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

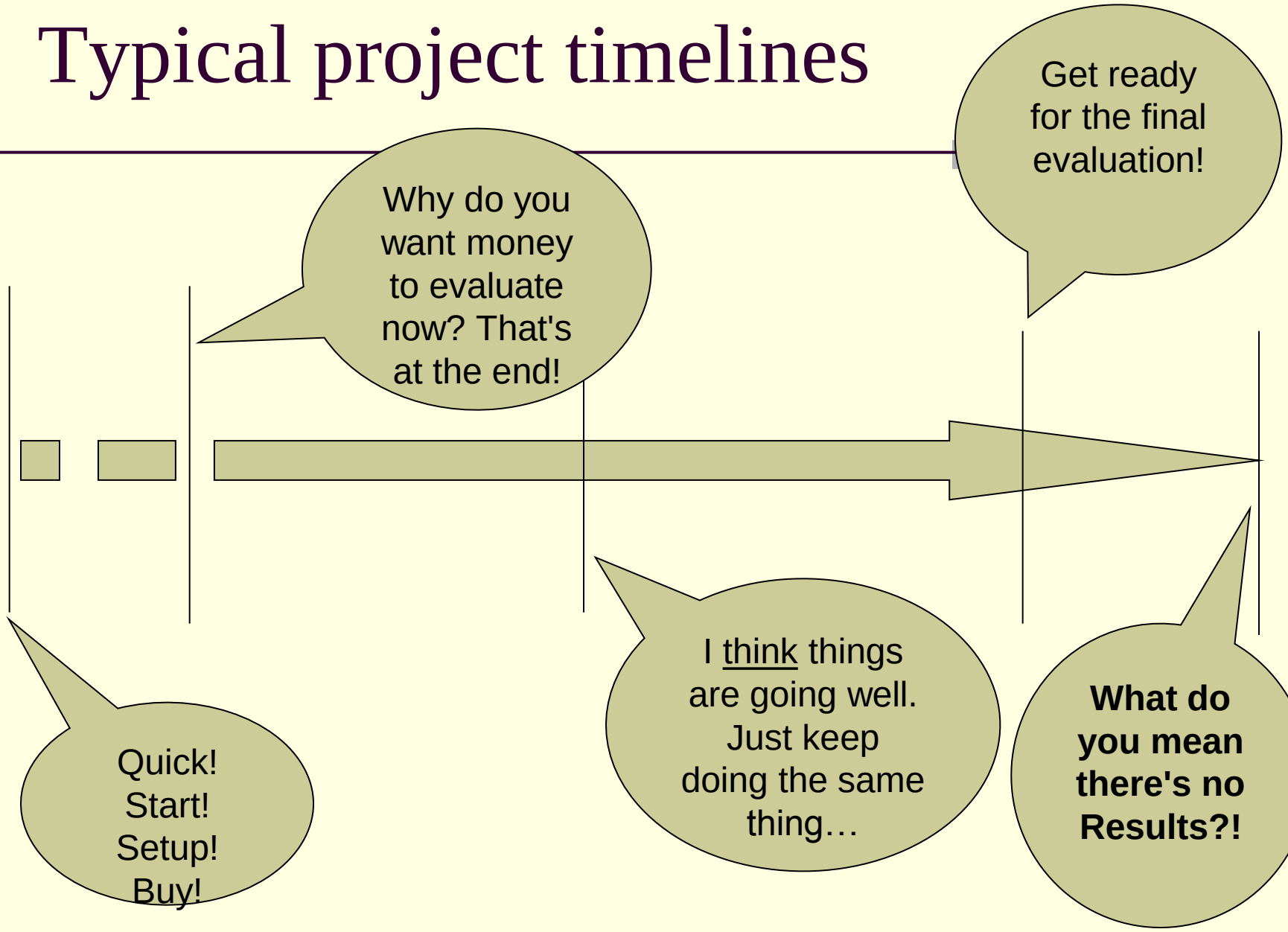
Dr. Alfredo L. Fort, MD, PhD
Scientist
WHO Reproductive Health and Research Department
Research Capacity, Policy and Programme Strengthening Unit

