

Appendix to Training Modules (Version 1)

Assessment of Knowledge, Skills and Needs

1a) What is your knowledge level in terms of monitoring and evaluation in each of the following health topics? (Rate your knowledge level on a scale of 0 (none) to 9 (outstanding))

Family planning and fertility	_____
Child mortality	_____
Child health - Integrated Management of Childhood Illnesses	_____
Child health - Expanded Programme on Immunization	_____
Safe Motherhood	_____
STDs/HIV/AIDS	_____
Nutrition	_____
Malaria and other tropical diseases	_____

1b) What two topics would you most like to strengthen your knowledge in monitoring and evaluation? (List two topics from those listed in question 1a above.)

Topic #1 _____

Topic #2 _____

2) What is your knowledge level of the following forms of data collection? (Rate your knowledge level on a scale of 0 (none) to 9 (outstanding).)

Census	_____
Population-based Survey	_____
Health Information System Data (HIS, HMIS)	_____
Health Facility Surveys	_____
Community Needs Assessment (non-random sample)	_____
Qualitative Methods (focus groups, in-depth interviews, etc.)	_____
Epidemiological study designs (case-control trials, randomized community trials, etc.)	_____

3) What is your primary and secondary level or unit of your interest in terms of monitoring and evaluation? (Indicate primary with 1 and secondary with 2.)

Global	_____
National	_____
Provincial / Regional	_____
District	_____
Project / NGO	_____
Community	_____

4a) How would you rank your skill level in each of these areas? (Rate your skill level on a scale of 0 (none) to 9 (outstanding).)

Program planning	_____
Program implementation	_____
M&E plan development (frameworks, data collection strategies, etc.)	_____
M&E data interpretation (e.g. data from DHS reports, service statistics, research studies)	_____
M&E data collection (e.g. survey of community, facility)	_____
M&E data analysis (e.g. simple analysis of survey data)	_____
Report writing	_____
Data dissemination (e.g. to policy makers and donors)	_____

4b) What are the two skills you would like to strengthen most? (List two skills from those listed in question 4a above.)

Skill #1 _____

Skill #2 _____

Case Studies

Using case studies as a basis for group projects allows workshop participants to have a hands-on experience in developing an M&E plan using a program design framework, selecting indicators and identifying data sources. Exercises throughout Core Modules 1, 2 and 3 refer to these case studies.

Participants are organized into groups of 4-6 according to their topic of interest. If time allows, each small group can design their own program using the case study sheet as a starting point for their discussion. Each group member should receive a copy of the case study for his or her group. Listed are ideas for the program purpose, target population and types of interventions. These lists are by no means exhaustive. If there is not sufficient time in the workshop program for groups to design their own program, the sample provided can be used as the basis for the training activities involving development of frameworks, selection of indicators and identification of data sources.

Family Planning Case Study

Purpose:

- Promote healthy families
- Promote small families
- Increase reproductive options for women and men

Target population:

- All men and women of reproductive age (15-49)
- Married men and women
- Young adults (15-24, or another age group)
- School-aged youth
- Pre-sexual youth
- Mobile populations (e.g. migrant/seasonal workers, truck drivers)
- Special populations (e.g. refugees)
- A specified population in Country X
- A specified population in District Y
- A specified population in the catchment area of a clinic, project or program.

Types of intervention:

Increase demand

- Media campaigns
- Youth education
- Family planning counselling provided at ANC and MCH services

Improve access

- Community Based Distribution
- Integrated services

Improve quality

- Provider training on service delivery, counseling, appropriate management of referrals, post-abortion care services, etc.
- Increase number of methods available
- Reduce stock-outs

Sustainability

- Diversify or increase funding sources for contraceptives and other clinic service

Sample of a Ministry of Health's national program:

In Country X the Contraceptive Prevalence Rate (CPR) is 15% and unmet need for family planning services is 29%. The National Family Planning Program targets married men and women of reproductive age (15-49) to promote smaller healthier families. Program activities include Information, Education and Communication (IEC) campaigns including radio spots and posters promoting contraception and family planning services available at public facilities; Community Based Distributors (CBDs) trained to promote and supply pills and condoms and to explain other methods available through health facilities; and providers at health centers and hospitals trained in family planning counselling and in an appropriate referral system.

