Monitoring

&

Evaluation

Toolkit for New Partners

American International Health Alliance, Inc.

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I. INTRODUCTION

AIHA's *Monitoring and Evaluation Toolkit for New Partners* is designed to serve as a reference guide for partnerships and contains information and resources related to AIHA's monitoring and evaluation (M&E) approach, systems and tools. The toolkit includes a glossary of basic M&E terminology, an overview of AIHA's monitoring and reporting tools, guidelines on development of performance indicators, as well as M&E-related requirements of USAID, AIHA's major funding source. The toolkit also provides selected reference materials partners may use in conducting their own M&E activities, such as survey questionnaires and focus groups.

Objectives of AIHA's M&E activities are to:

- improve the performance of programs, ensure optimum use of available resources, and provide feedback for programmatic decision-making;
- create systems that support learning from experience, help disseminate knowledge of best practices, and assist the replication of successful models, thus improving the relevance, methods, and effectiveness of partnerships and other programs;
- provide information to funding agencies and key stakeholders regarding progress and results of AIHA programs, as well as to strengthen support for the programs;
- provide feedback to AIHA partners as a means of engaging them in the program improvement processes;
- strengthen the capacity of its non-US partner institutions to conduct monitoring and evaluation, which will ultimately contribute to the sustainability of the programs and institutions.

Typically, AIHA focuses its monitoring & evaluation efforts on three levels and types of activities: partnership, and cross-partnership, and program-wide.

At the partnership level AIHA works closely with partners to assist them in developing a monitoring and evaluation framework. Partners receive assistance, as needed, in incorporating measurable objectives, outcomes and indicators into their workplans and in annually reassessing those objectives and revising workplans. AIHA works with partners to collect data to assist in monitoring progress toward technical, budgetary and scheduling objectives; to identify problems; and to improve performance on an ongoing basis. Partners are provided with standardized reporting formats that facilitate the collection of necessary data.

While working with individual partnerships, AIHA also supports programs such as in primary health care, women's health or mother-to-child transmission of HIV, that cut across or are common to multiple partnerships. For the purposes of monitoring and evaluating these programs, AIHA develops program-specific result frameworks, monthly reporting forms and conducts a number of qualitative evaluations in various program areas. Data from monthly forms are typically reported in AIHA quarterly reports to USAID.

At the program-wide level, AIHA has participated in numerous external program evaluations that, among other things, examine the effectiveness of the AIHA partnership methodology, along with program-wide outcomes. Many of these reports can be found on AIHA's Web site.

II. OVERVIEW OF SELECTED AIHA M&E-RELATED TOOLS

Initial Partnership Site Assessment Form: This form is intended as a basic tool to be adapted and used by US partners in gathering preliminary data during their initial visit to the overseas partners prior to workplan development. The document includes a wide range of questions designed to guide partners in assessing various factors relevant to developing a health-related program in a community, including demographics, health-related baseline data, training needs, community and local organizational resources, etc. Partners are expected to adapt the form to the specific needs of their partnership's focus areas.

Overall Partnership Workplan: The partnership workplan is a collaborative planning tool that guides partners to articulate the goal and objectives of their partnership and how they intend to accomplish those over the course of the funding period. In addition to outlining goals and objectives, the overall workplan addresses major areas of activity and expected outputs and outcomes along with performance indicators. The overall workplan is prepared at the start of the partnership, covers the entire partnership period, and serves as the main document for monitoring overall partnership progress. It must represent a joint effort among partners, be endorsed by all team members, and reflect the use of resources consistent with the partnership budget and projected in-kind contributions. AIHA provides a standard workplan template and guidelines for completion.

Annual Implementation Plan: The Annual Implementation Plan is prepared prior to the start of each program year and serves as a tool for partners in developing and monitoring specific action steps required to achieve the stated goal and objectives of a partnership. The implementation plan is used by AIHA and USAID to review and measure results on an annual basis. Typically, the Annual Implementation Plan is due to AIHA no less than 30 days prior to the start of a new fiscal year (August 31st), unless otherwise specified. This will provide sufficient time for partners and AIHA to discuss any issues and revise plans if necessary prior to submitting a final Implementation Plan to USAID for their concurrence.

Partnership Quarterly Report: Submitted by the US partners, this report provides quarterly updates on progress towards partnership workplan objectives. It reviews completion of scheduled activities, problems encountered, in-kind contributions, etc. AIHA uses this report to monitor the pace of workplan implementation, to collect qualitative information about progress, as well as to identify any potential problems. Information from these reports is incorporated into AIHA's quarterly report to USAID.

Partner Monthly Progress Reports: Collected from non-US partners by AIHA regional offices these monthly reports serve as a monitoring tool. The reports provide descriptive information on all partnership-related activities at the overseas partnership sites for the preceding month, including exchange follow-ups, trainings, outreach programs, health education, and media events; and identify obstacles to progress encountered by partners. These reports are summarized by the regional offices in their monthly reports submitted to AIHA/Washington and, on request, to USAID missions. They also serve as an information source for AIHA's Quarterly Reports to USAID.

Monthly Statistical Reports: Prepared by AIHA's non-US partners, these reports provide standard statistical information, such as the number of patient visits, number of professional trainings, etc., used by AIHA for both monitoring and evaluation purposes. The type and extent of data are determined by indicators incorporated in program-specific M&E results frameworks.

Annual Statistical Reports: These reports present aggregated annual data for each region where AIHA has active programs and is submitted to USAID at the end of each October. The reports focus on progress toward meeting agreed-upon benchmarks and performance indicators, and include data tables and success stories.

