

*"So what? I need results":*

monitoring and evaluating  
*impossible* Family Planning /  
Reproductive Health  
Programmes: an Introduction

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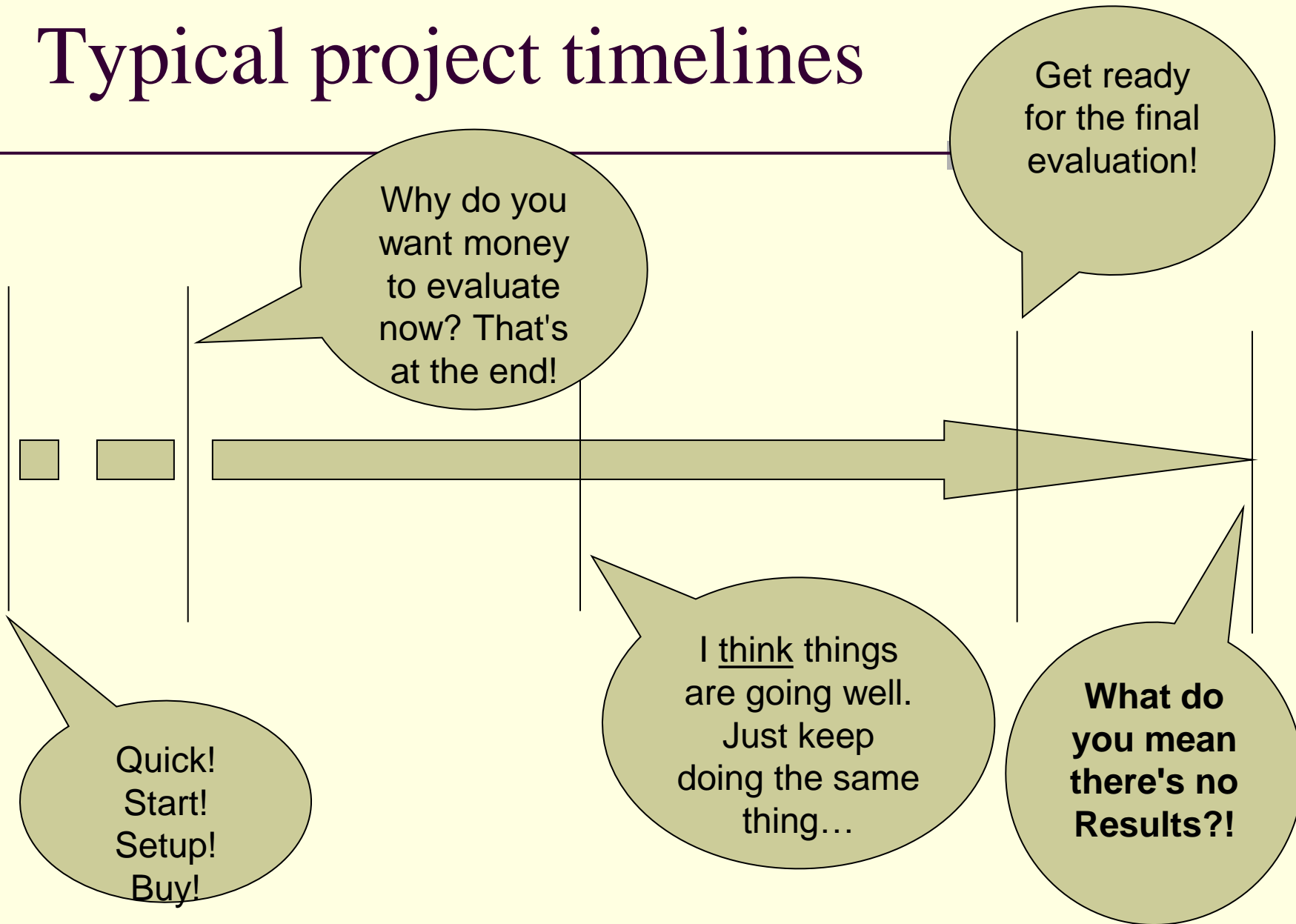
Training Course in Sexual and Reproductive Health Research  
Geneva 2013

# Typical projects / programmes

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- 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

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

Concerns about not being able to measure changes!