HIV/AIDS Case Study

Purpose:

- Reduce the spread of HIV
- Decrease stigma around HIV/AIDS
- Mitigate the impact of AIDS through increased care and support

Target population:

- Sexually active population
- Population of reproductive age (15-49)
- Youth (15-24, or another age range)
- Newborns and infants of HIV+ mothers
- People living with HIV/AIDS
- Commercial sex workers
- Injecting drug users
- A specified population in Country X
- A specified population in District Y
- A specified population in the catchment area of a clinic, project or program.

Types of intervention:

- Voluntary Counselling and Testing (VCT) Services
- School-based education
- Adult education at the community or clinic level
- Condom promotion / social marketing
- Development and enforcement of blood safety guidelines at health care facilities; blood screening at facilities or laboratories; reducing unnecessary transfusions at hospitals
- Reduce the risk of mother to child transmission
- Needle exchange or switch to use of non-injecting drugs
- Improved quality of care for people with HIV/AIDS in clinics, hospitals or in the home
- Support for families of people with HIV/AIDS
- Care and support of orphans
- Implementation of policies to reduce stigma around HIV/AIDS

Sample of a local NGO program:

In Country X there is a generalized HIV epidemic, with the prevalence among women between 15-49 presenting for antenatal care at 13% and continuing to rise. A local NGO is dedicated to reducing the spread of HIV among the sexually active population and mitigating the impact of AIDS through provision of quality Voluntary Counselling and Testing (VCT) services. Over the next 5 years, the NGO will facilitate the integration of VCT services in selected district hospitals and health centers where it does not yet exist, strengthen the quality of existing VCT services through supervision, increase access to quality AIDS care and support to those infected with HIV/AIDS by strengthening collaboration and partnerships with other agencies that provide such services, and promote positive behavior change among VCT users.

Child Health Case Study

Purpose:

- Decrease infant or child mortality
- Improve the health of children and families

Target population:

- Children under 5
- Infants
- Newborns
- In-school children
- Out-of-school children
- School-aged children
- Families
- A specified population in Country X
- A specified population in District Y
- A specified population in the catchment area of a clinic, project or program

Types of intervention:

Increase access to child and maternal health services

- Nutrition services (supplementation, fortification or hunger alleviation)
- Immunizations (clinic services, national immunization days, mop up campaigns)
- Oral Rehydration Treatment (ORT)
- Treatment for Acute Respiratory Infection (ARI)
- Increase number of service delivery points

Increase knowledge of detection and treatment of childhood illnesses

- Community education campaigns

Improve quality of services

- Implement Integrated Management of Childhood Illness (IMCI)
- Care during pregnancy (maternal tetanus toxoid immunization, nutritional support, STI/HIV testing, recognition of danger signs) (e.g. provider training and supplies)
- Delivery care (skilled attendant at birth, clean delivery, recognition of danger signs) (e.g. provider training and supplies)
- Care for newborns (exclusive breastfeeding, thermal control, postnatal visit) (e.g. provider training and supplies)

Sample of international NGO's program:

Country X suffers from an under 5 mortality rate of 200 per 1,000 live births. An international NGO has been present in the country for many years and continues to work with families to improve child health. The following activities are undertaken: community education on nutrition, child survival (including ORT), HIV/AIDS and family planning; micronutrient supplementation and strengthened capacity of the Ministry of Health and local NGOs to provide child health services through provider training and ensuring the availability of immunizations at clinics.

Safe Motherhood Case Study

Purpose:

- Increase the likelihood that pregnancies are intended and safe
- Increase the likelihood that deliveries are safe
- Improve the outcome of pregnancies and deliveries with complications

Target population:

- All women of reproductive age (15-49)
- At-risk women
- Couples of reproductive age
- Antenatal care clients
- Communities
- A specified population in Country X
- A specified population in District Y
- A specified population in the catchment area of a clinic, project or program

Types of intervention:

Improve community and individual response to obstetrical emergencies

- Transport system to emergency services
- Communication system
- IEC (nutrition, Tetanus Toxoid immunisation, antenatal care, delivery with skilled birth attendant, danger signs during pregnancy, and danger signs at birth.)

