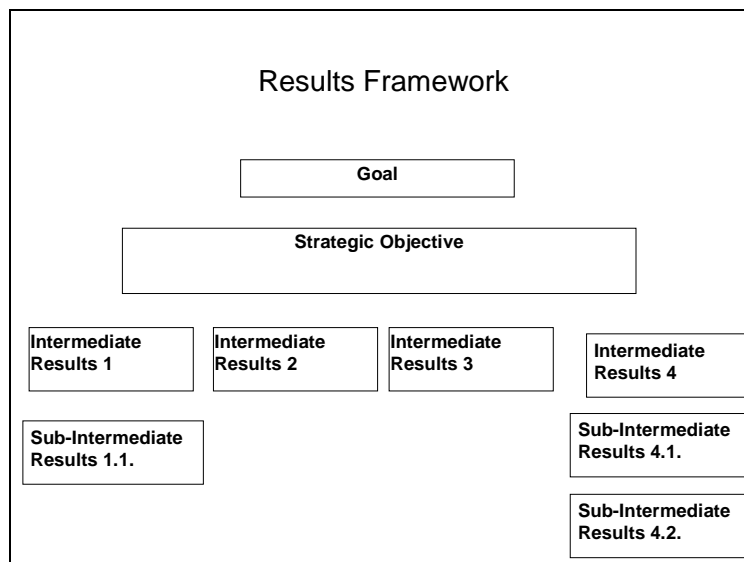
Goal: A goal is the statement of the long term aim of the project. Reduction of morbidity and mortality are common goals. Goals are the highest level and are typically not measured by the project. The fulfillment of the goal may or may not be verifiable within the life span of the project; however the fulfillment of the project’s more specific objectives and results should contribute to the realization of the goal.

Strategic Objective: A strategic objective (SO) is a statement of what the program plans to achieve during the life of the project. This achievement is the highest level result that a program can materially affect with its effort within the given restraints (such as time and funding). Strategic objectives are stated in terms of changes in the condition of targeted beneficiaries or changes in conditions that affect them. An example is improved health and nutrition status of children under 5.

Intermediate Result: An intermediate result (IR) is a discrete result or outcome necessary to achieve an objective or another intermediate result critical to achieving the strategic objective. Usually, projects have a limited number (three or four) of IRs that contribute to the strategic objective. Each IR may have **sub-IRs** that contribute to it. For example, an IR might be Improved Health Status of Vulnerable Target Populations. Sub-IRs might be:

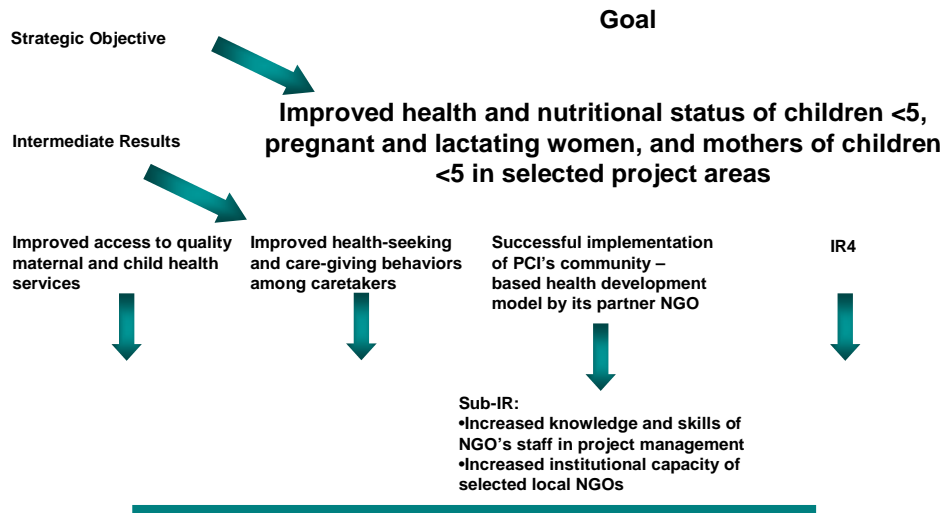
- Sub-IR 1.1: Increased knowledge and improved health practices and coverage related to key health problems and interventions
- Sub-IR 1.2: Improved quality and accessibility of key health services at health facilities and within communities
- Sub-IR 1.2: Increased capacity of communities, local governments and local partners to effectively address local health needs

The following diagram shows how the Goal, Strategic Objective, Intermediate Results and Sub-Intermediate Results are arranged into a results framework.