III. GLOSSARY OF BASIC M&E TERMINOLOGY

Monitoring
Continuous assessment of project implementation in relation to agreed schedules, and the use of inputs, infrastructure, and services by project beneficiaries. Monitoring provides managers and other stakeholders with continuous feedback on implementation, identifies actual or potential successes and problems as early as possible to facilitate timely adjustments to project operation. Program monitoring usually occurs at many levels, in varying forms, and in close collaboration with partners. Monitoring activities include:

1. Regular site visits
2. Internal monthly reports
3. Regular review of output and outcome data

Evaluation
Evaluation is a periodic assessment of a project's relevance, performance, efficiency, and impact (both expected and unexpected) in relation to stated objectives. Interim evaluations during implementation are a first review of progress, a prognosis of a project's likely effects, and a way to identify necessary adjustments in project design. Terminal evaluations, conducted at the end of the project, are part of a project's completion report. They include an assessment of a project's effects and their potential sustainability. The most popular tools used for evaluating programs and their components are:

Quantitative approach

1. Self-administered surveys – consist of questions that individual respondents complete by themselves. Self-administered questionnaires can be mailed or completed "on site."
2. Standardized Interviews – interviews can take place over the telephone, face-to-face, or throughout videoconferencing.
3. Structured record reviews – is a survey in which the surveyors use a specially created form to guide the collection of data (administrative and internal records)
4. Awareness/attitude questionnaires – such as KAP study (Knowledge, Attitude, Practice)
5. Patient satisfaction surveys
6. Pre- and post-test

Qualitative approach

7. Structured observations study – such surveys are designed to guide observers in focusing on specific actions or characteristics (usually conducted by expert panels or trained observers)
8. Focus groups
9. Key informant and in-depth interviews
10. Review and analysis of written documents
11. Benchmarking – comparing institutions, programs or practices against established standards or against one another

Formative Evaluation
Formative evaluation is typically conducted during the development or improvement of a program or product and it is conducted, often more than once, for in-house staff of the program with the intent to improve. It is a method of judging the worth of a program while the program activities are forming or happening. Formative evaluation focuses on the *process.*

Summative Evaluation
Summative evaluation is a method of judging the worth of a program at the end of the program activities. It refers to methods of looking at the results or overall effectiveness of a program to determine the extent to which the program or product met the stated goals and objectives. The focus of this evaluation is on the *outcome.*

Participatory Monitoring & Evaluation
Results-based M&E approach which seeks to engage key project stakeholders more actively in reflecting and assessing the progress of their project and in particular the achievement of results. Stakeholders are involved in defining what will be evaluated, who will be involved, when it will take place, the participatory methods for collecting information and analysis to be used and how finding are consolidated.

Results Framework (RF)
It represents the development hypothesis including those results necessary to achieve a strategic objective and their casual relationships and underlying assumptions. RF establishes a basis for measuring, analyzing and reporting results of the operating unit in terms of outcomes, outputs, indicators and specified goals. AIHA develops an outcome-oriented "Results Framework" based on USAID's performance monitoring system. The overall framework includes a series of underlying results frameworks for each AIHA program area, incorporating both partnership and cross-partnership programs, with goals and objectives relevant to the strategic objectives and "intermediate results" accepted by the USAID missions, and having a structured set of indicators covering all levels of programmatic activities, from inputs to outcomes.

Objective
A generic term used to express a purpose or goal representing the desired result that a program seeks to achieve. A good objective should meet the "SMART" criteria – it should be specific, measurable, attainable, realistic and time-bounded. Examples are: Increased capacity to deliver quality primary care services in targeted communities; Select populations better informed about diabetes care and treatment; Improved availability of communication and information resources in support of the TB program; etc.

Inputs
Quantified and time-bound statements of resources a program uses to achieve program objectives. Examples are staff, volunteers, facilities, equipment, curricula, financing, etc. Information on inputs comes largely from accounting and management records. A program uses *inputs* to support *activities*.

Activities
Everything what a program does with its inputs (resources such as staff, volunteers, equipment, curricula, etc.) to fulfill its mission. Program activities should be specific and measurable and should present well-defined events with easily describable beginning and end points. Examples include: providing different types of training to health providers, organizing educational courses, exchange travels, and many others. Program *activities* result in *outputs* and they enable to achieve specific goals and objectives.

Outputs
Outputs are tangible products of a program or project necessary to achieve its objectives. They are results of a program's activities. Usually outputs are measured in terms of the volume work accomplished, for example, the number of classes taught, medical professionals trained, counseling sessions conducted, educational materials distributed, patients served, etc. A program's outputs should produce desired *outcomes* for the program's participants. They should lead to desired benefits.

Outcomes
Outcomes are longer-term measurable improvements that can be directly attributed to partnership workplan activities. These are benefits for participants during or after their involvement with a program. Outcomes may relate to knowledge, skills, attitudes, values, behavior, condition, or status and generally demonstrate an increase or decrease in a significant situation/event or health status. Examples of outcomes include number or percent of referrals to specialists, hospitalization rates, percent of breast cancers detected at earlier stages vs. at late stages, adoption of clinical practice guidelines; levels of patient satisfaction; percentage of women initiating prenatal care in the first trimester, passage of new regional or national policies or legislation, decreased infant mortality rates, etc.

Impact (Overall Goal)
It can be defined as a long-term systemic change, which is expected to take place as a result of the partnership program. Impacts are benefits for the population or the health system as a whole during or after their involvement with a partnership program. An example of systemic change will be the improved health status of the population in the area where a partnership is active.

IV. SELECTING/WRITING PERFORMANCE INDICATORS

Indicators are signposts of change along the path to development. They make it possible to demonstrate results. They can also help in producing results by providing a reference point for monitoring, decision-making, stakeholder consultations and evaluation. In particular, indicators can help to 1) measure progress and achievements; 2) clarify consistency between activities, outputs, outcomes and goals; 3) ensure legitimacy and accountability to all stakeholders by demonstrating progress; and 4) assess project and staff performance. Indicators may be used at any point along the results chain of inputs, activities, outputs, outcomes and impacts.

The SMART way to select indicators

The following criteria and questions may be helpful in selecting indicators. As a memory aid, the acronym "SMART" summarizes key criteria, asking "Is the indicator specific, measurable, achievable, relevant and trackable?"

Auxiliary questions:

Selecting **S**pecific Indicators:

- Is it clear exactly what is being measured? Has the appropriate level of disaggregation been specified?
- Does the indicator capture the essence of the desired result?
- Does it capture differences across areas and categories of people?
- Is the indicator specific enough to measure progress toward the results?