Improve access to services and quality of care at service delivery points

- Identification of high risk pregnancies during antenatal care (e.g. training providers, supplies)
- Appropriate referral of high risk pregnancies
- STD management, including Voluntary Counseling and Testing (VCT) services for HIV
- Labor and delivery with skilled birth attendant
- Identification of complications during labor and delivery and appropriate referral (ante-partum hemorrhage, obstructed labor, ruptured uterus, retained placenta, mal-presentations, premature labor, premature rupture of membranes)
- Availability of emergency obstetric care
- Appropriate emergency interventions and management of complications (e.g. training providers, supplies)
- Postnatal care (identify danger signs after birth, postnatal visit with trained provider, family planning, immunization) (e.g. training providers, supplies)
- Post-abortion care (infection prevention, family planning counseling)

Sample of an international NGO's program:

The latest estimate of the Maternal Mortality Ratio (MMR) in Country X is 350 per 100,000 live births. An international NGO based in the US is implementing a project to improve Safe Motherhood by improving safe delivery. The target population is all pregnant women in the districts receiving the intervention. Activities include training providers at health centers and hospitals in providing high quality maternal and neonatal care, including emergency obstetric care; an IEC campaign to increase the use of health services crucial for maternal and neonatal survival; and with community organizations, develop life support plans for courses of action to be taken when a woman is experiencing danger signs during pregnancy, birth or postpartum.

Nutrition Case Study

Purpose:

- Improve health by reducing micronutrient deficiency disorders
- Reduce stunting and wasting
- Improve birth outcomes by decreasing low birth weight incidence and infant mortality

Target Population:

- Children under 5
- School-age children
- Adolescents
- Young adults (15-24)
- Pregnant women
- Families
- Single parent families
- Men and/or women of reproductive age (15-49)
- Refugees
- A specified population in Country X
- A specified population in District Y
- A specified population in the catchment area of a clinic, project or program

Types of Intervention:

Provision of nutrients

- Nutritional supplementation or fortification with micronutrients (e.g. Vit A, iron, iodine)

Increased probability of detection of micronutrient or protein-energy malnutrition

- Growth monitoring (e.g. training for providers, women)
- Health provider training in detecting malnutrition and interaction with other illnesses

Individual and/or community awareness of positive nutrition practices

- Community nutrition education (I EC)
- School-based nutrition education
- Health provider training in nutritional counseling
- Breastfeeding promotion

Sample of local NGO district-level project:

In five districts in Country X child nutrition is an important issue; growth monitoring has shown that stunting is a common problem. A local NGO has undertaken a child nutrition project to improve the situation for all children under five years of age in the five districts. Project activities include training community women in nutrition, growth monitoring, treatment of common illnesses, and proper weaning and strengthening local community organizations by implementing community participation campaigns and providing technical assistance.

Young Adult Reproductive Health Case Study

Purpose:

- Prevention of unprotected sexual intercourse
- Prevention of unintended pregnancy
- Prevention of STIs/HIV transmission
- Prevention of unwanted sex
- Safe motherhood
- Promotion of breastfeeding
- Nutrition promotion
- Anemia prevention and treatment for boys and girls

Target population:

- All young adults aged 15-24 (or other age groups)
- All adolescents aged 10-19 (or other age groups)
- Adolescents with children
- In school adolescents
- Out of school adolescents
- Sexually active young adults or adolescents
- A specified population in Country X
- A specified population in District Y
- A specified population in the catchment area of a clinic, project or program.

Types of interventions:

Improve access to services and quality of services

- Availability of adolescent-friendly reproductive health services (e.g. training providers on adolescent counseling)
- Condom distribution (at businesses, schools)
- Improve policies around adolescent access to services

Increase knowledge of reproductive health issues and services

- School-based education programs
- IEC (e.g. awareness of youth-friendly services, reproductive health education)

Other

- Access to education for adolescents and economic development

Sample of an international NGO:

Rates of pregnancy and HIV prevalence are high among urban adolescents in Country X. An international NGO is working with the Ministry of Health to improve access to reproductive health services for young men and women between the ages of 10 and 19. Program activities include working with policymakers to improve access to services for this population; providing assistance to the Ministry of Education to update the sex education curriculum taught in schools; training providers at government health centers to offer youth friendly services, including family planning and STI/HIV/AIDS screening and counseling; and launching an IEC campaign to advertise youth-friendly services.