The following is an example of a Results Framework from a Child Survival and Health Grant (PCI – Zambia)

Example – PCI



The following tool is useful for extracting information from the situation analysis to develop results. This tool should be used in a participatory manner with project partners. After results are determined, the goal and the strategic objective should be written.

Tool for Synthesizing Situation Analysis Data (1 per IR)

| | |
|--|-----------------------------------|
| DATA (strengths, gaps, challenges, opportunities, resources, partners, etc.) | |
| Secondary Analysis | |
| Participatory Qualitative Assessments | |
| HSDA | |
| Organizational Capacity Assessment | |
| SUMMARY—Intermediate Result Statement: | |
| <u>Summary of Main Challenges</u> | <u>Possible Strategies</u> |
| | |

All of these elements should be assembled into the generic results framework. At this point the framework can be used to develop strategies, activities and the M&E plan. This is a dynamic process, so that the SO and IRs may be adjusted based on what is feasible both to implement and measure.

Step three - Develop clearly defined strategies and activities that are linked to the conceptual framework.

The Results Framework that was developed in Step 2 serves as the basis for developing strategies and activities. Starting with the Results Framework ensures that strategies activities fit coherently into the project design. Strategies are the description of approaches adopted to accomplish a result or objective. They describe how a team plans to reach the intermediate result or objective. Activities are components of strategies that reflect what a project does on a day-to-day basis to achieve its results or objectives. The M&E system includes tracking completion of these activities.

The following is an example of strategies that are linked to a results framework:

Example:

- SO Improved health status of children < 2
 - IR1: Increased preventive health practices of mothers of children < 2
 1. Strategy: Work with Mothers’ groups to discuss solutions to health problems
 - IR2: Improved access to child health services
 1. Strategy: Establish community outreach program

As in the previous steps, this step should involve working with partners and stakeholders. The following three forms build on the tool mentioned above and may help to guide the discussion and ensure that strategies and activities are linked to the results framework.

- (1) For this form a results statement from the results that were written in step two is written on the table and possible strategies are discussed and written on the form. One form is filled out for each result.

Form 1.

| | |
|---|-----------------------------------|
| SUMMARY—Intermediate Result Statement: | |
| <u>Summary of Main Challenges</u> | <u>Possible Strategies</u> |
| | |

(2) Strategies should then be added to the results framework using the following form. This additional step helps to visualize the connection between strategies, results, strategic objective and the goal.

Form 2.

| Project Summary Results Framework | | |
|-----------------------------------|-----------------------------|------------------------|
| Goal | | |
| Strategic objective | | |
| Intermediate result 1. | | Intermediate result 2. |
| Sub-Intermediate result 1.1 | Sub-Intermediate result 1.2 | |
| Strategy #1 | Strategy #2 | Strategy #4 |

(3) The next form is a way of organizing activities that ensures their link to strategies and results. One form is used for each Intermediate Result.

Form 3. Action Plan (To be filled out for each IR)

| Strategies/ Activities | Person Responsible | Other Critical Institutions | Resource Available | Timeframe | | |
|---------------------------|-----------------------|-----------------------------------|-----------------------|-----------|------|------|
| | | | | Yr 1 | Yr 2 | Yr 3 |
| Strategy #1 : | | | | | | |
| Activities: | | | | | | |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| Strategy # 2: | | | | | | |
| Activities: | | | | | | |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |

Once this step has been completed, specific indicators, targets and M& E implementation plans can be developed.

Step four - Develop clearly defined indicators and targets that are linked to the results (and/or objectives) and activities.

Indicators: An indicator is a variable that measures one aspect of a program or project that is directly related to the program’s results or objectives. The value of an indicator changes from baseline to the time of the evaluation. An indicator presents this change in a meaningful way such as a percentage or number. Indicators are like clues, signs or markers that inform us on whether or not the program is achieving its results or objectives. Indicators provide benchmarks for demonstrating the achievements of a program.

