"So what? I need results": monitoring and evaluating impossible Family Planning / Reproductive Health Programmes: an Introduction

Dr. Alfredo L. Fort, MD, PhD
Scientist
WHO Reproductive Health and Research Department
Research Capacity, Policy and Programme Strengthening Unit

Training Course in Sexual and Reproductive Health Research
Geneva 2012
Typical projects / programmes

- Emphasis on start-up of activities ("quick results")
- Project managers know little of M&E (some couldn't care less!)
- "No research please"
- Consequences: few M&E staff, recruited late a/o insufficiently, scarce resources allocated
Why do you want money to evaluate now? That's at the end!

I think things are going well. Just keep doing the same thing…

Quick! Start! Setup! Buy!

What do you mean there's no Results?!

Get ready for the final evaluation!
Typical project mindframes

We are on a roll here, do not stop us to think about frameworks, etc.

Concerns about not being able to measure changes!

"Monitoring": concern about spending well, reporting on time, etc. (processy)

Panic! Retrofit! Tell case stories, anecdotes! Count trainings!

Excitement Gung-ho We know it all!
Mission impossible?
Basics of a good M&E system - Components

- Responsibilities (WHO)
- Indicators (WHAT)
- Methods (HOW)
- Timing (WHEN)
Basics of a good M&E system – Disposition

- Persuade
- Responsibilities (WHO)
- Indicators (WHAT)
- Timing (WHEN)
- Methods (HOW)
- Innovate
- Train
- Adapt

M&E System
Framework

- Originates from project / programme objectives
  - Differentiate Goals from objectives and tasks / activities

- Elements:
  - Indicators / variables
  - Sequence
  - Relationships
  - Time (Before – During – After)
A Model Conceptual Framework

Goals and objectives (illustrative)

- Goal: Improve reproductive health in region X
- Objectives
  - Obj 1: Increase couples' access to reproductive health services
  - Obj 2: Improve quality of RH services

**Challenge:** How to translate from management language to evaluation terms!
Activities and tasks (Illustrative)

Supply
- Improve logistics (contraceptives, medicines)
- Improve equipment (delivery, C-section)
- Train providers
- Strengthen performance system (job descriptions, use of protocols, supervision, recognition, etc.)

Demand
- Formative research (socio-cultural factors for access)
- BCC (social marketing / advertising)
Building the framework I: from the goal to indicators - [Outcome]

<table>
<thead>
<tr>
<th>Management</th>
<th>Evaluation</th>
</tr>
</thead>
</table>
| Goal: "Improve Reproductive Health" | ■ Total (& Adolescent) Fertility Rate  
■ Contraceptive Prevalence Rate  
■ Unmet need for Contraception  
■ Births delivered by SBA |

**Important:** Maternal mortality – not possible to measure!
## Building the framework II: from objectives to indicators - [Outputs]

<table>
<thead>
<tr>
<th>Management</th>
<th>Evaluation</th>
</tr>
</thead>
</table>
| **Obj 1: "Increase access to RH services"** | - ANC coverage  
- Institutional deliveries  
- % postpartum FP |
| **Obj 2: "Improve quality of services"** | - % stockouts (comm, meds)  
- Provider performance (index)  
- Client perception |
Building the framework III: from activities / tasks to indicators – [Inputs-Processes-Outputs]

<table>
<thead>
<tr>
<th>Management</th>
<th>Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving logistics, equipment</td>
<td>■ $ spent on new equipment&lt;br&gt;■ % orders delivered on time&lt;br&gt;■ Number of warehouses with appropriate storage conditions</td>
</tr>
<tr>
<td>Training providers</td>
<td>■ Number of providers trained&lt;br&gt;■ % of providers who passed knowledge and skills test</td>
</tr>
</tbody>
</table>
Building the framework III: from activities / tasks to indicators — [Inputs-Processes-Outputs]

<table>
<thead>
<tr>
<th>Management</th>
<th>Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthening the performance system</td>
<td>% providers with agreed-upon job descriptions</td>
</tr>
<tr>
<td></td>
<td>% of providers who used the partograph appropriately last month</td>
</tr>
<tr>
<td>Enhancing demand</td>
<td>FGDs conducted to find out what people need</td>
</tr>
<tr>
<td></td>
<td>Number of leaflets in local language distributed in community in last quarter</td>
</tr>
</tbody>
</table>
Our illustrative framework (adapted)

**Systems:**
- Social
- Cultural
- Economic
- Political
- Legal

**Development Programmes**
- Human & Financial Resources
  - $ spent on equipment
  - Providers trained
- Policy Environment

**Individual factors**
- Women's Status & Empowerment

**Functional areas**
- Providers passing K&S test
- JDs
- Appropriate warehouses
- Timely deliveries
- Use of partograph

**Service delivery**
- Increased access
  - ANC
  - Institutional deliveries
  - Postpartum FP
- Improved quality
  - Stockouts
  - Provider performance
  - Client perception

**Increased demand**
- FGDs
- IEC in community

**Outcomes:**
- Improved Reproductive Health
  - TFR (Adol)
  - CPR
  - UMNC
  - Births by SBA

**M&E**
- Inputs
- Process/Functional Outputs
- Service Outputs
- Outcomes
Basics of a good M&E system - Components

- Responsibilities (WHO)
- Indicators (WHAT)
- Methods (HOW)
- Timing (WHEN)

M&E System
Operative aspects

- Responsibilities (Who)
  - "Everyone" = Nobody!
  - Hire/Assign M&E persons
  - Write clear JDs, expectations
  - Train and support them (PI: K&S, JD, tools, org'l support, incentives, individual factors)
Methods (How) I: Technical
Use all tools of the trade: quantitative, qualitative, epi, clinical, social sc, etc.