Post-Abortion Care (PAC) Case Study

Purpose:

- Reduce the risk of poor health outcomes due to abortion complications
- Decrease number of unplanned pregnancies
- Improve the policy environment around abortion-related services

Target populations:

- Women of reproductive age (15-49)
- Women attending health clinics
- Women attending district hospitals
- Underserved women (e.g. young, poor or displaced)
- A specific population in Country X
- A specific population in District Y

Types of interventions:

Improve quality of PAC services

- Training service providers in counseling (including family planning), infection prevention, clinical techniques, and involving male partners in treatment and follow-up care with woman's consent
- Ensure adequate supplies of essential medications and surgical equipment at facilities

Improve access to PAC services

- Establish referral system (e.g. train community health workers in proper referrals)
- Service provision at lower levels of health care system and in the private sector
- Integrate post-abortion care into existing sexual and reproductive health programs
- Promote sustainability of services (e.g. training for medical students, strategic planning for PAC services rather than provision on an emergency basis to reduce costs, creation of partnerships with family planning clinics and safe motherhood programs, political support from MOH)

Increase demand for PAC services

- Community support/education/awareness-raising

Improve policy environment

- Development of national norms and standards of PAC
- Inclusion of the cost of PAC supplies in regular health budgets
- Development of local training capability to ensure routine training of providers

Sample of international NGO's program:

Complications from abortion are a significant contribution to Maternal Mortality Ratio (MMR) of 380 per 100,000 live births in Country X. An international NGO carrying out reproductive health programs by working with the Ministry of Health in rural settings is adding post-abortion care services to their programs in order to reduce the risk of infection and death resulting from abortion. The target population is women of reproductive age in three rural districts. Program activities will include integrating PAC into the existing MOH reproductive health program by training providers in counseling, infection prevention and treatment of incomplete abortion and a community awareness campaign.

Handouts for Participants

The following handouts are referred to in the text below some slides in the Training Modules.

Sample Performance Monitoring Plan Outline

Draft

TABLE OF CONTENTS

Introduction

- Purpose of Performance Monitoring Plan**
- Program Background**

Present Results Framework and Causal Linkages

- Strategic Objective: Increased use of FP/MCH and HIV/AIDS preventive measures**
- Intermediate Result 1: Policy and Legal Environment**
- Intermediate Result 2: Availability of Quality Services**
- Intermediate Result 3: Demand for Services**

Data Collection

- Surveys**
- Health Management Information Systems**
- Contractor Reports**
- Qualitative Studies**

Reporting and Dissemination

- Donor Reporting Requirements**
- Dissemination and Use of Results**

Roles and Responsibilities

- Program Implementer**
- Implementing Partners**
- Monitoring and Evaluation Consultants**

Indicators

- List of Indicators by Result**
- Targets for Indicators**
- Details on Individual Indicators**

Sample Portion of a Performance Monitoring Plan

SO 3.2 Increased Utilization of Quality Primary Health Care in Select Populations

A. SO Overview of the Results Framework

[Country background and summary of health situation, issues]

[Prognosis and ongoing developments in country related to health]

[Donor/program/project focus, special interests] [Partnerships]

[Involvement and activities to date; progress and/or results to date]

[Current health program issues in broader context]

[Intended involvement and activities to move forward] [Partnerships]

Critical Assumptions

[Examples]

- That implementation will not be unduly disrupted by frequent changes in Ministries of Health leadership and policy affecting sector development;
- That the respective Ministries of Health and Partners will deliver necessary clinical equipment, supplies and facility improvements in a timely and effective manner;
- That the security situation will allow implementation to continue [in all or parts of the project area];
- That the Government relaxes exit visa protocols and NGO/PVO registration to facilitate partnership possibilities.

Causal Linkages

Achievement of this objective [will progress through specified causal linkages]

[Overall vision of how the program/project will reach ultimate objectives]

[One way to structure this section is to work upward through lower levels to higher levels of your Strategic Framework]

[Explain interrelationships among different activities/results and how these interactions may help cause the ultimate outcome]

[Explain any drawbacks or potential hindrances to achieving goals]

B. Monitoring & Evaluation Plan

[Larger context of planning, e.g. your M&E plan's connection to donor's anticipated results or log frameworks, your M&E plan's connection to M&E goals of your "headquarters", your M&E plan's connections with partner plans]

1. Rationale for Choice of Performance Indicators

SO 3.2 Increased Utilization of Quality Primary Health Care (PHC) in Select Populations

Performance indicators:

- Percent of children age less than 1 year completely vaccinated against hepatitis B virus (HBV)
- Percent of sputum smear positive TB patients cured through DOTS approach in target areas
- Percent of total outpatient visits that occurred in PHC practices in pilot sites

These indicators are [quantitative, qualitative] [direct, indirect] measures of ??? [utilization of PHC (indicators on HBV vaccination and visits to PHC) ; quality of PHC (indicator on TB cure rate)].