Indicators need to be:

- Valid (an accurate measure of a behavior, practice or task)
- Reliable (consistently measurable, in the same way, by different observers)
- Measurable (quantifiable using available tools and methods)
- Precise (is operationally defined so people are clear about what they are measuring)
- Programmatically important (linked to a public health impact or achieving results or objectives needed to achieve a public health impact)
- Timely (can be measured at an interval that is appropriate to the level of change expected)
- Comparable (can be compared across different target groups or project approaches)

When selecting indicators it is important to keep in mind that they should be:

- Consistent with project design
- Available
- Affordable
- Useful
- Limited in number

Being consistent with project design means that indicators measure what the project is actually impacting and that they are linked directly to a project result or objective.

The information needed for an indicator must be available. An indicator such as the number of consultations to non-traditional health practitioners per month in the project area would not be practical to include in the M&E system when no mechanism exists to collect this information.

The indicators must be affordable. If collecting information for an indicator is expensive, it should only be collected as part of evaluations or alternatively less expensive indicators should be selected for the M&E system.

There are three key uses for indicators: to evaluate the project; to monitor the progress of the program; and as part of management in order to determine if activities are carried out as planned. Indicators for evaluation purposes should describe the results of the project. Where possible, a project should select standard indicators for evaluation purposes because they have been tested for validity and reliability and they allow comparison between projects or sites. In addition they tend to be available through existing data collection methodologies. An example of an evaluation indicator would be increased percentage of children 0-23 months whose births were attended by skilled health personnel.

In the area of maternal and child health, a number of standard key indicators have been developed. Most of these can be measured using available tools and methods. For example, the Child Survival and Health Grants Program developed a population based Knowledge, Practice and Coverage (KPC) survey with standard indicators for the technical areas covered by the program (Immunization; Control of Diarrhea; Breastfeeding and Infant and Young Child Feeding; Birth Spacing/ Family Planning; Acute Respiratory/ Pneumonia; Malaria; Maternal Health; Newborn care; STIs; and HIV/AIDS). These indicators are compatible with DHS. The tool can be accessed at: <http://www.childsurvival.com/kpc2000/kpc2000.cfm#FieldGuide>.

Another good reference for maternal and child health indicators is the Measure Evaluation Guide for Monitoring and Evaluation of Child Health Programs. The indicators in this document are consistent with DHS and MIC surveys. This document can be accessed at: <http://www.cpc.unc.edu/measure/publications/pdf/ms-05-15.pdf>. In addition United Nations' Millennium Development Goals (MDG) have been established with specific indicators for each goal. These indicators are also consistent with DHS and MICS and can be accessed at: http://millenniumindicators.un.org/unsd/mi/mi_goals.asp.

Monitoring indicators help project stakeholders and managers understand the progress of the project in time for adjustments to be made to project implementation. They may be a sub-set of evaluation indicators or they may be proxy indicators that indicate that the project is on the right track. For monitoring, projects can include a small group of evaluation indicators in data collection performed on routine supervision visits. LQAS methodology (which is one methodology used by KPC surveys) can be carried out during these visits to obtain this information. It is sometimes easier to use proxy indicators for monitoring. For example in order to determine increased percent of deliveries with skilled attendance at birth, the evaluation indicator may be based on a population survey such as the KPC, but the monitoring indicator may be births in the health center. Information on births in the health center is easy to collect; represents a trend in coverage; and links to the existing health information system.

Management needs should be taken into consideration when selecting indicators. A project manager should think about what he or she needs to ensure daily completion of activities. This includes inputs such as funds; supplies and drugs; equipment and personnel. In addition, a plan should be in place to monitor completion of basic activities or processes. Indicators for this include number of training sessions held or number of group health education sessions held. Indicators should be directly linked to the activities defined during step 3. This ensures that the monitoring indicators are linked to the project design.

When selecting indicators it is important to limit the number of indicators especially for evaluation purposes. One or two indicators per result and/or objective are usually sufficient for evaluation purposes. One or two indicators that measure monitoring toward results are also usually sufficient and may be the same as for evaluation. Managers usually need more information in order to manage the project. For management it is important to think about basic inputs and activities that must be monitored in order to judge if activities are implemented as planned and that help managers make decisions. Information not linked to a decision should not be collected.

The following are sources of information for measuring indicators:

- Health service statistics
- Project reports
- Community-based registers
- Surveys
- Health facility assessments
- Organizational capacity assessments

The following M&E planning matrix is useful for organizing indicator selection and in ensuring that indicators are linked to project results. This matrix will continue to be useful in the next step, which is developing a plan for data collection, analysis and use.