Training Course in Sexual and Reproductive Health Research
Geneva 2011

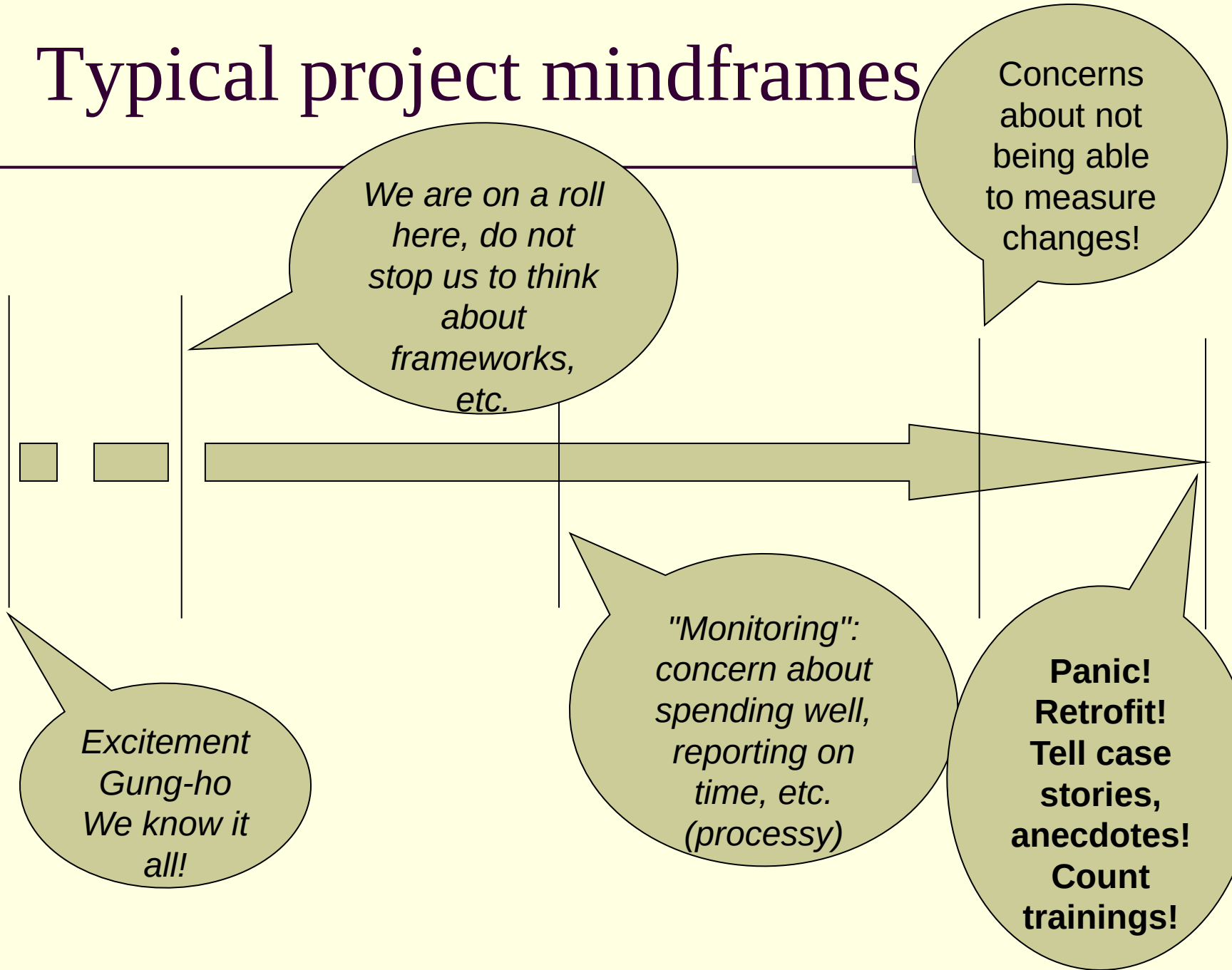
Typical projects / programmes