Selecting **M**easurable Indicators:

- Are changes objectively verifiable?
- Will the indicator show desirable change?
- Is it a reliable and clear measure of results?
- Is it sensitive to changes in policies and programs?
- Do stakeholders agree on exactly what to measure?

Selecting **A**chievable Indicators:

- What changes are anticipated as a result of the assistance?
- Are the result(s) realistic? For this, a credible link between outputs, contributions of partnerships and outcome is indispensable.

Selecting **R**elevant Indicators:

- Does the indicator capture the essence of the desired results?
- Is it relevant to the intended outputs and outcome? To judge the relevance of indicators one may have to identify the target groups and their needs, expectations and criteria.
- Is the indicator plausibly associated with the sphere of activity?

Selecting **T**rackable Indicators:

- Are data actually available at reasonable cost and effort?
- Are data sources known?
- Does an indicator monitoring plan exist?

For the purposes of AIHA's workplans it is also important to select those indicators that are time-bounded and will capture changes within specified timeframe.

Be sensible and practical in applying these criteria. No one indicator will satisfy all criteria equally well. Ultimately, the choice of indicator is determined through a holistic assessment of validity and practicality.

Types of Indicators

Output/process indicators
Output indicators measure the quantity of goods and services produced and the efficiency of production.

Examples:
# of model centers opened
# of trainers trained in TB-related topics
# of preventive visits

Outcome indicators
Outcome indicators measure specific data that track a program's success on outcomes. They describe observable, measurable characteristics or changes that represent achievement of an outcome.

Examples:
% of PHC partnerships with active community-based initiatives
% of targeted health professionals using evidence-based knowledge resources
% of community members in project area able to correctly identify key TB-related facts/information

Impact indicators
Represent measurable and observable changes on the level of the population or the health system as a whole. Impact is considerably more difficult to measure than outcomes, because measures of systemic change often involve complex statistics about economic or social welfare and depend on data that are gathered from beneficiaries. In addition, in many instances the impact of a partnership work is delayed and can be assessed only after the partnership has graduated.

Examples:
% decrease in spending on antibiotics in selected hospitals
% decrease in newborn deaths from meconium aspiration syndrome
% decrease in rates of targeted nosocomial infections

Baseline, Target and Timeframe

Indicators require a baseline, target and timeframe in order to be useful in verifying the results of an intervention. This makes it possible to demonstrate change over time.

Baseline – is the situation before a program or activity, and is the starting point for results monitoring. Ideally, the baseline should be gathered and agreed upon by stakeholders when a program is being formulated. In some cases, it may be possible to retroactively ascertain approximately where one was when the program started, perhaps from data included in past annual review exercises. When retroactive data do not exist, it still may be possible to obtain a measure of change over time. For example, to establish a baseline pertaining to governance in a hospital one might ask a number of physicians: "Compared to three years ago, do you feel more or less involved in decision-making process in your hospital?" A clear tendency among respondents towards "more" or towards "less" provides a valid indication of whether change has occurred or not. When it is impossible to retroactively establish any sense of change, establish a measure of where one is now. This will at least allow for the assessment of change in the future.

Target – is the situation expected at the end of a program or activity. The key to establishing targets is realism. Target-setting must be based on a thorough review of the factors that

influence the development problem being addressed, what partners are doing, and what degree of change can realistically be associated with the program contribution. Factors to consider in establishing targets include: a) past trends, i.e. change observed over previous periods; b) how well others have done; c) limits to progress; and d) the existence of objective international, sectoral or other quality standards.

Timeframe – refers to observations taken at specified point in time or within a given period of time.

Performance Indicator Reference Sheet: SAMPLE

Performance Indicator Reference Sheet
Objective (#): **indicate the # of the objective and state objective exactly as it appears in the results framework or Performance Monitoring and Evaluation Plan (PMEP).** *Example:* ***Objective #1: Population is better informed about TB*** **Indicator (#):** *include the number of the indicator in reference to the objective it is measuring* **Example:** Indicator 1.1: % of general population identifying TB as a curable disease **Date Established:** *provide month and year when indicator was established* **Example:** April 2004
a. Description
Precise Definition(s): *Each key word or words used in the indicator must be clearly defined in order to explain precisely what is being measured. In the case where individuals are being counted in the indicator, describe the "universe" they represent – i.e., what region, institution, or other grouping are they part of?* **Example:** The general population of Moldova will be represented through a randomized sampling of approximately 1,200 persons who will be administered a KAP (knowledge, attitudes and practices) survey. Correct identification will be determined by their response to a Yes/No question about whether TB is a curable disease. **Unit of Measure:** *Describe if the indicator will be measured in numerical, percent or qualitative value and how that value will be calculated.* **Example:** (%) Number of people who identify TB as a curable disease divided by all people surveyed. **Disaggregated by:** *In cases where disaggregation is desired, meaningful and possible, indicate at what levels the data will be disaggregated.* **Example:** gender, age, rural/urban, rayon **Justification/Management Utility:** *Provide the reason(s) for selecting this indicator, any assumptions being made about causality, and how this indicator tells us whether the objective was accomplished. Be as thorough as possible.* **Example:** Improved levels of knowledge among the general population that TB is a curable disease can indicate the effectiveness of the project's TB public awareness and education activities. This particular fact is important in encouraging TB patients to seek treatment, as well as increasing the continuation of treatment and decreasing negative attitudes toward persons with TB. **Other examples: 1)** This indicator allows program managers to measure success in increasing knowledge of lower-risk sexual behavior among the high risk population group. If knowledge has been increased regarding the dangers of non-usage of condoms, then the percentage of people reporting condom use should show an increasing trend. **2)** This outcome indicator reflects changes in service quality and other factors as a result of interventions by AIHA-sponsored activities.
b. Plan for Data Collection
Data Collection Method: *Describe how the data will be collected. Examples of possible collection methods include monthly statistical reports submitted to AIHA or a national entity by a healthcare facility; chart reviews; various kinds of surveys; observations and site visits; meeting records; etc. Be as specific as possible.* **Example:** A specific question about whether TB is curable will be included in KAP surveys to be conducted among a randomized sample selected from a minimum of 5 cities; the sample size will be approximately 1,200 people and each survey is expected to take three-four weeks to administer. Baseline survey will be conducted in 2004 with a follow-up in 2006. **Data Source(s):** *Indicate where the data originates from, whether it is a healthcare facility, survey results, surveillance system, project records, or other.* **Example:** KAP surveys

Timing/Frequency of Data Collection: *Indicate how often/when the data for the indicator will be collected. Some data may be collected routinely and as often as monthly; others may be quarterly or only annually or even less frequently. The timing and frequency will depend on the nature of the indicator and when changes are expected to be observable/achievable.*

Example: Twice during the project period: once in 2004 and again in 2006.