Monitoring and Evaluation Planning Matrix

| Results | Indicator (evaluation AND monitoring) | Description/ Definition of indicator | Source of data | Frequency of collection | Point person | Baseline value |
|---------|---------------------------------------|--------------------------------------|----------------|-------------------------|--------------|----------------|
| SO | | | | | | |
| IR 1 | | | | | | |
| IR 2 | | | | | | |
| IR 3 | | | | | | |
| IR 4 | | | | | | |

Targets: A Target is a statement of the expected value of an indicator, and the date by which the change is to be achieved. Setting a realistic target requires a solid indicator and good baseline data. Project targets are often set based upon a "benchmark", which is the best level of performance on the indicator that a district, region, province or country has been able to achieve, or on international set targets (e.g. Roll Back Malaria targets for malaria control.) Extensive consultation is required with various partners, governmental and non-government organizations, and the general public (community) to establish realistic and achievable targets. An example of a target would be increase exclusive breastfeeding from 20% to 40% in the project area by the end of the 5 year project. The higher the target is set, the more resources the project (PVO, partners, communities...) will need to allocate to activities linked to this target.

Projects often set initial targets at the time of proposal development based on secondary data information. These targets are later refined after actual baseline values are collected from baseline assessments, such as the KPC or Health Facility Assessments. In addition to targets for the end of the project, it may be useful to set mid-term or annual targets to assess how the project is progressing.

Step five - Develop a plan for data collection, analysis and use.

Once indicators have been selected, the next step is to determine details of how data will be collected, analyzed and used. At this time it is good to review how the M&E system is linked to

the program design in order to be sure that enough information will be collected to measure results or objectives and that unnecessary information is not collected. At this time, indicators can be adjusted in order to make sure that they are feasible and practical to collect. In some cases wording of results can be altered to ensure that information can be collected to measure results. This avoids the situation of having a result that looks interesting, but is impossible to measure. This process can be summarized by the following steps:

- Review the results framework.
- Review indicators developed for the SO and IRs of the Results Framework
- Make sure indicators are selected for both monitoring and evaluation
- Determine the best sources of monitoring (periodic) and evaluation information for each indicator.
- Make sure indicator collection is feasible and that indicators reflect results and strategies.
- Consider who and how the information will be used
- Fill out the M&E planning matrix introduced in step 4

The M&E planning matrix that was introduced as part of step 4 is an important tool for organizing how information for indicators will be collected and used. Filling out this form ensures that indicators will be carefully identified and defined; that sources and methodologies for this data will be identified; and that the frequency of data collection and the person responsible for collection will be identified. Baseline information will be recorded after baseline assessments have been carried out. The following are details about how to fill out each column of the table:

- Indicator Description
 - Make sure numerator and denominators are defined.
 - Describe the time period for the indicator (i.e., no stock-outs in the last 3 months).
 - Describe the target population.
- Source of Data
 - Make sure that there is a clear source of data for each indicator.
 - Determine if the source is too complicated or expensive, eliminate or rewrite indicator for a more appropriate source.
- Frequency
 - Make sure information is collected often enough for decision making.
 - Make sure frequency of collection does not create a burden for staff or population.
- Point Person
 - Make sure someone is responsible for collecting the information.
- Baseline Value
 - Add this after baseline studies are performed.

After the form is filled out review the indicators and ask the following questions for each indicator on the matrix:

1. Does it help judge whether results are reached or whether or not the project is on the way to reaching them?
2. Is the information easily obtained?
3. Are the costs (both time and money) for obtaining the information reasonable given the resources of the project?

Then take a look at all the indicators to be sure that all results have indicators and that donor required indicators are included. For example: are Rapid CATCH indicators included in M&E systems for Child Survival and Health Grants? These are required by the donor.

Next, determine how information will be analyzed and used. This information should be written into the M&E plan. This is another opportunity to refine indicators. Any indicator that is not used for a decision should be eliminated. The following are groups that will use information: Donors, Partners, National Health Leaders, Project managers and communities. At this time it is important to specify how information will be shared with these groups, for example: Regular meetings with partners; community feedback and discussion sessions; or monthly reports.

Step six - Implement baseline and final assessments that measure progress toward achievement of results (and/or objectives) and monitoring systems that let you know if project implementation is on track.