Percent of children age less than 1 year completely vaccinated against hepatitis B virus (HBV) [Particular issues of this indicator in context of M&E plan; alternatives considered and reasons for not using; recognized drawbacks or potential problems of this indicator in terms of program/project activities and desired results]

Percent of sputum smear positive TB patients cured through DOTS approach in target areas. [Particular issues of this indicator in context of M&E plan; alternatives considered and reasons for not using; recognized drawbacks or potential problems of this indicator in terms of program/project activities and desired results]

Percent of total outpatient visits that occurred in PHC practices in pilot sites. [Particular issues of this indicator in context of M&E plan; alternatives considered and reasons for not using; recognized drawbacks or potential problems of this indicator in terms of program/project activities and desired results]

IR 3.2.1 Select Populations are Better Informed about Personal Health Care Rights and Responsibilities

Performance Indicators:

[Go through the same exercise of explaining indicators and the development of your reasoning behind selecting each; potential problems foreseen with measurement or other issues]

[Etc.— Repeat for all results listed in your Strategic Framework]

2. Methodology for Analyzing the Data

[Explain how you will know what your data means. In other words, how do you plan to aggregate/disaggregate data and why, what are the important units of analysis, what are your plans for triangulating information (ensuring validity of your data/results), where do you foresee comparability within countries or across projects]

3. Plans for Complementary Evaluations

These evaluations are planned to complement program performance monitoring:

[Examples]

- a follow-up investigation into the causes of the increased infant mortality rate over the past 5 years;
- an HIV/AIDS outbreak investigation;
- evaluations of partnership programs, regarding results achieved and/or prospects for sustainability;
- small-scale research studies to evaluate quality of provider practice in key clinical areas.

Performance Indicator Reference Sheet

Strategic Objective: 3.2 Increased utilization of quality primary health care in select populations

Intermediate Result: N/A

Indicator: A. % of children less than 1 year of age completely vaccinated against hepatitis B virus (HBV)

Date Established: 01/01

Date Last Reviewed:

A. Description

Precise Definition(s): "Completely vaccinated" is defined as receiving 3 doses of hepatitis B vaccine.

Unit of Measure: % of children immunized

Disaggregated by: Geographic location

Justification/Management Utility: If immunization coverage exceeds 75%, this is considered to be a well-established prevention program for HBV infection. In addition, the indicator will indirectly reflect the quality of the general immunization program. The indicator will demonstrate the government commitment for public health policy changes and resource allocation. Monitoring the indicator for a long period of time will show the consistency of public health policy within the government.

B. Plan for Data Collection

Data Collection Method: : Official data on HBV immunization coverage will be requested annually. Sera-survey studies and immunization coverage assessment are planned initially to validate official statistics and again 3 years after initial assessments.

Data Source(s): Official government data on HBV immunization coverage. Sera-survey studies and immunization coverage assessment provided by CDC.

Timing / Frequency of Data Collection: Annual

Estimated Cost of Collection: : Cost within Inter-Agency Agreement budget

Responsible Organization/Individual(s): Mr. Smith, CDC Regional Director, OST, USAID

Location of Data Storage: Full data files will be kept within USAID Performance Monitoring Plan files

C. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)

Data Analysis: Comparison to baseline and targets

Presentation of Data: Data will be presented in tabular form

Review of Data: Annual report

Reporting of Data: Consider highlighting in report narrative as required.

D. Data Quality Issues

Initial Data Quality Assessment: Official government data will be compared to sera and coverage surveys to determine data quality

Known Data Limitations and Significance (if any): Official data limited by accuracy of oblast data collection. Survey data limited by sample size and may not be generalizable beyond study sites.

Actions Taken or Planned to Address Data Limitations: Biostatistics training for counterparts on various levels

Indicator Reference Sheet – Suggested Concepts/Topics

Strategic Objective: To which of the Programs Strategic Objectives (SO's) does the result measured by this indicator contribute?

Intermediate Result: To which of the SO's Intermediate Results (if appropriate) does this indicator measure a contribution?

Lower Level Result: To which lower-level result (if appropriate) does this indicator measure a contribution?