Estimated Cost of Collection: *Indicate cost of data collection, if applicable. If you don't know the exact numeric value use adjectives such as: minimal, moderate, etc. If there is no cost involved, write "none."*

Example: $10,000 per survey

Responsible Organization/Individual(s): *Identify individual(s) or organization(s) responsible for collecting the data.*

Example: AIHA will contract with a polling/research agency to conduct the surveys; AIHA's communication consultant for the project will oversee activities.

Location of Data Storage: *Identify where the collected data will be stored. In the example of the Moldova TB project, data for most indicators will be stored at the National TB Program and National Reference Laboratory.*

Example: AIHA office

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

Data Analysis: *Describe how the data will be analyzed and by whom.*

Example: Results for each survey will be aggregated and analyzed by the polling/research agency that conducts the surveys. They will also analyze differences in results between the two surveys in order to show changes in public awareness about TB as a curable disease. Analysis will include disaggregated data by gender, etc.

Other examples: 1) Comparison to baseline and targets;

2) Comparison of targets to actual performance in aggregate and by clinic type. Examine trends.

Presentation of Data: *Briefly indicate in what form data will be presented, whether in text form or tables and graphs with disaggregation, tabular form, etc.*

Example: Text report with tables

Review of Data: *Indicate responsible entity(s) for reviewing the data and the timeline for review.*

Example: Data will be reviewed by AIHA's Moldova office and M&E unit after each of the two surveys.

Reporting of Data: *Indicate how and when data will be reported and to whom. Also describe how the data will be used.*

Example: Data from the baseline survey will be reported in AIHA's annual analytical report to USAID in 2004; results of the follow-up survey will be reported at the end of the project period as part of AIHA's summary report to USAID. A separate and more detailed report of the two surveys will be prepared, submitted to USAID and the National TB Program, and posted on AIHA's Web site.

d. Data Quality Issues

Initial Data Quality Assessment or Date of Initial Data Quality Assessment: *Describe what you consider to be the quality and reliability of the data that will be collected, and give explanations for your assessment.*

Example: The quality of the data is expected to be very good as the question being asked is very simple and direct. AIHA will use an independent polling agency experienced in administering such surveys in order to increase objectivity.

Known Data Limitations and Significance (if any): *Describe here any limitations on the validity or scope of the data and discuss any significance of the limitations to the objective being measured. This may include such issues as small sample size, certain geographic regions not being covered, respondents to surveys not being completely honest (social desirability bias), etc. Any anticipated obstacles to data collection should also be mentioned here.*

Example: It will not be possible to survey the same individuals in the first and second surveys, so changes in knowledge will reflect overall awareness among the population rather than changes in awareness among particular individuals. However, given the randomized approach, the large sample size, and the project's public awareness campaigns being directed at the general population, we will be able to measure overall changes in awareness.

Other examples: 1) There is a significant time lag in the reporting of those statistics;

2) Impact may be difficult to measure and even demonstrate within the planning period.

3) Behavior change is not usually evident until a longer period of time than the annual reporting period.

4) Minimal risk of inaccuracy in reporting, reliance on recollection of respondents.

Actions Taken or Planned to Address Data Limitations: *Describe how any data limitations indicated above will be addressed, for example through training or double-checking. If no action is required, write "none required."*

Example: None required

Other examples: 1) Health Information Systems Development Project might improve the quality of reporting from the MoH by improving their data collection process;

2) Training of the administrative staff in data collection methods and chart review.

e. Results Tracking Data

BASE LINE **DATA***		**TARGETS AND ACTUAL RESULTS**					
		Insert first year for which data will be collected **Example:** 2006		***Insert second year, if applicable***		***Insert third year, if applicable***	
YEAR	**VALUE**	**Target****	**Actual*****	**Target**	**Actual**	**Target**	**Actual**
2004	**TBD**	**TBD**					

***Baseline data:** *If at all possible, provide baseline data for this indicator, giving the year and value. In this example, the baseline will be determined once the initial KAP survey is conducted.*

****Target:** *Provide best estimate (better to be conservative than overly optimistic) for what the indicator is expected to be over the course of the project. In this example, the target for 2006 cannot be estimated until we have baseline information.*

*****Actual:** *These values will be filled in at the end of each year to compare the targeted n umbers with actual results.*

V. FOCUS GROUP GUIDELINES[1]

One of the useful tools for gathering information of various kinds is conducting a focus group, usually consisting of ten to twelve people. The focus group study provides qualitative data and it is a way to better understand how people (patients, health providers, stakeholders) feel or thing about certain issues, products, or services.