The last step in this process is collecting baseline data information. There are three main aspects to this process: Determining data collection methodologies and sources of information; Adapting instruments; and working with partners to use findings to set targets and adjust the project. Methodologies for collecting this information are usually quantitative and allow for calculation of frequencies, rates, averages and coverage. Sources for baseline data include surveys, census, health service delivery assessments, service delivery statistics, policy documents and project records.

Important sources of information

Sources of Information Used by National Health Information Systems: health projects usually work closely with the Ministry of Health and projects should ensure that project monitoring and evaluation systems are relevant to national systems so that project generated information is useful for decisions that MOH personnel make, that project managers use incorporate MOH information in their own decision making processes and in order to help strengthen the MOH system. For this, it is important to understand sources of information used by national and district level health information systems (HIS). The following describes sources of information that are relevant to Ministries of Health and other groups that work at the national level.

Routine Data Sources: Data are collected on a continuous basis, such as information collected on a patient-by-patient or daily basis at health facilities. These data are collected by facility-based staff and recorded on standard reporting forms that are sent to higher levels in the system where they are aggregated. Data are most often service statistics such as the number of cases seen by disease category; number of deaths at the facility; number of pregnancies and births; number of vaccinations given and estimates of coverage using local population data; and the number of outreach visits conducted. These data may all be useful for monitoring or evaluating elements of program performance. The advantage of this method is that it uses routine systems and does not require additional resources.

Though the data are collected continuously, processing of and reporting on the data often occur only periodically. For example, information from health facilities may be compiled into monthly

reports. Health facilities may submit their reports to district health offices which then also compile them into monthly reports. The advantages of this method are that data can be obtained on a timely basis. Early detection and correction of problems can be conducted. A disadvantage of the method is that it can be difficult to get estimates of catchment areas or target populations. Not all individuals in the community may go to these facilities so estimates of morbidity may not be representative of the population. Mortality is often not captured from routine data sources in developing countries because many persons die at home and not in health facilities. These data also do not present any information on health worker performance – a critical element of quality of care.

Vital registration is another form of routine data. Developing countries, however, often have incomplete registries of births and deaths on a national level. In some settings it may be possible to track all households in a community using regular visits by trained workers. This system allows data on vital events (births, deaths, pregnancies, episodes of illness) to be gathered, and also allows tracking of household knowledge and practices – and the collection of health indicator data. If regular visits are complete and sustained, then an accurate picture of the health status of a population can be obtained (since sampling is not required). When establishing census-based systems, strategies for local use of data for planning and monitoring purposes need to be developed and strategies for sustaining household visits over time need to be elaborated upon.

Demographic surveillance is another form of routine data collection which focuses on a specific geographic area or specific diseases. Sample Vital Registration with Verbal Autopsy (SAVVY) is a system of surveillance sites based on a nationally representative sample, which collects vital (births and deaths) information and classifies the death by cause.

Non-Routine Data Sources: Data from these sources are collected on a periodic basis. Common examples are household surveys (national and community), national censuses and facility surveys. Advantages of these sources are that they provide both numerators and denominators and they include those who use and do not use health facilities. Some disadvantages are that they can be costly to conduct and are sometimes done on an infrequent basis.

The Child Survival and Health Grants program has developed a population based Knowledge, Practice and Coverage Survey (KPC), used by grantees to collect household information at baseline and end of project. For this survey, mothers of children less than 24 months are interviewed. The tool encompasses the areas of: Immunization; Control of Diarrhea; Breastfeeding and Infant and Young Child Feeding; Birth Spacing - Family Planning; Pneumonia; Malaria; Maternal Health; Newborn care; STIs; and HIV/AIDS. This tool can be accessed through the following link to the CSTS website <http://www.childsurvival.com/kpc2000/kpc2000.cfm#FieldGuide>.

The tool consists of Rapid CATCH questions, 15 modules and descriptions of standard sampling methodologies. Rapid CATCH indicators are standard indicator that provide a broad view of the child health situation in the project area and should be collected by all projects independent of the technical areas that they plan to work in. Rapid CACTH questions are supplemented by selecting questions from the modules that are relevant to the project technical areas. Two

sampling methodologies can be used to implement the KPC survey, 30-cluster and LQAS (Lot Quality Assurance Sampling). Both methodologies use the same questions and indicators. Both have standard sample sizes. Both yield coverage data for the entire project area.