Indicator: PROVIDE THE EXACT WORDING OF THE INDICATOR THAT WILL MEASURE/TRACK A SINGLE IMPACT OF ONE OF YOUR ACTIVITIES. BE AS PRECISE AS POSSIBLE, PROVIDING A DESCRIPTION THAT IS CLEAR AND POINTS TRANSPARENTLY TO THE PARTICULAR INFORMATION WHICH YOUR DATA AND CALCULATIONS WILL PROVIDE.

Date Established: When did relevant parties agree on the reporting of this indicator?

Date Last Reviewed: When did relevant parties last review/discuss/alter the indicator?

A. Description

Precise Definition(s): EVERY SIGNIFICANT TERM FROM THE EXACT WORDING OF THE INDICATOR MUST BE VERY CLEARLY DEFINED IN THIS SECTION. IT IS NOT ENOUGH MERELY TO RESTATE THE INDICATOR, NOR IS IT SUFFICIENT TO LIST THE PARTICULAR ITEMS YOU ARE PLANNING TO INCLUDE OR EXCLUDE FROM YOUR DATA CALCULATIONS. THIS SECTION MUST DEFINE THE CATEGORIES SO THAT ANYONE NOT FAMILIAR WITH YOUR PARTICULAR PROGRAM WOULD NONETHELESS BE ABLE TO APPLY CRITERIA OR OTHERWISE KNOW EXACTLY WHICH CATEGORIES OF DATA SHOULD BE INCLUDED IN INDICATOR CALCULATIONS AND WHICH SHOULD NOT.

Unit of Measure: Normally, the unit of measure should be either NUMBER (#), or PERCENTAGE (%)

Method of Calculation:

THIS MUST BE A MATHEMATICAL DESCRIPTION OF THE EXACT ACTIONS (ADDITION, SUBTRACTION, DIVISION, MULTIPLICATION) THAT WILL BE PERFORMED ON THE RAW DATA TO ARRIVE AT THE VALUE OF THE INDICATOR THAT WILL BE REPORTED. IT MUST MATCH EXACTLY WITH THE INDICATOR PROVIDED IN THE TOP SECTION, AND ITS ELEMENTS MUST MATCH THE ITEMS DETAILED IN THE PRECISE DEFINITION. ANY INCONSISTENCY MUST BE RESOLVED BEFORE THE INDICATOR REFERENCE SHEET CAN BE CONSIDERED FINALIZED.

Disaggregated by: *List significant subdivisions in the data that will routinely be divided for the normal presentation of data (e.g. by sex, by facility type, by rural/urban location, etc.), if any*

Justification/Management Utility: WHAT ARE THE ACTIVITIES THAT SHOW THAT THIS SPECIFIC INDICATOR IS AN ESPECIALLY APPROPRIATE MEASUREMENT OF YOUR PROJECT'S IMPACTS OR RESULTS? WHY ARE THESE INCREMENTAL RESULTS SIGNIFICANT IN OR FOR THE HEALTH SECTOR? IN WHAT WAY WILL MONITORING OF THESE RESULTS CONTRIBUTE TOWARD PROGRAM SUCCESS? TOWARD WHAT RESULTS AT A HIGHER LEVEL, OR WHICH OVERARCHING GOALS, WILL THESE INDICATORS ULTIMATELY CONTRIBUTE?

B. Plan for Data Collection

Data Collection Method: List the source(s) of the raw data, the levels of collection (is a third party aggregating data or calculating some intermediate indicators that may affect your indicator values?), and describe the steps involved in the collection of any/all information needed to construct the indicator's value for a given reporting period. Too much detail is better than too little detail here.

Data Source(s): As specifically as possible, identify the documents, databases, organizations, and/or individuals that/who will provide raw information or final figures that will be reported through this indicator.

Timing / Frequency of Data Collection: Normally, this should be reported here in terms of the timing or frequency of indicator calculation. If data is collected every month but the indicator will be calculated/reported (i.e., collected by USAID) only annually, the frequency listed here should be Annually.

Estimated Cost of Collection: Unless this is a special survey or other new M&E activity outside of current or ongoing plans, it will often be appropriate to note here that the cost will fall within the contract budget, or other similar language. This section helps USAID keep track of new budget items or any not previously included in standard or routine obligations.