- 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

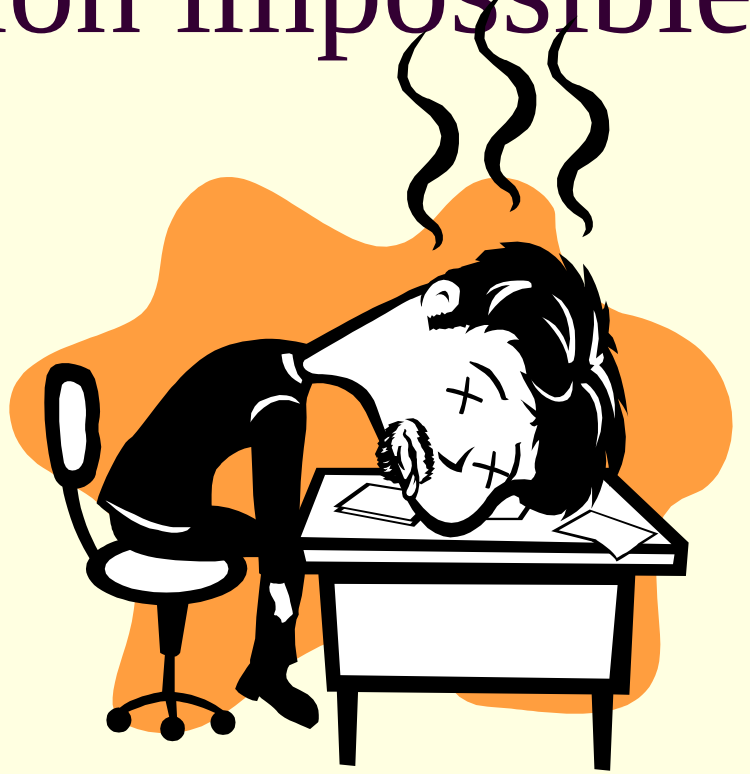
Typical project timelines