The 30-cluster methodology is based on collecting a sample size of 300, which is collected through 30 clusters of 10 households each. This methodology does not require a list of households and requires only visiting 30 locations in the project area. LQAS is based on a sample size of 95 to determine coverage for the entire project area and 19 to determine if the project is reaching targets in supervision areas. It involves visiting 95 locations in the project area and requires a household list. Questionnaire development for LQAS is more complicated for projects that measure information on different target populations at the same time, such as children 0-11 months and children 12-23. In addition projects must be sure to interview household for each of these sub-groups at each of the 95 interview locations selected in LQAS. For both methodologies, it is important to closely follow their standard methodologies, especially regarding sample size determination. This is important in order to ensure that denominators for all indicators are large enough to draw meaningful conclusions. LQAS can be included in a monitoring system to track whether or not supervision areas are reaching targets.

Questionnaires for both sampling methodologies are adapted from the KPC tool. It is important to be sure that appropriate questions are included in the questionnaire so that project results and objectives can be measured. The following tables help to ensure this:

Table 1

| Project Result and or Objective | Questions on Grantee Questionnaire | Numerator - denominator for indicator that will be collected from the Grantee questionnaire |
|---------------------------------|------------------------------------|---|
| | | |
| | | |

Table 2

| Rapid Catch Indicator | Questions on Grantee Questionnaire | Numerator/ denominator for indicator that will be collected from the Grantee questionnaire |
|-----------------------|------------------------------------|--|
| | | |
| | | |

Information collected at baseline will also be collected at the end of the project to see if the project achieved results. The same methodologies and questionnaires used at baseline should be used at the end of the project. This information can also be collected at project mid-term to help judge progress and point out areas in project implementation that need adjustment.

Information from population base surveys should be combined with information from other sources such as health service delivery assessments in order to provide baseline figures for the project. Health facility surveys usually focus on out-patient services at first-level and referral

facilities. Hospital-based, in-patient care is not included. Facilities in the project area are sampled. Instruments are adapted, translated and pre-tested. Instruments measure health worker clinical performance in the management (assessment, classification, treatment and counseling) of key child health problems (ARI, diarrhea, malaria, measles, and nutrition). Direct observations of practice are required, as well as exit interviews with caretakers of young children when they leave facilities. Health worker performance outcome measures are important measures of quality of care, and can be used to monitor improvements in clinical practice. Once baseline information is collected it should be discussed with partners in order to set targets and make adjustments to the project activities.

Project monitoring systems should be set up to measure monitoring indicators that were identified in previous steps. Sources of this information include the following: health service records, monthly reports of partners and project staff, supervision reports, training reports, LQAS data collected during supervision and review of planned activities against accomplishments.

Examples of a nationally representative household surveys are:

Demographic and Health Survey (DHS) and UNICEF-Multiple Indicator Survey (MICS) are comprehensive large sample surveys that include information on maternal and child health, reproductive health, HIV/AIDS, and mortality. A national sampling frame is usually used, although data can often be disaggregated to the level of province or district. These surveys provide useful background data for identifying health priorities. Because of their expense, they are typically done not more than every 3-4 years.

Alternate Conceptual Frameworks:

Some organizations prefer to develop M&E systems using conceptual frameworks that are different from the Results Framework or prefer to use a combination of the Results Framework with elements from other conceptual frameworks. Two commonly used frameworks are the Logic Model and the Log Frame.

The logic model provides a clear path backwards from impact and outcomes to processes and inputs needed to achieve the impact. In this model inputs lead to processes which lead to outputs, outcomes and finally impact. This model provides a clear link from resources to program outputs and on to impact. Indicators can be developed for each element of the logic model leading to specific outcomes. This model can be related to the results framework and used to complement the results framework. In general impact in the logic model is the same as the goal of the results framework; outcomes in the logic model are the same as results in the results framework; and processes and outputs are the activities that are connected to the results framework.