Responsible Organization/Individual(s): With as much clarity as possible, identify the person and position within each relevant organization who will have responsibility either for providing relevant data or for otherwise contributing to indicator calculation. In most cases, there will be at least one USAID person and position identified here AND at least one Implementing Partner person and position.

Location of Data Storage: In cases where raw data and calculated indicators will be stored by separate organizations, it is a good idea to note each location where portions of the information that would be necessary to reconstruct the indicator value will be stored.

C. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)

Data Analysis: Monitoring indicators typically should be analyzed at least through comparison to baselines and targets, and considered in terms of their implications for program performance.

Presentation of Data: Most often, indicator values will be presented in tables. Graphical presentation may be more appropriate for some indicators. Qualitative indicators may require more narrative explication.

Review of Data: Most often, indicator values will be reviewed annually, or less frequently for less frequently calculated/reported indicators (see "Timing/Frequency of Data Collection" above).

Reporting of Data: What is the reporting schedule within USAID - SO team only, or will this indicator be reported further up to higher levels of oversight, e.g. in R4 annual report?

D. Data Quality Issues *THIS SECTION REPORTS ONLY ON ISSUES RELATED TO DATA QUALITY. ISSUES OF INDICATOR DEFINITION, PERFORMANCE, RELEVANCE, OR DATA AVAILABILITY OR ALTERNATIVE STANDARDS SHOULD BE EXPLAINED OR EXPLORED IN OTHER SECTIONS*

Initial Data Quality Assessment: (VALIDITY CONCERNS) GIVEN WHAT YOU KNOW AT THIS POINT IN TIME, HOW DO YOU FEEL ABOUT THE POTENTIAL FOR PROBLEMS WITH THE QUALITY OF THE DATA THAT YOU WILL EVENTUALLY COLLECT AND USE TO CALCULATE THIS INDICATOR? DO YOU THINK YOUR DATA VALIDLY MEASURE THE RESULT TARGETED BY THIS INDICATOR? DO YOU THINK YOUR MEASUREMENTS ARE VALID METRICS FOR THE (CONCEPTUAL) RESULT YOU ARE TRYING TO TRACK HERE? DO YOU EXPECT INSTITUTIONAL OR OTHER CHALLENGES TO ARISE THAT MIGHT AFFECT THE DEGREE OF MEASUREMENT ERROR OR OTHER SYSTEMATIC ERRORS IN YOUR DATA?

Known Data Limitations and Significance (if any): (Reliability Concerns) Even if your indicator is valid, is your data reliable? Do you foresee any gaps or inconsistencies in the data that might affect the soundness of the indicator's calculated value, or your ability to interpret/understand the meaning of the indicator? If limitations arise, do you judge them likely to be highly significant, trivial/unimportant, or somewhere in-between?

Actions Taken or Planned to Address Data Limitations: Think of all of the things that could go wrong with your planned indicator when you start trying to gather information about real results of your program activities. How will you try to mitigate or correct for any gaps or mismeasurement that may be due to difficulties with the data, as noted in the previous two sections?

E. 1 Performance Data Table

Key to Table: If items are disaggregated or if subsets are provided in parentheses, or any other key to understanding the table at a glance is required, explanatory information should be provided here.

Rationale for Selection of Baselines and Targets:

How exactly have you determined a baseline for your indicator value(s)? If no exact baseline was available, what information did you use for a proxy measure and how did you adjust or otherwise interpret that data in order to arrive at what you consider to be a reasonable approximation of a baseline?

How exactly have you determined a target (or targets) for your indicator values? If you have extrapolated from existing partial data or estimated based on data from another geographical area, explain your reasoning.

	TARGET/PLANNED	ACTUAL	COMMENTS
2000 (Baseline)			
2001			
2002			
2003			
2004			
2005			
Final			

Comments

After calculation of indicator values for one or more periods, note here any adjustments you have had to make. Adjustments may be needed, for example, according to information provided in any of the sections above (e.g., data that was expected to be available turned out not to be available (for certain disaggregations, for example); data whose quality was already suspect was in the end judged to be of insufficient validity or reliability; data collection that depended on cooperating government or NGO entities did not occur or was incomplete). In addition, further (unanticipated) issues may have arisen in defining, collecting, calculating, or otherwise arriving at sound and transparently interpretable indicator values. Any such additional information that would be helpful for people interpreting the meaning or significance of the indicator values should be discussed here.