*Excitement  
Gung-ho  
We know it all!*

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

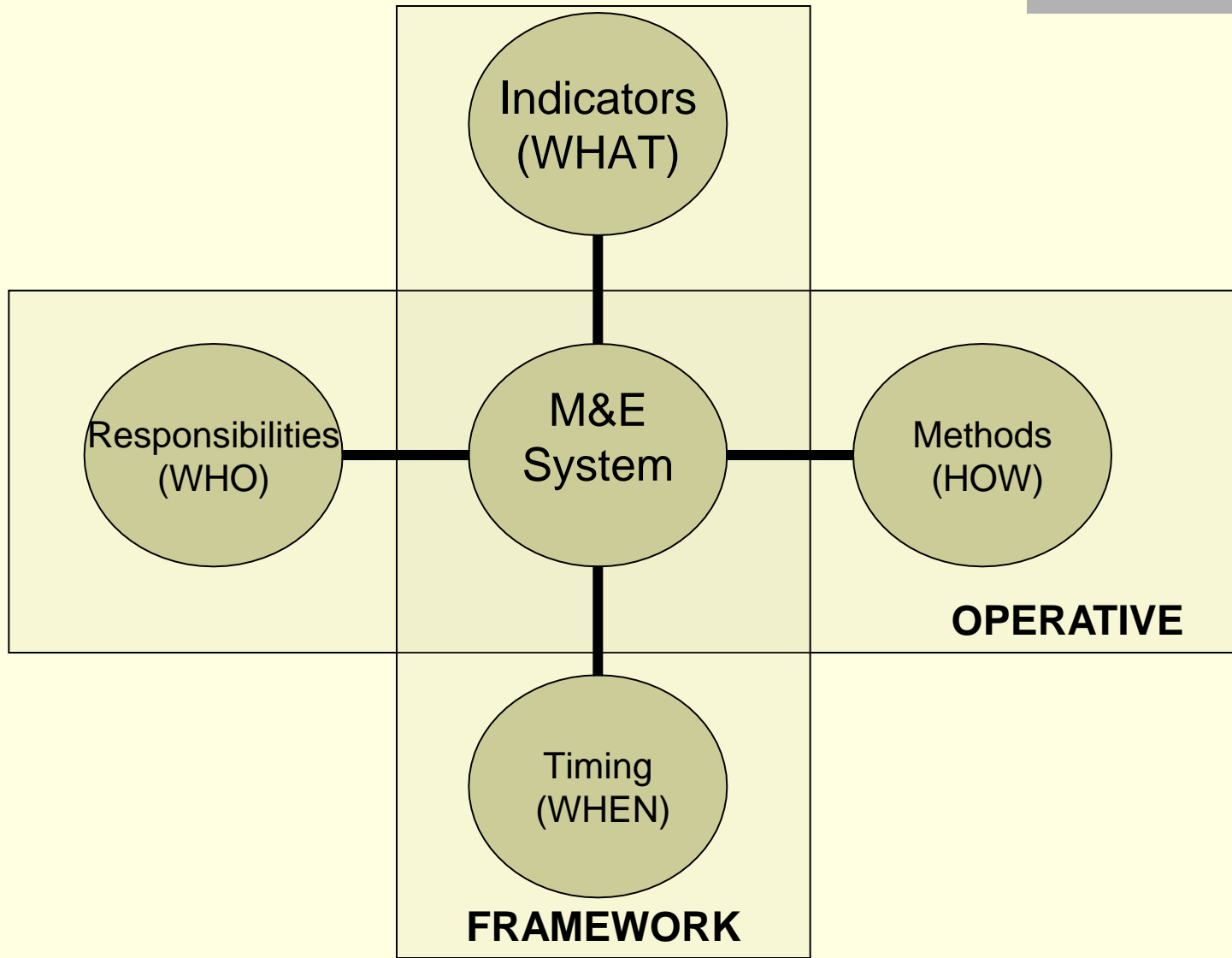
**Panic!  
Retrofit!  
Tell case stories,  
anecdotes!  
Count trainings!**

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# Mission impossible?