The following table describes the type of information included in each element.

| Input | Processes | Output | Outcomes | Impact |
|---|-------------------------------------|--|--|--|
| Funds, supplies, equipment, etc.. | Training | Trained staff | Improved quality of care in health centers | Decreased Infant and Child Mortality Decreased Maternal Mortality |
| Staff, funds, supplies, equipment, etc.. | Clinic based treatment and Services | Patients receiving treatment and services | Patients are cured | Decreased Infant and Child Mortality Decreased Maternal Mortality |
| Policies - guidelines and procedures, community members, staff, supplies, etc.. | Home-based Care | Mothers adequately caring for sick children | Early and or improved care (in the home) for sick children | Decreased Infant and Child Mortality |
| Policies - guidelines and procedures, staff, funds, supplies, equipment, infrastructure, etc... | Outreach services | Children and mothers receiving services such as immunization services in the community | Improved access to preventive health services | Decreased Infant and Child Mortality Decreased Maternal Mortality |

The Log Frame provides a good way of organizing details of an M&E system. These details are linked to project objectives, outputs and activities. The following table describes the elements of a Log Frame:

| Project Description | Performance Indicators | Means of Verification | Assumptions |
|---|---|---|---|
| Goal: The broader development impact to which the project contributes - at a national and sectoral level. | Measures of the extent to which a sustainable contribution to the goal has been made. Used during evaluation. | Sources of information and methods used to collect and report it. | |
| Purpose: The development outcome expected at the end of the project. All components will contribute to this. | Conditions at the end of the project indicating that the Purpose has been achieved and that benefits are sustainable. Used for project completion and evaluation. | Sources of information and methods used to collect and report it. | Assumptions concerning the purpose/goal linkage. |
| Component Objectives: The expected outcome of producing each component's outputs. | Measures of the extent to which component objectives have been achieved and lead to sustainable benefits. Used during review and evaluation. | Sources of information and methods used to collect and report it. | Assumptions concerning the component objective/purpose linkage. |

| | | | |
|--|---|--|---|
| <p>Outputs: The direct measurable results (goods and services) of the project which are largely under project management's control.</p> | <p>Measures of the quantity and quality of outputs and the timing of their delivery. Used during monitoring and review.</p> | <p>Sources of information and methods used to collect and report it.</p> | <p>Assumptions concerning the output/component objective linkage.</p> |
| <p>Activities: The tasks carried out to implement the project and deliver the identified outputs.</p> | <p>Implementation/work program targets. Used during monitoring.</p> | <p>Sources of information and methods used to collect and report it.</p> | <p>Assumptions concerning the activity/output linkage.</p> |

References

Introduction

Many of the references listed below are now web-based and contain their highlighted (in blue) “hyperlinked” website address. To access them, use an electronic copy of this document (which you can access from our website: <http://www.childsurvival.com/documents/usaiddcfm>). Simply click on the blue highlighted website address of the reference that you want to find in this document, and you will automatically be connected to that site/reference online. Another option is to be online using your browser, and manually cut and paste/or type in the website address for the reference you want to find from this document.

Some of the references still remain available only in hard copy, and an attempt has been made to provide information on how to obtain them. All documents published under USAID-funded projects can be obtained from USAID’s Development Experience Clearinghouse (DEC), <http://www.dec.org>. The order number of each document begins with PN- or PD- and appears in parentheses at the end of the citation.

This reference list is by no means the last word on any of these interventions or cross cutting strategies. This annex cannot possibly be exhaustive, but rather can help steer the user in the right direction when researching these areas.

This is a dynamic list, as are the TRMs in general. We ask that throughout the year you provide us with information on the availability and usefulness of each entry, as well as additional resources that you think should be added to this list, as appropriate, so that next year we can continue to update it. Please send comments and recommendations to Michel Pacqué at CSTS⁺ <mailto:Michel.C.Pacque@orcmacro.com>.

Essential References

MEASURE Evaluation. A Guide for Monitoring and Evaluating Child Health Programs
<http://www.cpc.unc.edu/measure/publications/pdf/ms-05-15.pdf>

MEASURE Evaluation. Compendium of Child Survival Monitoring and Evaluation Tools
<http://www.cpc.unc.edu/measure/publications/html/ms-00-08.html>

MEASURE Evaluation - Compendium of Maternal and Newborn Health Tools
<http://www.cpc.unc.edu/measure/publications/html/ms-02-09.html>

USAID PVO/NGO Flexible Fund - Program Design Monitoring and Evaluation:
<http://www.flexfund.org/resources/training/pdme.cfm>

KPC Knowledge Practice and Coverage Survey

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