Indicator Reference Sheet - Example

Strategic Objective: SO 3.2 Increased utilization of quality primary health care in select populations

Intermediate Result: N/A

Indicator: C. % of total outpatient visits that occurred in PHC practices in pilot sites

Date Established: 01/2001

Date Last Reviewed: 03/18/2001

A. Description

Precise Definition(s): Primary Health Care Practices (PHCPs) are defined as units that serve a mixed population where all three basic specialties (pediatrics, internal medicine, obstetrics/gynecology) are represented in the practice; that are funded by the government on a per capita usage basis; and that have a score on the Minimum Standards Assessment (see IR 3.2.2 C) greater than zero. Outpatient visits are those client visits that occur in PHCPs and polyclinics both within and outside hospitals and do not result in a stay overnight. Pilot sites are defined in project documents; for the purposes of this indicator, specific sites are listed with Performance Data Tables.

Unit of Measure: %

Disaggregated by: Pilot regions where appropriate

Justification/Management Utility: The SO represents the overall objective of reforms and USAID assistance in the context of these reforms, which is strengthening Primary Health Care. This will be accomplished through integration of all health sector functions, assisted on all levels with USAID inputs. USAID-supported activities include advocacy, training, and IEC toward improving the rational use of Health Care facilities, particularly focusing on greater use of PHCPs and fewer resources expended on costly, unnecessary in-patient care. USAID inputs are reflected in the four IRs and the SO indicator represents the integrated contributions of all four IRs. As PHCPs are strengthened and communities and individuals better understand their health rights and responsibilities, patients are more likely to utilize these facilities for their routine and outpatient needs. Therefore PHCP utilization for outpatient care as a percentage of all outpatient visits is an appropriate SO indicator.

B. Plan for Data Collection

Data Collection Method: IP will obtain reports annually from health information systems in each country and input outpatient and facility data into the IP's Target Indicators Database. The IP will calculate and report the percentages to the Mission.

Data Source(s): Ministry of Health reports [[Specific Titles as Available](#)] and Health Insurance Fund data.

Timing / Frequency of Data Collection: Annual

Estimated Cost of Collection: Cost within contract budget

Responsible Organization/Individual(s): [Program person responsible for overseeing data collection, database entry, and indicator calculation]and [USAID person responsible for collecting indicator reports and verifying data quality].

Location of Data Storage: Raw data and calculations stored in project database; yearly calculations recorded in USAID Mission Performance Monitoring Plan files

C. Plan for Data Analysis, Reporting, and Review (schedule, methodology, responsibility)

Data Analysis: Calculation of the percentage from the raw data sources and comparison with baseline and targets

Presentation of Data: Tabular form

Review of Data: R4 (mid-January)

Reporting of Data: Annual Report performance data tables

D. Data Quality Issues

Initial Data Quality Assessment: Data quality should be generally good because it is reported through official sources and is not politically controversial. Both existing and emerging systems have it in their own interests to report these data accurately.

Known Data Limitations and Significance (if any): The total number of visits may have to be adjusted to exclude visits related to sick leave or applications for drivers license etc. Depending on the structure of the health delivery system as it continues to evolve, there also may be minimal issues related to separating PHC practice visits from other outpatient visits.

Actions Taken or Planned to Address Data Limitations: 1) Standardizing analysis; 2) standardizing the definition of visits; and 3) working with MOH to separate PHC practices in all reports.

E1. Performance Data Table

Method of Calculation:

Numerator: Number of outpatient visits to PHC facilities in each pilot site

Denominator: Total number of outpatient visits in each pilot site

Multiply the result by 100 to present the information as a percentage.

Key to Table: n/a

Rationale for Selection of Baselines and Targets: Baseline has been calculated from last year's data. Targets have been projected based on implementor's past experience with primary health care development programs here and elsewhere and represent what is believed to be a reasonable expectation of the rate of progress.

	TARGET/PLANNED	ACTUAL	COMMENTS
2000 (Baseline)	-	6%	
2001	8%		
2002	10%		
2003	12%		
2004	14%		
2005	16%		
Final	16%		

Comments: Pilot sites include [list here]. No disaggregation is necessary.

SCHEDULE FOR DATA COLLECTION ACTIVITIES

Data Collection Activity	Year	Indicators Relying on Data	Responsibility (Sole or Shared)	Costs Estimated Budget (total, shared)
1.		a. b. c. d.		

Monitoring and Evaluation References

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