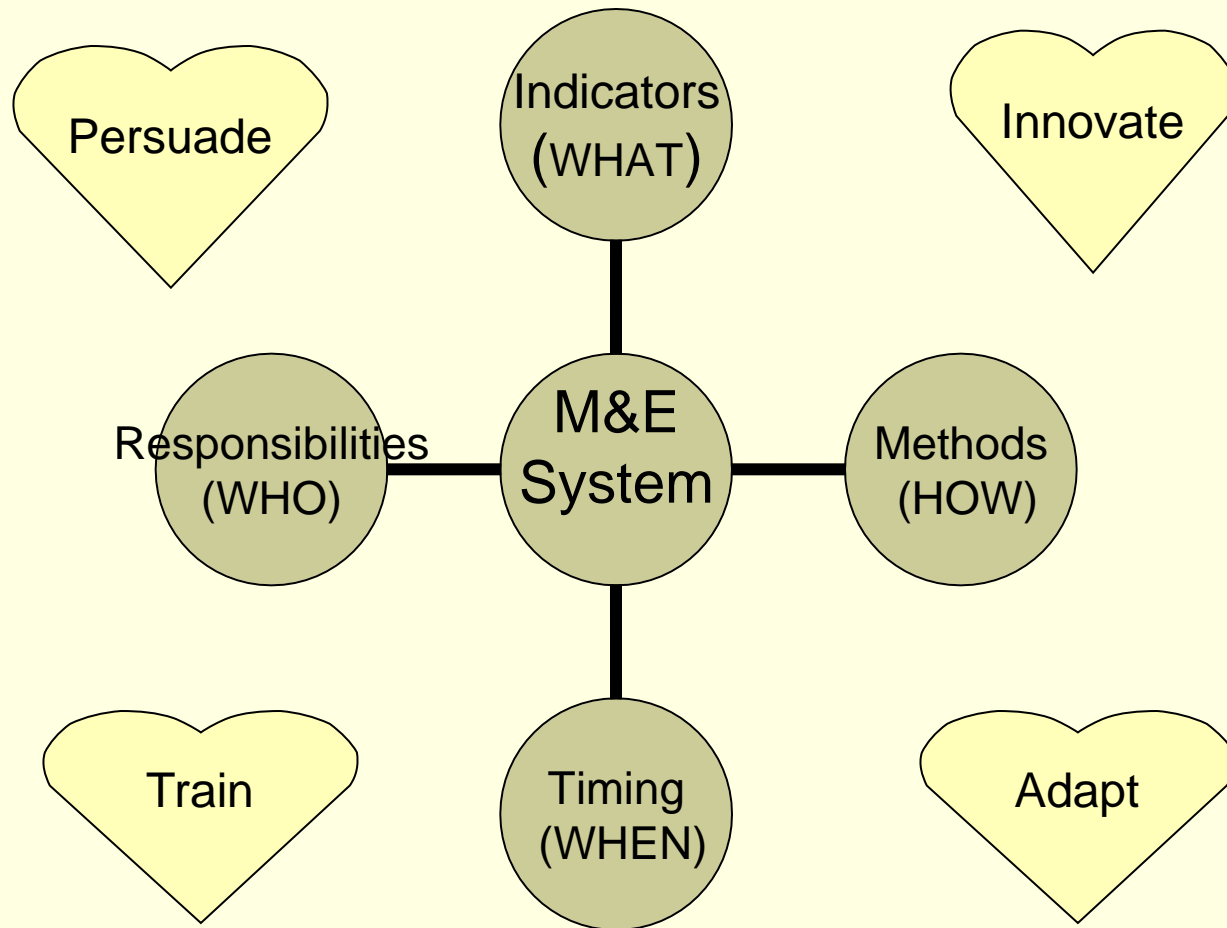


# Basics of a good M&E system - Components



# Basics of a good M&E system – Disposition

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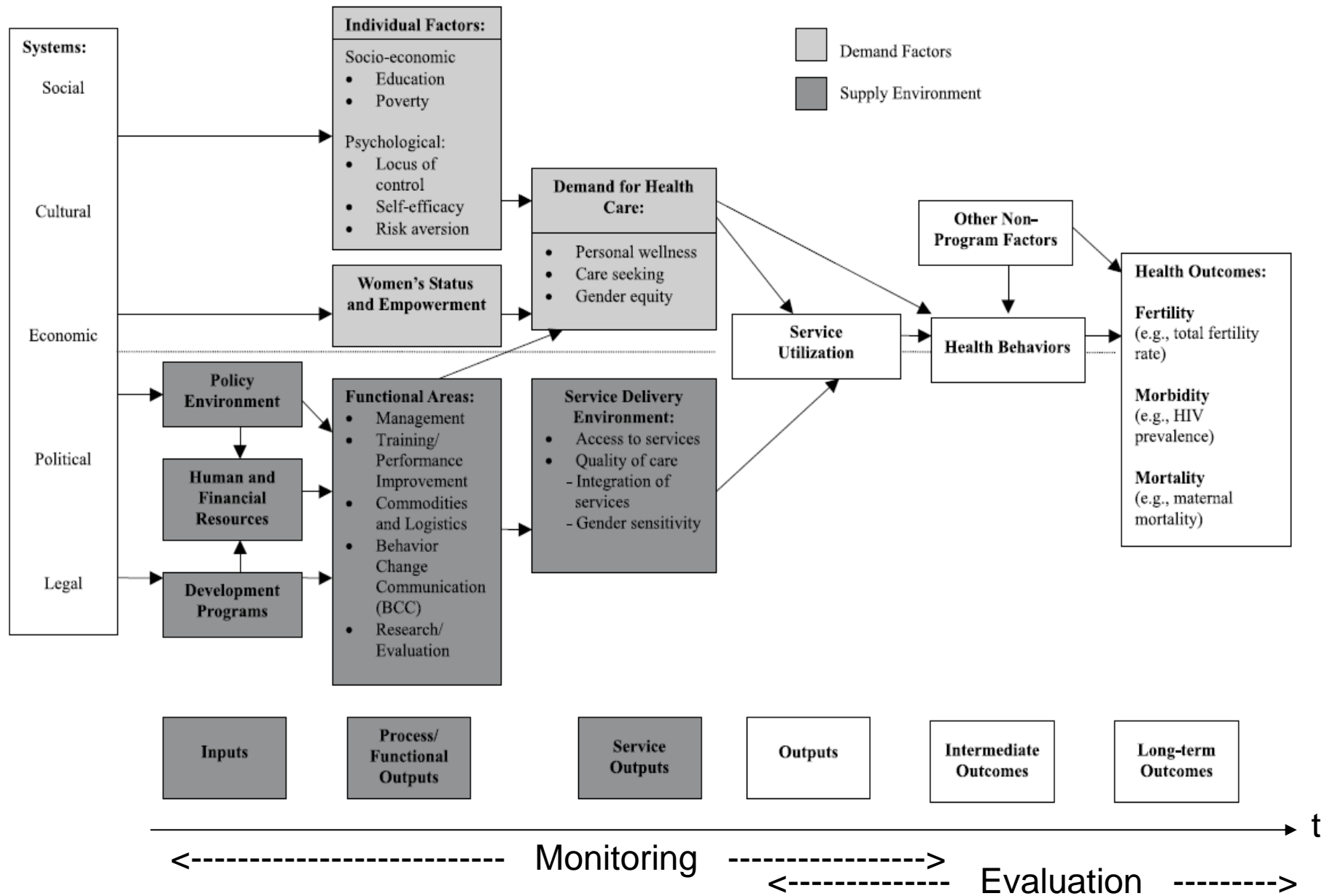
# Framework

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- 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)

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- 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)

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## 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"	<ul style="list-style-type: none"><li>■ Total (&amp; Adolescent) Fertility Rate</li><li>■ Contraceptive Prevalence Rate</li><li>■ Unmet need for Contraception</li><li>■ Births delivered by SBA</li></ul>

**Important:** Maternal mortality – not possible to measure!

# Building the framework II: from objectives to indicators - [Outputs]

<b>Management</b>	<b>Evaluation</b>
Obj 1: "Increase access to RH services"	<ul style="list-style-type: none"><li>■ ANC coverage</li><li>■ Institutional deliveries</li><li>■ % postpartum FP</li></ul>
Obj 2: "Improve quality of services"	<ul style="list-style-type: none"><li>■ % stockouts (comm, meds)</li><li>■ Provider performance (index)</li><li>■ Client perception</li></ul>