- **Clinic-based information** (for outputs)
  - From records (e.g., ANC coverage),
    - Numerators: good recording, avoid double-counting
    - Denominators: catchment population, updated
  - From observation
    - E.g., provider performance
      - Create, innovate – e.g., create indices from observation checklists (e.g., see next slide)
    - E.g., stockouts (in last 6 months)
      - By medicine/commodity, type and all meds/commdts
  - From surveys
    - E.g., client perceptions
      - Exit interviews (compare with observations)
<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of client</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Number of living children</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Last delivery date or age of youngest child</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>History of complications with pregnancy</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Last menstrual period (assess if currently pregnant)</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Desire for a child or more children</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Desired timing for birth of next child</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Breastfeeding status</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Regularity of menstrual cycle</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Took the client’s blood pressure</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Weighed the client</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Asked the client about smoking</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Asked the client about symptoms of STIs (e.g., abnormal discharge)</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Asked the client about chronic illnesses (heart disease, diabetes, hypertension, liver or jaundice problem, breast cancer)</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Looked at the client’s health card (either before beginning the consultation or while collecting information or examining the client)</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>
Community-based information

- From household questionnaire surveys (for outcomes)
  - E.g., CPR, deliveries by SBA
    - Sampling from catchment population
    - Use proven questions, methods (e.g., DHS)
- From in-depth interviews or FGDs (for context, case histories, explanation of results)
  - E.g., traditions favouring and preventing use of services
  - E.g., leaders' perceptions of changes in facilities
  - E.g., providers' initial attitudes and feedback on training
More on methods

- Measurements: quality or nothing
- Mantra: compare, compare, compare (like-with-like)
- Before-and-after (Baseline – Endline)
- A vs B (Intervention vs Control): quasi-experimental if not random allocation; also cluster random if not unit random
- Why control? Because *things naturally change*, or because *there are other influences* in a place
- Avoid contamination, esp with community interventions (e.g., social marketing)
- Ensure ethical considerations (e.g., training vs no training or different approaches?)
More on methods

- Sampling size: if baseline is quite low and intervention will increase substantially (e.g., level of performance), and population is homogeneous (e.g., physicians using partograph), sample size need not be too large.

- Baseline: 50%, Expected result: 80%, 95% confidence level, 80% power → need 45 physicians in each group

- Survey: if in a population of 50,000 you expect 60% delivering at a health facility (and accept a 10% margin of error) = need to interview 260 WRA
Evaluation designs: from weaker to stronger

Scientific strength of design

- Scientific strength of design

+ Scientific strength of design

A' RA

A

A' NRA

A

A

B C D

...........

1 Intervention X 2
Methods (How) II: Managerial
How will this brilliant system work?

- Early on, convene managers, explain framework in simple terms, and needs.
- Do not start with the $, but with a warning: you want results at the end of the project? – start now!
- EXTREMELY IMPORTANT: "increase", "improve" means change, thus need BASELINE!
- NO BASELINE, BYE BYE RESULTS! (only options: "retrofit", assume, anecdotal, qualitative, case stories, etc.)
- Train, refresh, insist, persuade, bug…
More management of M&E

- Setup framework as early as possible, but be ready to adjust portions as required (e.g., new elements in programme)
- Develop orientation & training materials for managers and M&E colleagues
- Report frequently (but concisely!) to senior managers – e.g., baseline results: "How we found the place"
- Develop and have budgets ready for M&E activities – e.g., "How much is it going to cost to run this workshop on setting up a database, collecting and analysing data?"
Tips ("The perfect is enemy of the feasible")

- Go for results, but do not forget processes and individual/anecdotal material (in the end, everyone loves them!)
- Do not fall in the trap! It is not research, it's a "review," you are not doing a survey, it's an "assessment," we are "checking on the progress…" → Adapt
- Being flexible is not being lousy – keep necessary rigor
- Be aware of lack of generalizability: either from qualitative methods, or from small pilot interventions ("validity"; scaling-up)
- Be honest in what can and cannot be achieved – e.g., though management would like to see changes in maternal mortality rates in a small area or in a short time, they have to know that such is not possible (however, you can demonstrate changes in "proxy" indicators, e.g., more women attended and better care)
References – further reading

- For a framework and construction of indicators: J. Bertrand and Escudero, G., Compendium of Indicators for Evaluating Reproductive Health Programs, Volume One. MEASURE Evaluation Manual Series, No. 6, August 2002
- For discussion on what can be accomplished with different assessments and evaluation designs: JP Habicht, CG Victora and JP Vaughan, Evaluation designs for adequacy, plausibility and probability of public health programme performance and impact, International Journal of Epidemiology, 1999; 28: 10-18
- For a Monitoring and Evaluation Toolkit, with tips on how to build a framework and indicators: http://www.rhrc.org/resources/general_fieldtools/toolkit/causal.html
- For M&E plans for Adolescent SRH programs: S Adamchak, K Bond, L MacLaren et al, A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs, FOCUS on Young Adults, Tool Series 5, June 2000