Focus group interviews are useful when:

- You are looking for the range of ideas or feelings that people have about something;
- You are trying to understand differences in perspectives between groups or categories of people;
- The purpose is to uncover factors that influence opinions, behavior, or motivation;
- You want ideas to emerge from the group;
- You want to pilot test ideas, materials, plans, or policies;
- You need information to design a large-scale quantitative study;
- You need information to help shed light on quantitative data already collected;

Qualities of good focus group questions:

- Sound conversational;
- Use words the participants would use when talking about the issue – do not use acronyms, jargon, and technical lingo unless you are talking to a group of experts;
- Are easy to say;
- Are clear;
- Are usually short;
- Are usually open-ended – these questions imply that a few words or a phrase are insufficient as an answer;
- Are usually one-dimensional;
- Include clear, well-thought-out directions;

Categories of questions:

- Opening questions – used to get people talking and to help people feel comfortable; all participants are asked to answer this question, going one by one around the table. The opening questions should be easy to answer, for example: *"Tell us your name and tell us how long you have been attending diabetes counseling sessions."*
- Introductory questions – introduce the topic of discussion and get people to start thinking about their connection to the topic. These questions encourage conversation among participants, for example: *"How did you learn about the diabetes counseling?"*
- Transition questions – move the conversation into the key questions. They serve as the logical link between the introductory questions and the key questions, for example: *"Think back to when you first became involved with diabetes counseling. What were your first impressions?"*
- Key questions – drive the study. Typically, there are two to five questions in this category. These are usually the questions that require the greatest attention in the analysis, for example: *"What was particularly helpful about the counseling you received? What was particularly frustrating about the service? Are you any different because you received these counseling?"*
- Ending questions – bring closure to the discussion, enable participants to reflect on previous comments, and are critical to analysis, for example: *"If you had a chance to give advice to the director of this program, what advice would you give? Is there anything that you came wanting to say that you didn't get a chance to say?"*

[1] Based on R. A. Krueger and M. A. Casey's book: *"Focus Groups - A Practical Guide For Applied Research"*

Guidelines for a moderator:

Beginning of the session:

1. Introduce yourself.
2. Thank everyone for their attendance.
3. Clearly state the reason for the meeting
4. Ask participants to briefly introduce themselves (opening questions)
5. Explain reasons for recording the session, for example: *"As you can see, we will be tape recording our conversation to guarantee the thoroughness of the final report. Also, my assistant will be taking notes but she/he won't participate in our discussion. You can be assured that all of your comments will be kept in strict confidence and that the report will reflect only collective responses and will not identify individual participants."*
6. Explain the rules of the Focus Group meeting, for example: *"Just a couple of **ground rules** before we get started:*
    - *It is important that each of you is an active participant in the conversation. I will make every effort to allow each of you to speak. In some cases, this may mean that I will have to interrupt someone. You do not need to raise your hand or be called on. (Explain if you are going to use a round-table approach.)*
    - *Only one person should speak at a time.*
    - *Please keep your comments to the point.*
    - *There are no wrong answers. All your opinions are very valuable, so please be honest in your remarks."*

Main session:

7. Proceed with introductory, transition and key questions

Wrapping up:

8. Proceed with ending questions

End of session:

9. Close the Focus Group by thanking the participants for attending.

Other important hints for moderators:

- Carefully and clearly word each question. Once each person has spoke, facilitate discussion around the answers to each question, one at a time.
- After each question is answered, carefully reflect back a summary of what you heard (the note taker can do this).
- Ensure even participation. If only a few people are dominating the conversation, try to call on others.

VI. SUCCESS STORIES

AIHA uses "success stories" as one means of demonstrating the success of its programs. USAID has recognized the value of these stories and often requests them for reports to Congress. Success stories are anecdotal in nature, and qualitative rather than quantitative. AIHA uses success stories frequently in its publications and includes them as a part of its annual reports. Partners are encouraged to collect success stories and to share them with AIHA, either in quarterly reports or at any time. Such stories can be gathered during exchange trips to the region.

Types of Success Stories Typically Used by AIHA:

	Purpose	Length	Elements
Annual Report	To provide brief anecdotal evidence that supports statistical data contained in annual reports.	One paragraph: 5-8 sentences	* Organized by program area * Clear link to a program objective * Just enough detail to make story substantive * Written by regional and DC program staff
Publications	To provide more in-depth human interest stories that demonstrate impact of partnership program on health care providers/educators and their patients/students.	One story per page	* Story told from two perspectives (double-sided/one story per side): e.g. doctor and patient * Reliance on in-depth interviews * Highly-compelling stories * Requires much up-front work * Written by Publications staff after gathering preliminary info from partners and/or regional offices

Tips for Writing a Success Story

- Maintain a "bank" of potential stories by keeping a list of good stories and anecdotes as you hear them, that way when you need them, you can go back to the source. Listen for interesting, compelling, and/or unique stories.
- Be pro-active about seeking out additional information: ask follow-up questions
- Have a particular program objective in mind that the story supports and clearly convey the outcome.
- Focus on dramatic, impressive outcomes, not everyday occurrences.
- Keep succinct and to the point, without too many details.
- If including quotes, interview people who are articulate.
- Try to schedule one-on-one interviews, because people are more willing to open up without fear or embarrassment.
- Take time to develop a list of questions prior to talking with patients/providers

Examples of Synopses for "2-sided" Success Stories:

A) PART I: As a result of the training she received during both partnership exchange trips to Minneapolis and several AIHA regional workshops on STIs, gynecologist ____ changed the way she interacts with young patients. Now she openly discusses safe sex and reproductive health issues with the teenage girls she sees, teaching them to take an active role in their own health.

PART II: At only 15, ____ had already contracted an STI twice. She said she didn't know how to tell her boyfriend he should seek treatment and was too embarrassed ask him to wear a condom during sex. Dr. ____ not only treated ___'s condition, she also counseled her on the importance of safe sex and the value of her own health. She encouraged ____ to attend group

counseling sessions held at the WWC where girls gained the confidence and life skills necessary to deal effectively with such situations.

B) PART I: Due to her work with the Dubna/La Crosse partnership, Vetokhina—a feldsher—was given the opportunity to develop her skills and become manager of the Diabetes School. Now she is a leader, rather than someone who just follows orders.

PART II: By taking part in classes at the Diabetes School, Anton has learned how to manage his condition and live a normal, active life that includes study at Dubna International University, playing sports, and working part-time.

VII. DESIGNING SURVEY QUESTIONNAIRES[2]

Hypotheses & Variables: A hypothesis can be described as "a tentative answer to a research question" or a "provisional prediction".