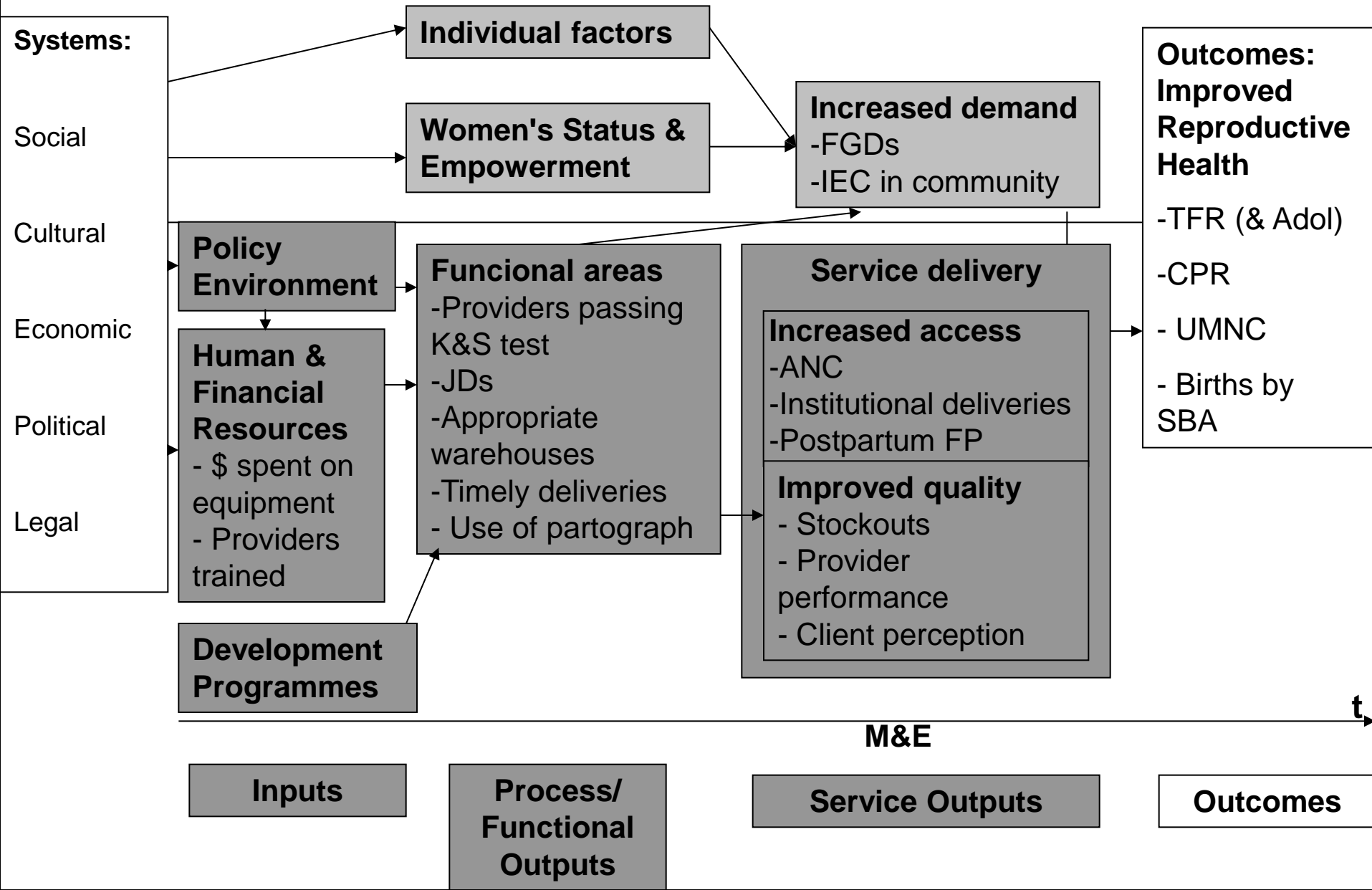
# Building the framework III: from activities / tasks to indicators – [Inputs-Processes-Outputs]

<b>Management</b>	<b>Monitoring</b>
Improving logistics, equipment	<ul style="list-style-type: none"><li>■ \$ spent on new equipment</li><li>■ % orders delivered on time</li><li>■ Number of warehouses with appropriate storage conditions</li></ul>
Training providers	<ul style="list-style-type: none"><li>■ Number of providers trained</li><li>■ % of providers who passed knowledge and skills test</li></ul>