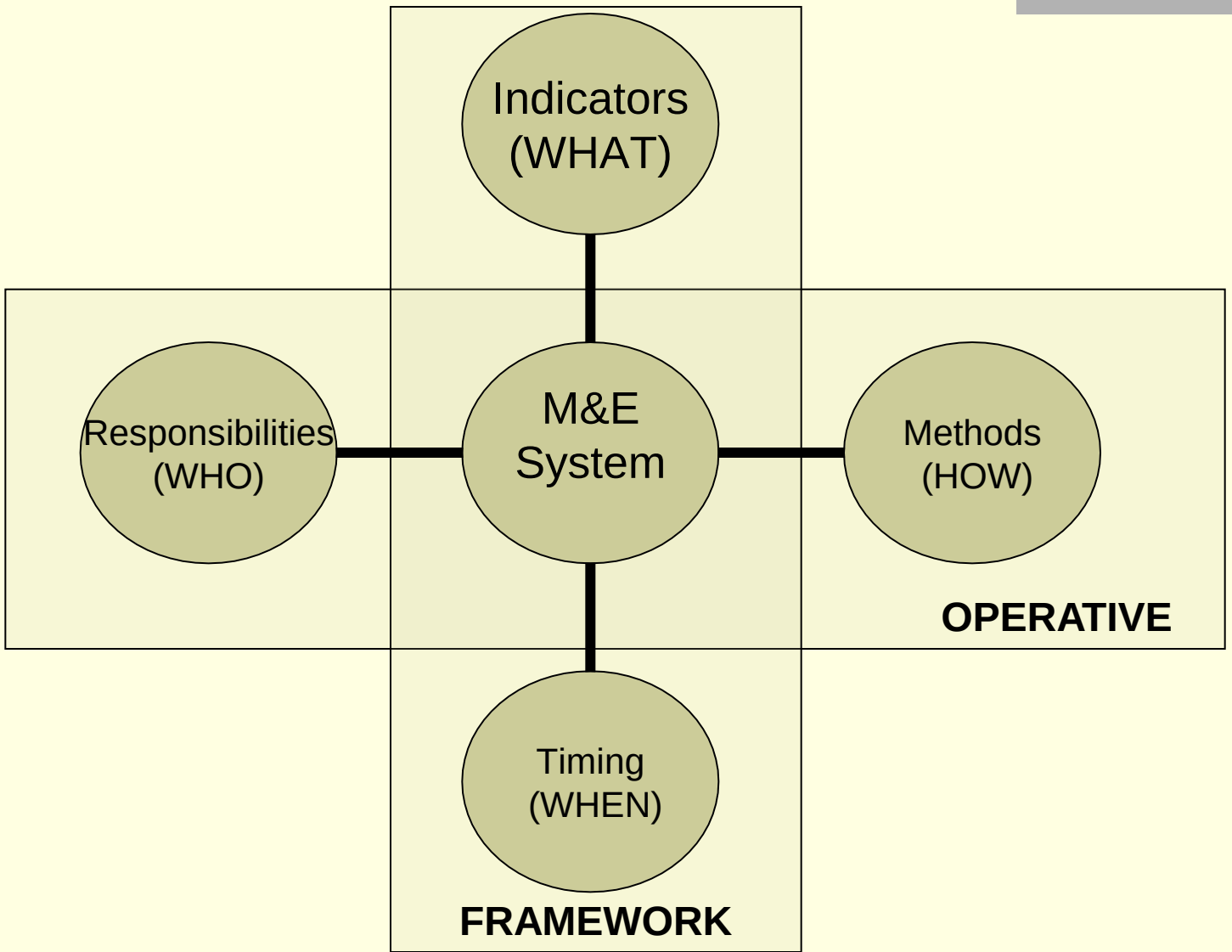
Typical project mindframes



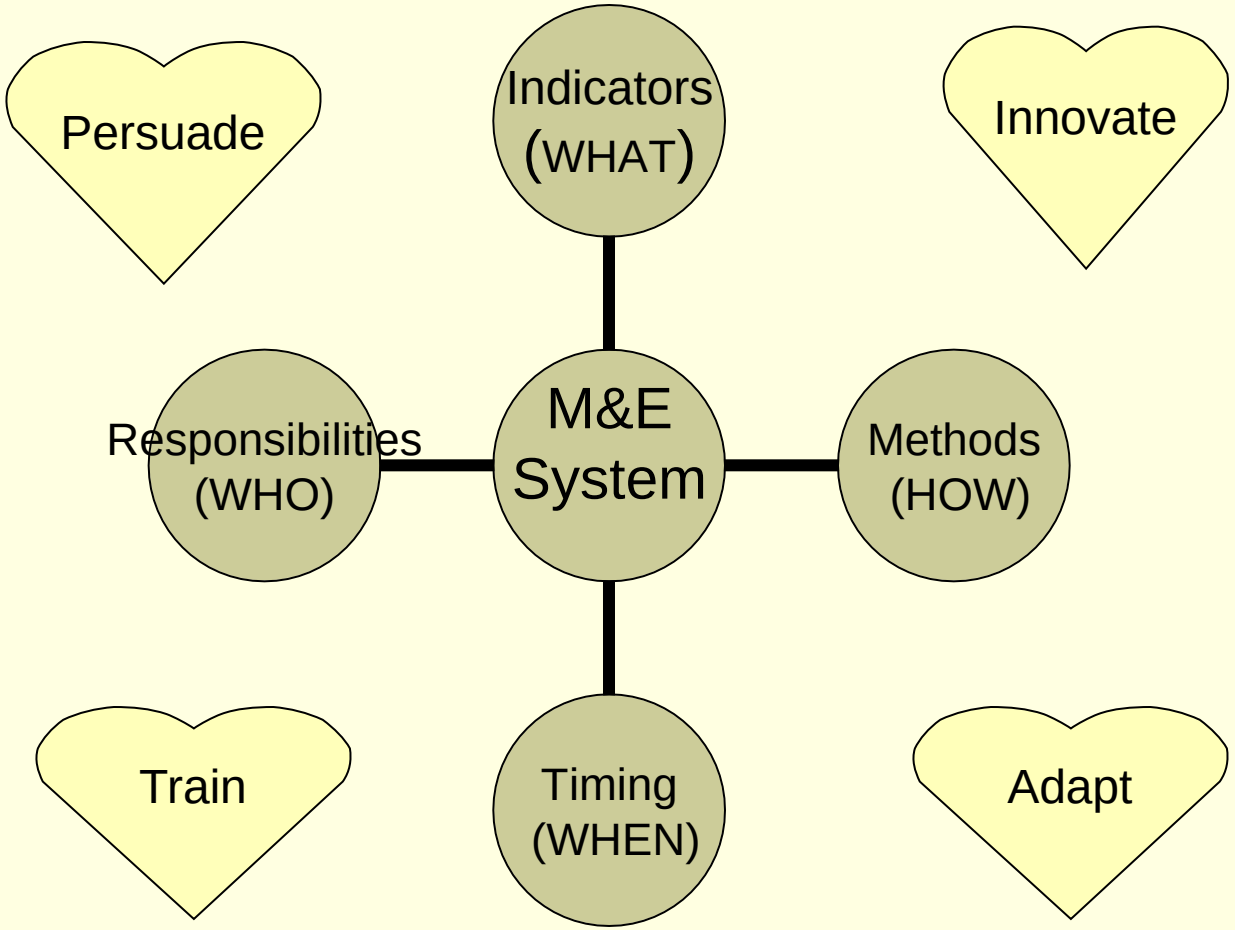
Mission impossible?