Hypotheses should be:

- Stated clearly, using appropriate terminology
- Testable
- Statement of relationships between variables
- Limited in scope

Examples of hypotheses:

- Health education programs influence the number of people who smoke
- Educational brochures affect changes in patients' lifestyle
- Attendance at patient education lectures influences changes in diet

In the above examples, "something" (e.g. diet, lecture attendance) affects "something else" (e.g. changes in diet, patients' lifestyle). These are variables. A variable is anything which is free to vary, and in order to describe them quantitatively, they have to be expressed in appropriate units (e.g. # of people who smoke, # of patients who changed their diet).

QUESTION TYPES:

Closed-ended questions

a) Name: Dichotomous **Description:** *Question offering two choices*
Example: Did you smoke at all yesterday?
Yes / No

b) Name: Multiple **Description:** *Question offering three or more choices*
Example: Which of these clinics do you prefer?
Polyclinic #1 / Polyclinic #2 / Polyclinic #3 / Hospital #1

c) Name: Likert scale **Description:** *Statement with which respondent shows the amount of agreement / disagreement*
Example: Health care providers at this clinic are very competent:

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

d) Name: Semantic differential **Description:** *Scale is inscribed between two bipolar words and respondent selects the point that most represents the direction and intensity of his / her feelings*
Example: The degree I am taking is.....

Interesting :_____:_____:_____:__X___:_____:_____:_____: Boring
Useful :_____:_____:_____:_____:_____:_X____:_____: Useless
Easy :_____:__X___:_____:_____:_____:_____:_____: Difficult

[2] Based on a workbook by Alison Galloway (http://www.tardis.ed.ac.uk/~kate/qmcweb/qcont.htm)

e) Name: Rank order ***Description:*** *Respondent is asked to rate or rank each option that applies. This allows to obtain information on relative preferences, importance etc. Long lists should be avoided (respondents generally find it difficult to rank more than 5 items)*

Example: Please indicate, in rank order, your preferred health care provider, putting 1 next to your favorite through to 5 for your least favorite.

- Internist
- Cardiologist
- OB/Gyn
- Nurse
- Midwife

f) Name: Numeric ***Description:*** *Respondent specifies a particular value (can include decimal places)*

Example: How far (to the nearest kilometer) did you travel today to reach this clinic? _____km

Advantages of Closed-Ended Questions

- Quick to answer
- Easy to code
- No difference between articulate and inarticulate respondents

Disadvantages of Closed-Ended Questions

- Can draw misleading conclusions because of limited range of options
- Researcher / interviewer cannot deal with qualifications to responses e.g. "Yes, but….." or "It depends" where only Yes/No are given as options

Open-ended questions

a) Name: Unstructured ***Description:*** *Question that respondents can answer in an unlimited number of ways*

Example: Why did you enroll for this education training/workshop?

……

b) Name: Word Association ***Description:*** *Words are presented one at a time and respondents give the first word that comes to mind*

Example: What is the first thing that comes to mind when you hear the following?

Lecture:	*Interesting*
Presenter:	*Exciting*
Diet:	*Challenge*
Treatment:	*Rewarding*

c) Name: Sentence completion ***Description:*** *Incomplete sentences are presented, one at a time, and respondents are asked to complete the sentence*

Example: My worst experience while visiting the clinic happened when…….

d) Name: Story completion ***Description:*** *An incomplete story is presented and respondents are asked to complete it*

Example: I came to the clinic, while waiting for my physician……. (NOW COMPLETE THE STORY):

Advantages of Open-Ended Questions

- Greater freedom of expression
- No bias due to limited response ranges
- Respondent can qualify their answers

Disadvantages of Open-Ended Questions

- Time consuming to code
- Researcher / interviewer may misinterpret (and therefore misclassify) a response

INSTRUCTIONS IN QUESTIONNAIRES

General instructions

- Indicate who you are (give name of your institution) and the reason for the survey.
- Address issues of confidentiality and/or anonymity, for example:*"All of the information you give me will be treated as completely confidential and it will not be possible for anyone to identify the information you give me when I write up the project report"*.
- (If applicable) indicate how the person was selected to receive the questionnaire.

Question instructions

- Ensure that each question (or block of similar questions) has a clear instruction on how to respond.
- Indicate the form of the answer (numeric, tick-box, rank etc.) and how many answers are expected, such as *"most relevant"*, *"one only"* or *"all which apply"*

Routing instructions

- Ensure that the route which they should take is clearly specified. For example, *"If YES, please go to Question 15"*

Question Order

- Your respondents may refuse to co-operate if your survey begins with awkward or personal questions.
- It is generally best to keep all questions dealing with demographic information (such as age) at the end of the questionnaire.

The Layout of the Questionnaire

- Print clearly and allow adequate space between questions

PROBLEMATIC QUESTIONS

Hypothetical questions

A question in which you are asking respondents to indicate what they think they would do under particular imaginary circumstances. These can't always be avoided in some attitudinal research, but they are difficult to administer and often give rise to unreliable answers.

Presuming/leading questions

These are often included in poor questionnaires because the researcher feels strongly about a topic and assumes that everyone will be of the same opinion.

Questions which rely on memory

Problems which tax the respondent's memory too much are likely to lead to non-response or inaccurate replies.

Questions requiring prior knowledge

For example, "What is your National Insurance number?"

Sensitive questions
Include personal details / age/ income. If you have to ask sensitive questions, the problem can be alleviated somewhat by the use of groups. For example, "*Can you tell me the number on this card which corresponds to you income group?*

1. Under $ 25,000
2. $26,000 - $45,000
3. $45,000 - $85,000
4. Over $86,000

Mutually exclusive responses
In the show card above, you will note that somebody earning exactly $45,000 would perhaps wonder whether to give answer 3 or answer 7. You should always watch out for questions where the multiple choice answers are not mutually exclusive and where a respondent will be uncertain about which category he/she falls under.
Long questions
If your questions are too long and detailed, the respondent may get lost and the responses will relate only to the beginning or the end of the question.