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

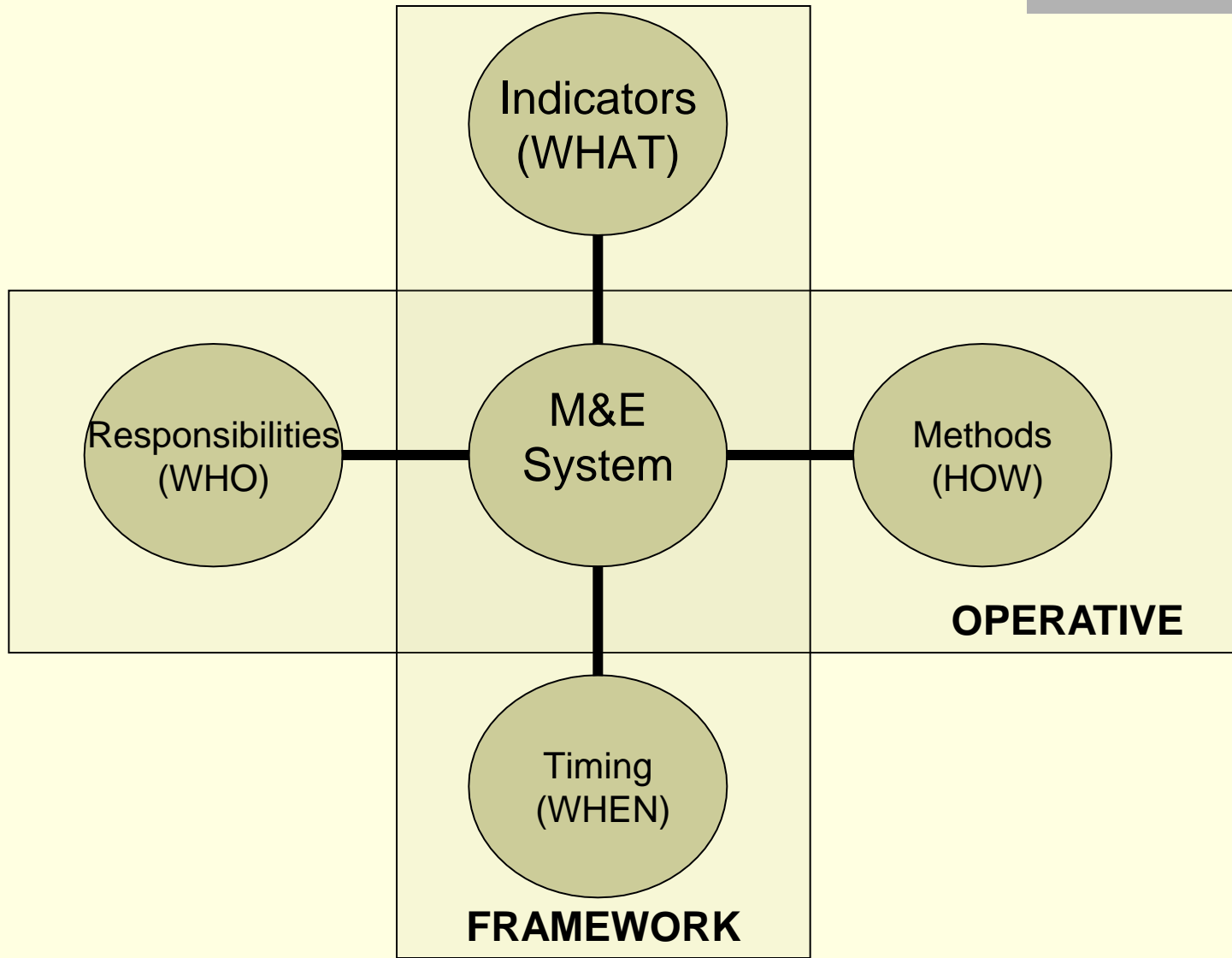
<b>Management</b>	<b>Monitoring</b>
Strengthening the performance system	<ul style="list-style-type: none"><li>■ % providers with agreed-upon job descriptions</li><li>■ % of providers who used the partograph appropriately last month</li></ul>
Enhancing demand	<ul style="list-style-type: none"><li>■ FGDs conducted to find out what people need</li><li>■ Number of leaflets in local language distributed in community in last quarter</li></ul>

# Our illustrative framework (adapted)





# Basics of a good M&E system - Components



# Operative aspects

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- 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.