Basics of a good M&E system - Components



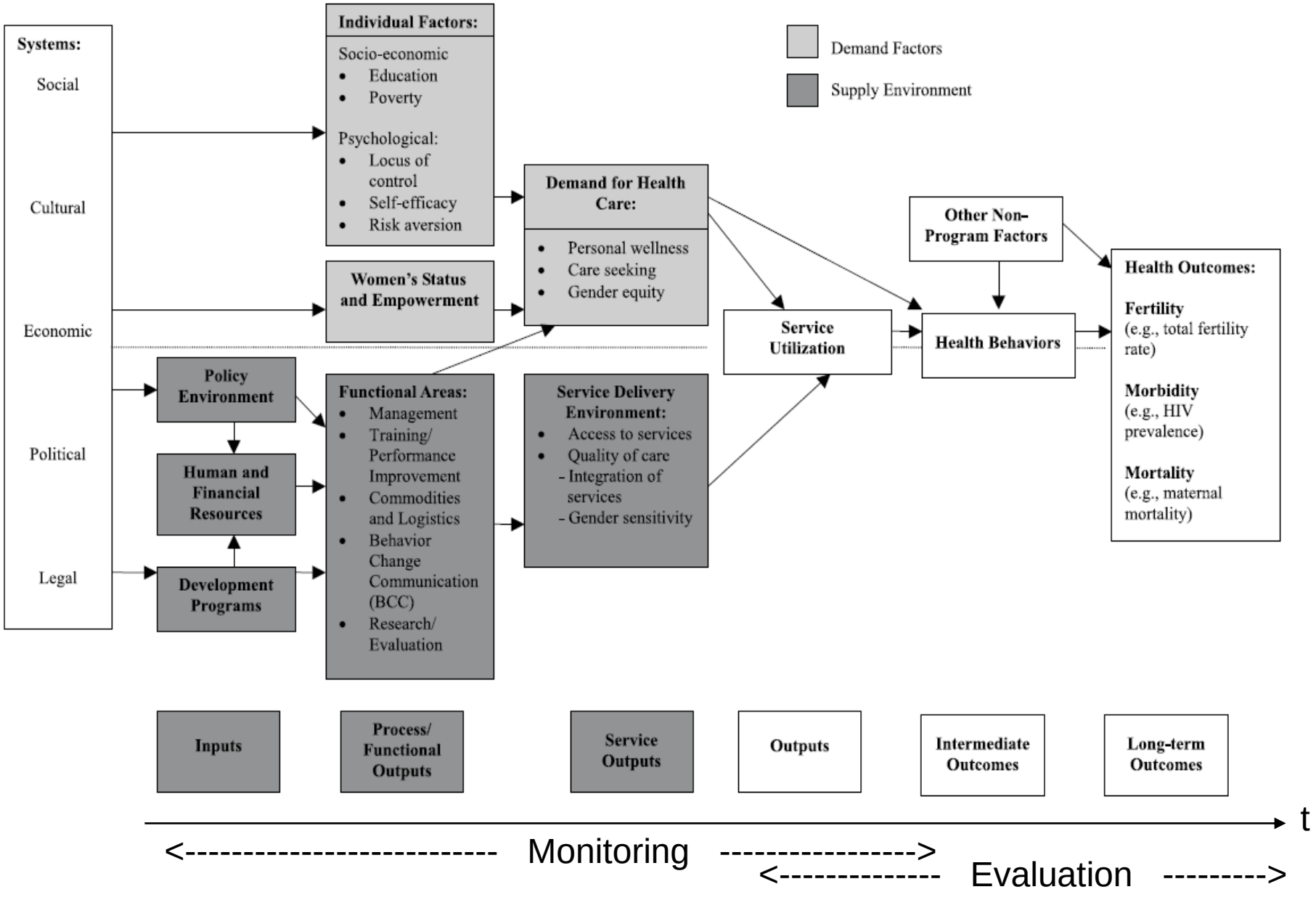
Basics of a good M&E system – Disposition



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



Adapted from: J. Bertrand and Escudero, G., Compendium of Indicators for Evaluating Reproductive Health Programs, Volume One. MEASURE *Evaluation* Manual Series, No. 6, August 2002.

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]

Management	Evaluation
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]