CHECKLIST FOR QUESTIONNAIRES

Before you "pilot" your questionnaire try going through the following checklist to spot whether any of these common mistakes apply to your own questionnaire:
1. Have you avoided all leading questions?
Make sure you haven't included phrases like *"Wouldn't you say that….."* or *"Don't you agree that……."*
2. Is the question as specific as possible?
Avoid using words like *"occasionally"*, *"regularly"*, *"often."* For example, if ask respondents *"how often they visit the clinic"* one person's idea of *"regularly"* may be every couple of months, and another person's understanding will be every month. It is better to give explicit categories such as *"More than once a week," "Every week," "More than once a month"* etc.
3. Are the questions going to be understood by all respondents?
Avoid the two extremes of vocabulary (a) technical jargon; (b) slang or colloquialisms
4. Is each question applicable to all respondents?
If not, you will need a "filtering" question first
5. Are any of your questions double-barreled?
For example: *"Are your lectures and tutorials enjoyable and easy to understand?"* Yes / No.
You may, of course, find the lectures in a subject easy but the tutorials more difficult, or you may find both easy to understand but do not enjoy them.

PILOTING YOUR QUESTIONNAIRE

Before you deliver any questionnaire, you should "pilot" test it to check that it is going to function effectively. Pilot survey tests how long it takes to complete the questionnaire, checks that the questions are not ambiguous, checks that the instructions are clear, and allows you to eliminate questions that do not yield usable data.

As a rule of thumb, try to pilot on about 5-10% of your final sample number. Based on obtained results you should alter your questionnaire. The results from the pilot study should not be included with your final results.

VIII. USAID'S M&E PROCESSES AND TERMINOLOGY

Operating under a series of cooperative agreements with the United States Agency for International Development (USAID), AIHA and its partners are expected to follow various requirements for reporting results that contribute to USAID's performance goals. The following is a brief overview of USAID's selected processes and terminology:

A guiding principle for developing and implementing an M&E plan at the regional level is to work closely with USAID missions to arrive at an appropriate approach that serves both AIHA's and the missions' reporting and management needs. Coordination with the missions includes:

- review of USAID's region-specific strategic objectives and intermediate results;
- identification of indicators that contribute to the mission's annual report process;
- agreement on selected indicators and timeframe for reporting against indicators;
- concurrence from missions on evaluation strategies for different types of partnerships;
- presentation of annual analytical reports; and
- ongoing discussions of M&E processes and outcomes.

USAID defines a result as: a significant, intended, and measurable change in the condition of a customer, or a change in the host country, institutions, or other entities that will affect the customer directly or indirectly; and results are typically broader than USAID-funded outputs and require support from other donors and partners not within USAID's control.

USAID's definition of results includes three key principles:

1. Results are determined by customer aspirations--along with the priorities of the Agency's stakeholders; customer feedback helps us keep on track in actually achieving them; and customer views inform how we judge their merit.
2. Results are achieved at different levels -- the output level, the outcome level, the intermediate level, and the strategic objective level.
3. Results are linked by causal relationships; i.e., a result is achieved because related, interdependent result(s) were achieved.

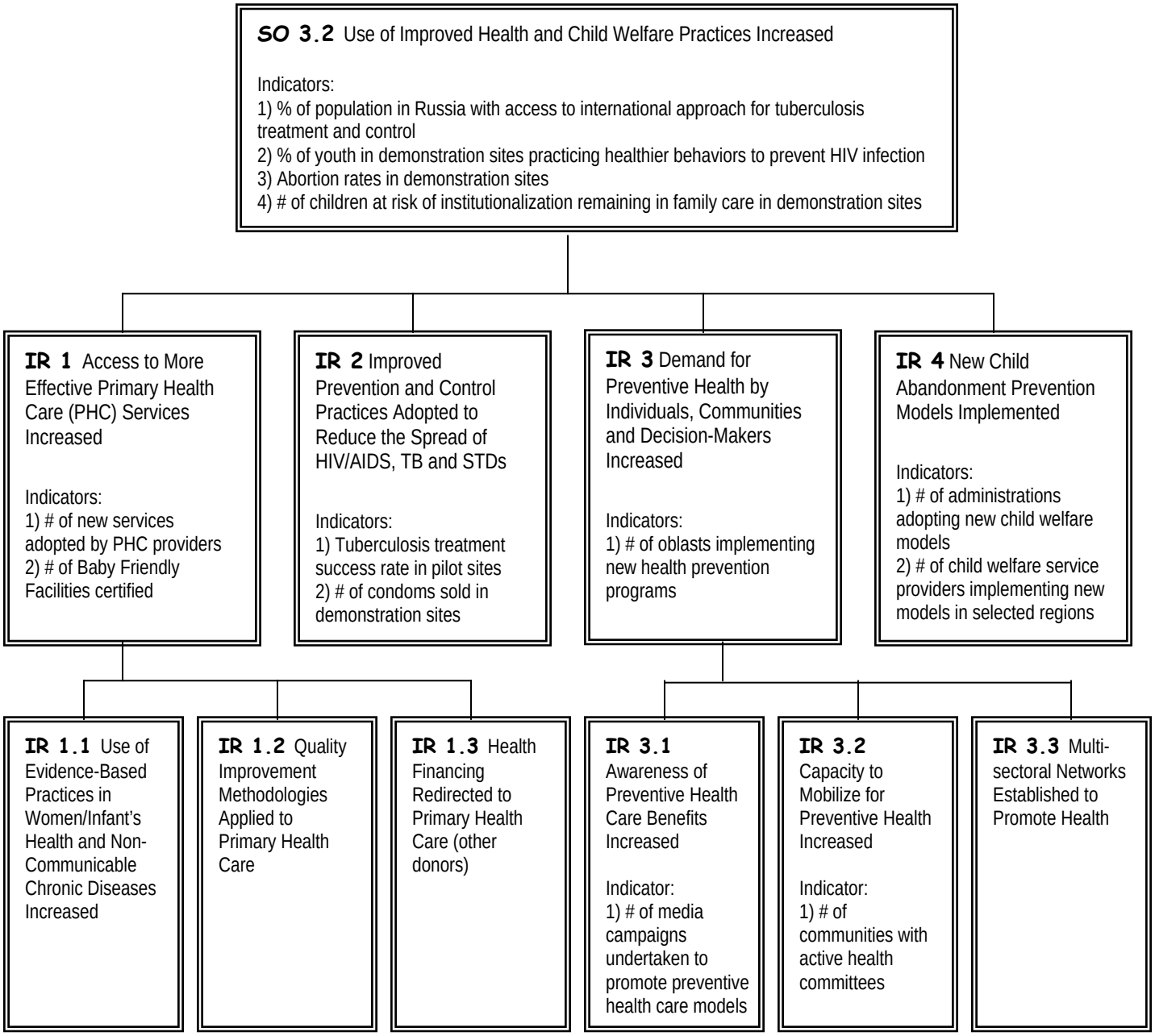
The results that are of interest to USAID, its customers and stakeholders are:

Strategic Objective (SO) – the highest level result for which a USAID Operating Unit (including USAID field Missions and regional entities) is held accountable.

Intermediate Results (IRs) – are essential steps to the achievement of a Strategic Objective. They are measurable results that may capture a number of discrete and more specific results. Intermediate Results and associated outputs are the highest level of result for which development partners (e.g., partners such as non-governmental organizations, the host country government, other donors, and customers) are typically held accountable.

Results Framework – a planning, communications, and management tool. It includes the objective and the Intermediate Results (IRs), whether funded by USAID or its partners, necessary to achieve it. The framework also conveys the development hypothesis implicit in the strategy and the cause-and-effect linkages between the IRs and the objective. It includes any critical assumptions that must hold for the development hypothesis to lead to achieving the relevant objective. Typically, it is laid out in graphic form supplemented by narrative.

The following figure, taken from USAID/Russia's 1999-2005 Strategy document, illustrates the Mission's strategic objective framework for health.



IX. USEFUL INTERNET RESOURCES

The following is a selected list of useful Internet resources for monitoring and evaluation, particularly within the international development and health contexts, as well as specific resources related to HIV/AIDS, and several general M&E resources.

Agency for Healthcare Research and Quality
http://www.ahcpr.gov/

Centers for Medicare and Medicaid Services
http://www.cms.hhs.gov/statistics/health-indicators/default.asp

OMNI - Internet resources in health and medicine
http://omni.ac.uk/browse/mesh/detail/C0525061L0771841.html

The United States Agency for International Development – M&E Performance
http://www.usaid.gov/pubs/sourcebook/usgov/mep.html

CDIE Performance Monitoring and Evaluation Tips
http://www.dec.org/usaid_eval/#004

The World Bank Group - Operations Evaluation Department
http://www.worldbank.org/oed/ index.html

World Health Organization
http://www.who.int/research/en/

Child and Adolescent Health and Development
http://www.who.int/child-adolescenthealth/New_Publications/CHILD_HEALTH/Pharm/sect8.htm

UNAIDS/Monitoring and Evaluation
http://www.unaids.org/en/in+focus/monitoringevaluation.asp

MEASURE Evaluation (a USAID-funded project)
http://www.cpc.unc.edu/measure/

HIV/AIDS-related Resources

The Synergy Project
http://www.synergyaids.com/

USAID – HIV/AIDS Resources
http://www.usaid.gov/our_work/global_health/aids/index.html#

UNAIDS - The Joint United Nations Programme on HIV/AIDS
http://www.unaids.org/en/default.asp

World Bank HIV/AIDS
http://www1.worldbank.org/hiv_aids/

The Global AIDS Coordinator

http://www.state.gov/s/gac/

WHO HIV/AIDS Programme
http://www.who.int/hiv/en/

HRSA HIV/AIDS Bureau
http://hab.hrsa.gov/

HIV/AIDS Survey Indicator Database
http://www.measuredhs.com/hivdata/start.cfm/

General M&E Resources

American Evaluation Association
http://www.eval.org/

MedicalSurveys.net
http://www.medicalsurveys.net/

Overview of Statistical Concepts
http://www.statsoft.com/textbook/stathome.html

A Guide for Project M&E
http://www.ifad.org/evaluation/guide/annexa/a.htm

Resources for Methods in Evaluation
http://gsociology.icaap.org/methods/

X. JOB DESCRIPTIONS FOR PARTNERSHIP M&E COORDINATOR AND DATA COORDINATOR

M&E Coordinator (US Partner)

Essential Duties

- Serve as M&E resource person for the partnership.
- Serve as point person for AIHA on issues related to M&E and participate in related meetings organized by AIHA.
- Work closely with his/her overseas counterparts (including Data Coordinator, if one exists) on M&E activities related to partnership.
- Provide support and input on issues related to partnership data collection, design of surveys, and implementation of program/partnership assessments.
- Participate in the initial partnership assessment trip to assess and collect quality baseline data.
- Play an active role in developing partnership workplans, focusing especially on development and definition of indicators.

Data Coordinator (Non-US Partner)

Essential Duties

- Serve as M&E resource person for the non-US partner and as point person for AIHA on M&E-related issues.
- Collect and review partnership statistical data (monthly, quarterly, and annual).
- Submit partnership statistics to the regional office using standard templates provided by AIHA, where applicable.
- Work closely with his/her US counterpart (M&E Coordinator) on M&E activities related to partnership.
- Assist in collecting quality baseline data.
- Provide support (including logistical support) in coordinating surveys and other external evaluation activities taking place within the partnership site.
- Participate in M&E-related meetings organized by AIHA.

XI. AIHA M&E CONTACTS

AIHA's monitoring and evaluation activities are coordinated in the Washington office through an M&E Unit, working in close coordination with other program staff in Washington and with regional offices. AIHA has designated an M&E Coordinator in each regional office to serve as a liaison with the M&E Unit and to coordinate monitoring and evaluation activities in the regions. The following are names and contact information of the M&E Washington, DC and regional staff:

Washington, DC M&E Unit:

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Central Asia
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Russia
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M&E Resources on the AIHA Website:
http://www.aiha.com/index.jsp?sid=1&id=8692&pid=3531