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- 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:

## ■ 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

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- 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?)

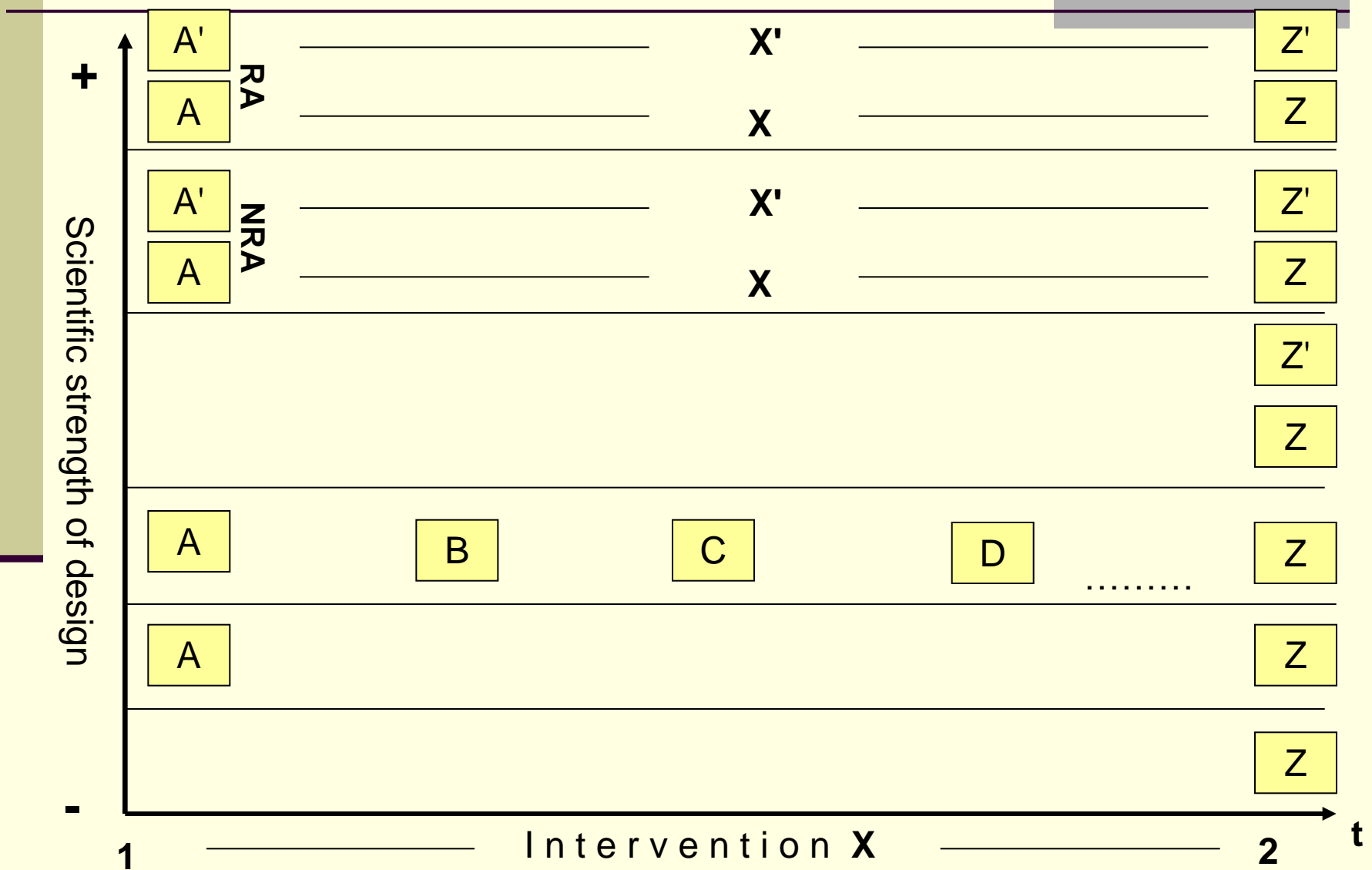
# More on methods

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- 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?

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- 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

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- 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*")

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- 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

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- **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](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