Management	Evaluation
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

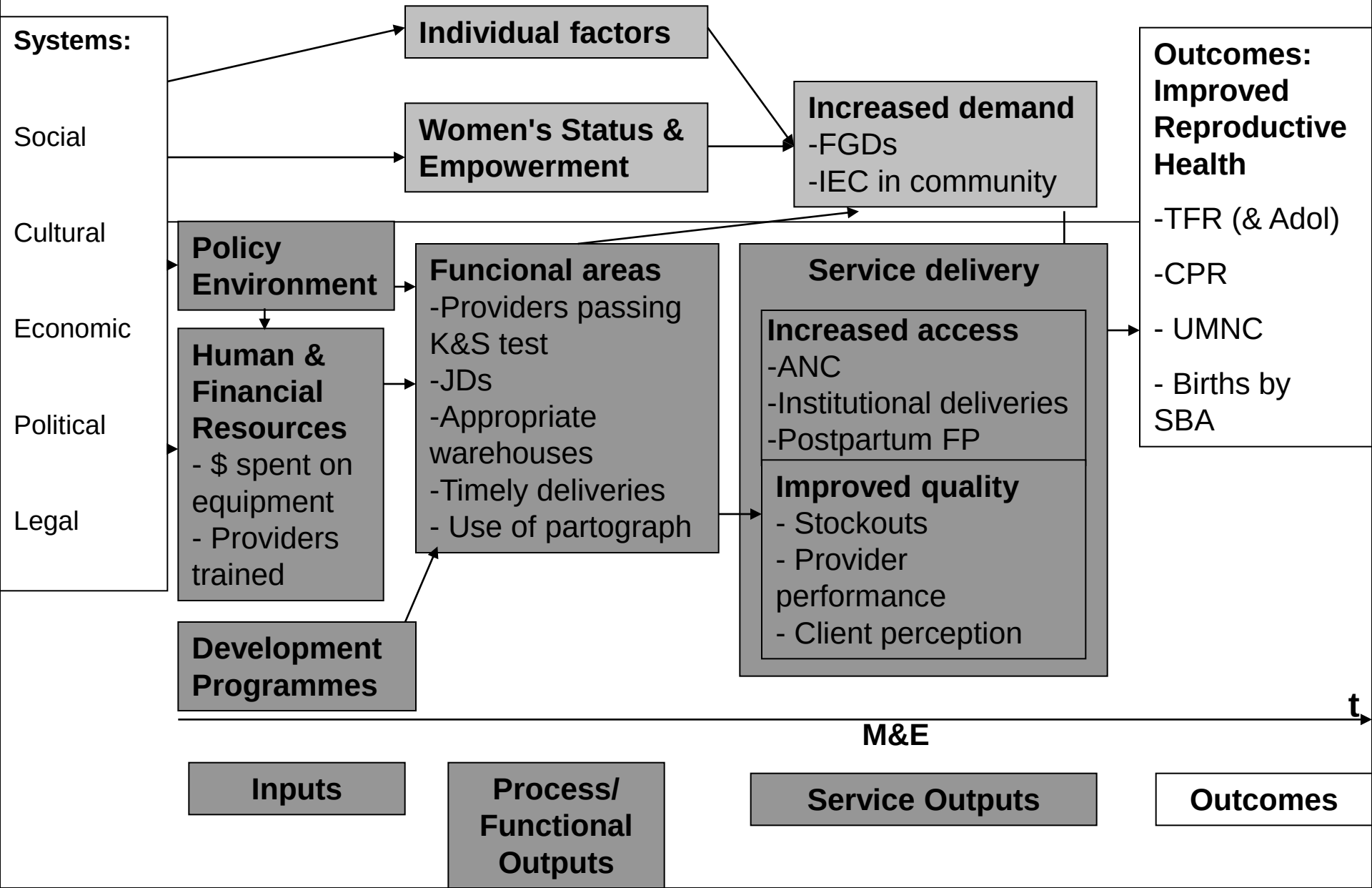
Building the framework III: from activities / tasks to indicators – [Inputs-Processes-Outputs]

Management	Monitoring
Improving logistics, equipment	▪$ spent on new equipment ▪% orders delivered on time ▪Number of warehouses with appropriate storage conditions
Training providers	▪Number of providers trained ▪% of providers who passed knowledge and skills test

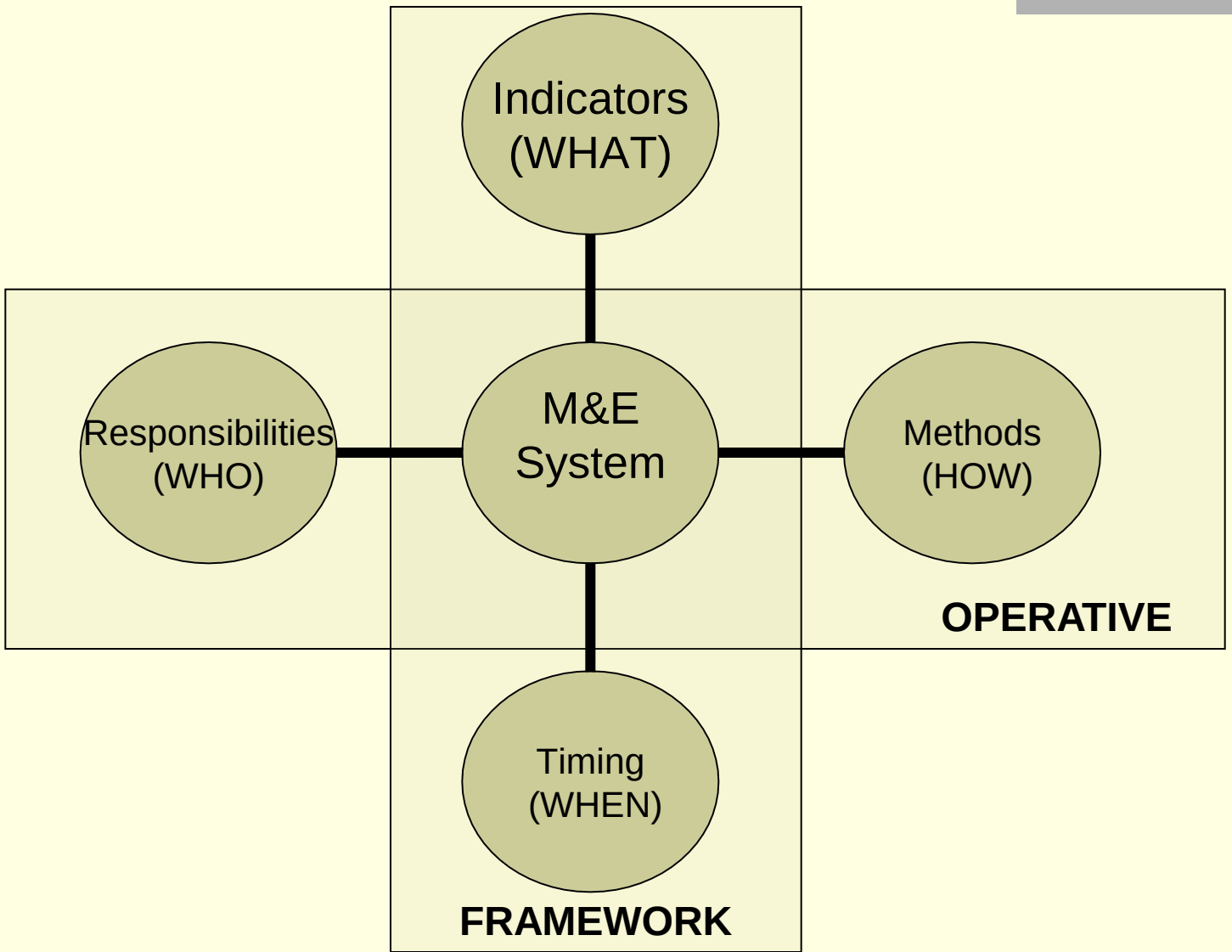
Building the framework III: from activities / tasks to indicators – [Inputs-Processes-Outputs]

Management	Monitoring
Strengthening the performance system	▪% providers with agreed-upon job descriptions ▪% of providers who used the partograph appropriately last month
Enhancing demand	▪FGDs conducted to find out what people need ▪Number of leaflets in local language distributed in community in last quarter

Our illustrative framework (adapted)



Basics of a good M&E system - Components



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)

105	CLIENT'S PERSONAL INFORMATION AND REPRODUCTIVE HISTORY. INDICATE BELOW WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT VOLUNTEERED INFORMATION ON THE FOLLOWING ITEMS:					
01	Age of client	1	2	8		
02	Number of living children	1	2	8		
03	Last delivery date or age of youngest child	1	2	8	5	
04	History of complications with pregnancy	1	2	8	5	
05	Last menstrual period (assess if currently pregnant)	1	2	8	5	
06	Desire for a child or more children	1	2	8		
07	Desired timing for birth of next child	1	2	8		
08	Breastfeeding status	1	2	8	5	
09	Regularity of menstrual cycle	1	2	8	5	
106	RECORD WHETHER THE PROVIDER PERFORMED ANY OF THE FOLLOWING PHYSICAL EXAMINATIONS OR ASKED ANY OF THE FOLLOWING HEALTH QUESTIONS.	YES		NO	DK	
01	Took the client's blood pressure	1		2	8	
02	Weighed the client	1		2	8	
03	Asked the client about smoking	1		2	8	
04	Asked the client about symptoms of STIs (e.g., abnormal discharge)	1		2	8	
05	Asked the client about chronic illnesses (heart disease, diabetes, hypertension, liver or jaundice problem, breast cancer)	1		2	8	
06	Looked at the client's health card (either before beginning the consultation or while collecting information or examining the client)	1		2	8	

From: National Coordinating Agency for Population and Development (NCAPD) [Kenya], Ministry of Medical Services (MOMS) [Kenya], Ministry of Public Health and Sanitation (MOPHS) [Kenya], Kenya National Bureau of Statistics (KNBS) [Kenya], ICF Macro. 2011. *Kenya Service Provision Assessment Survey 2010*. Nairobi, Kenya:

http://www.measuredhs.com/pubs/pdf/SPA17/SPA17.pdf

- 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

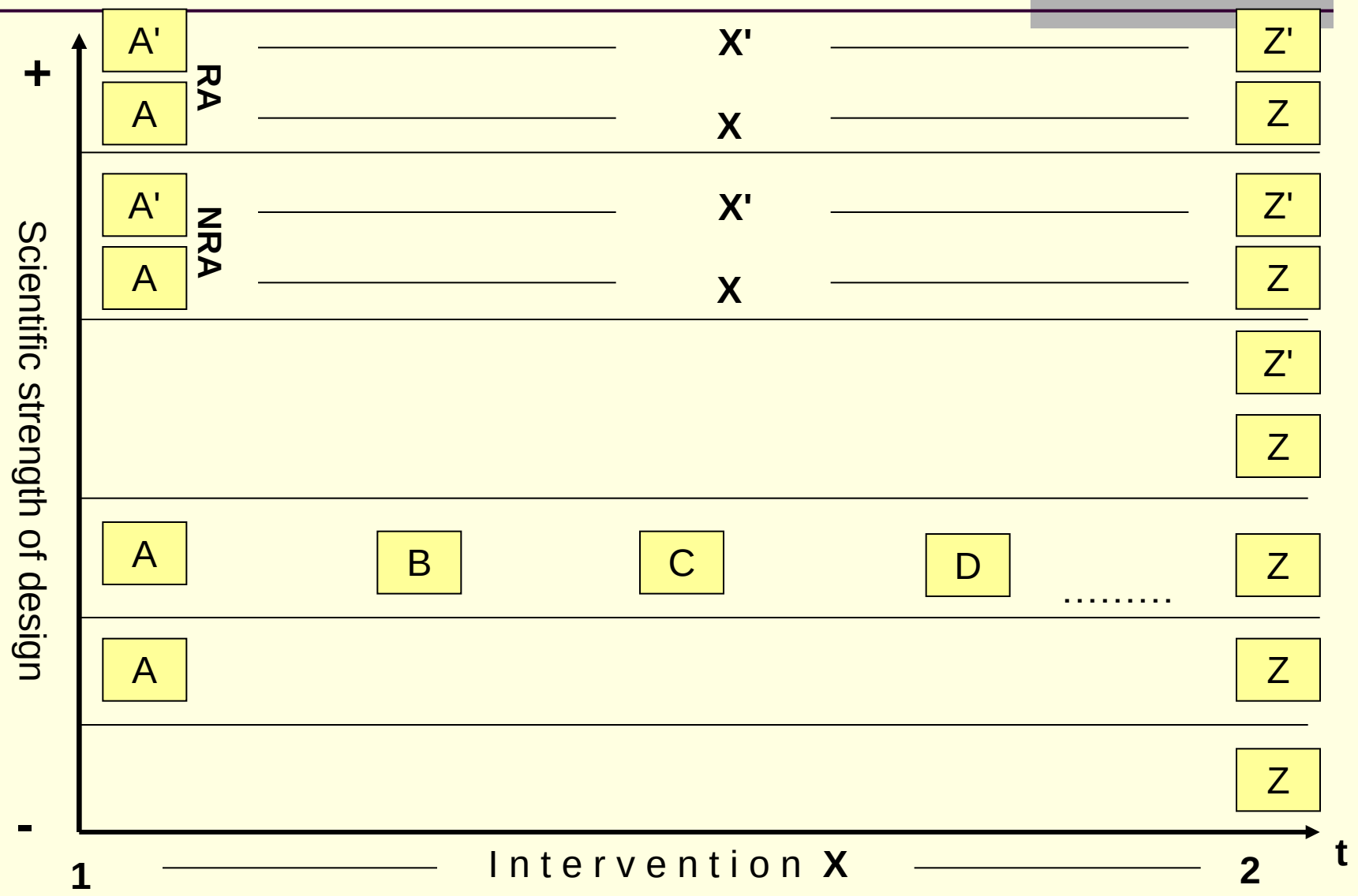
More on methods

- 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



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 presentation of different types of research and evaluation designs**: AA Fisher, JR Foreit, J Laing, J Stoeckel and J Townsend, HIV/AIDS Intervention Studies: An Operations Research Handbook, The Population Council, 2002
- **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 how to assess quality of care in facilities, including instruments**: Quick Investigation of Quality (QIQ) A User's Guide for Monitoring Quality of Care in Family Planning, MEASURE Evaluation Manual Series, No. 2, Carolina Population Center, University of North Carolina at Chapel Hill, 2001
- **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

Assignment

- Develop an M&E framework for a 3-year initiative to reduce maternal mortality due to postpartum haemorrhage, through wide training of midwives and upgrade of health facilities in active management of the third stage of labour (AMTSL)
- If you wanted to evaluate improved performance, from an average 45% who at baseline know well how to perform AMTSL, how many providers would you need to demonstrate it? And, would you need a "control" group?

Quick evaluation of this talk

- YOU WILL BE GIVEN A SHEET WITH THREE QUESTIONS. PLEASE PROVIDE YOUR OPINION ANONYMOUSLY:

1. What did you like about this talk?

   _____

   _____

2. What could be improved on this talk?

   _____

   _____

3. Rate on a scale from 1 to 10 how you liked – disliked the talk (PLEASE CIRCLE)

   _____

1 2 3 4 5 6 7 8 9 10

Disliked Neither Liked