

M&E Fundamentals

A Self-Guided Minicourse

Nina Frankel
Anastasia Gage

MEASURE Evaluation



This guide was made possible by support from the U.S. Agency for International Development (USAID) under the terms of Cooperative Agreement GPO-A-00-03-00003-00. The opinions expressed are those of the authors and do not necessarily reflect the views of USAID or the United States government.

January 2007

MS-07-20



Printed on recycled paper

Acknowledgments

This course has been created by the following staff at MEASURE Evaluation: Nina Frankel, Anastasia Gage, Erin Luben, and Kavita Singh.

Thanks to the reviewers who provided their insights and suggestions: Sian Curtis, Gustavo Angeles, Charles Teller, Virginia Lamprecht, Jim Shelton, Anupa Deshpande, Bhakti Mehta, and Fran Tain.

Indispensable help was also provided by Chris Davis from the INFO Project and Teresa Tirabassi from Multimedia Services at the Johns Hopkins Center for Communication Programs. In addition, Billy Saelim, Stephen Barrett, Ed Van Duinen, and Anton Zuiker at MEASURE Evaluation provided essential technical support. Layout and copyediting was by Nash Herndon of MEASURE Evaluation.

Notes

This course is based on the M&E fundamentals Web course created by MEASURE Evaluation for the U.S. Agency for International Development's Global Health Learning Web site at <http://www.globalhealthlearning.org>.

This publication follows an interactive version of the course found in MEASURE Evaluation's on-line training resource Monitoring & Evaluation Network of Training Online Resources (MENTOR), available at http://www.cpc.unc.edu/measure/training/mentor/me_fundamentals



MENTOR also includes free downloadable training materials on monitoring and evaluation topics and can be found at <http://www.cpc.unc.edu/measure/training/mentor>.

Underlined, boldfaced words in this manual denote terms defined in the Glossary of Terms (page 71).

Table of Contents

M&E Fundamentals	1
1. Basic M&E Concepts	3
2. M&E Plans	13
3. Frameworks	23
4. Indicators	35
5. Data Sources	51
Final Exam	61
Glossary of Terms	71
Bibliography	77

M&E Fundamentals

PURPOSE

Monitoring and evaluation (M&E) is an essential component of any intervention, project, or program. This mini-course covers the basics of program monitoring and evaluation in the context of population, health, and nutrition programs. It also defines common terms and discusses why M&E is essential for program management.

OBJECTIVES

At the end of this course, you will be able to:

- ▲ identify the basic purposes and scope of M&E;
- ▲ differentiate between monitoring functions and evaluation functions;
- ▲ describe the functions of an M&E plan;
- ▲ identify the main components of an M&E plan;
- ▲ identify and differentiate between conceptual frameworks, results frameworks and logic models;
- ▲ describe how frameworks are used for M&E planning;
- ▲ identify criteria for the selection of indicators;
- ▲ describe how indicators are linked to frameworks;
- ▲ identify types of data sources; and
- ▲ describe how information can be used for decision-making.

This course takes approximately two hours to complete. It follows an interactive version found on the MEASURE Evaluation Web site at:

https://www.cpc.unc.edu/measure/training/mentor/me_fundamentals

TIME

When you read that the prevalence of low birth weight in a country is 20%, have you ever wondered how this calculation was derived?

Or when you hear that the percentage of married women of reproductive age in a rural area using a modern contraceptive method rose from 52% to 73%, do you wonder how people know this?

These types of statistics and other similar information result from “monitoring and evaluation” or “M&E” efforts. M&E is the process by which data are collected and analyzed in order to provide information to policy makers and others for use in program planning and project management.

Monitoring* of a program or intervention involves the collection of routine data that measure progress toward achieving program objectives. It is used to track changes in program performance over time. Its purpose is to permit stakeholders to make informed decisions regarding the effectiveness of programs and the efficient use of resources.

Monitoring is sometimes referred to as **process evaluation** because it focuses on the implementation process and asks key questions:

- ▲ How well has the program been implemented?
- ▲ How much does implementation vary from site to site?
- ▲ Did the program benefit the intended people? At what cost?

WHAT IS MONITORING AND EVALUATION?

WHAT IS MONITORING?

Highlights

Examples of program elements that can be monitored:

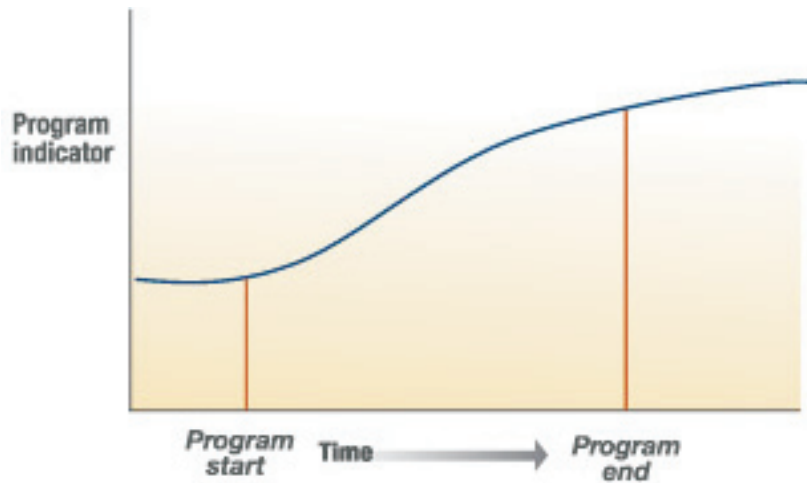
- ◆ Supply inventories
- ◆ Number of vaccine doses administered monthly
- ◆ Quality of service
- ◆ Service coverage
- ◆ Patient outcomes (changes in behavior, morbidity, etc.)

* Underlined, boldfaced words in this manual denote terms defined in the Glossary of Terms (page 71).

Highlights

Monitoring usually pertains to *counting, tracking* and *collecting*, for example:

- ◆ Counting clients seen or health workers trained
- ◆ Tracking condoms distributed
- ◆ Collecting data on clinic clients



A graphic illustration of program monitoring over time could look like this. The program indicator being measured on the “Y” axis could be any element of the program that needs tracking, such as the cost of supplies, the number of times the staff provide certain information to clients, or the percentage of clients who are pleased with the services they received.

Monitoring:

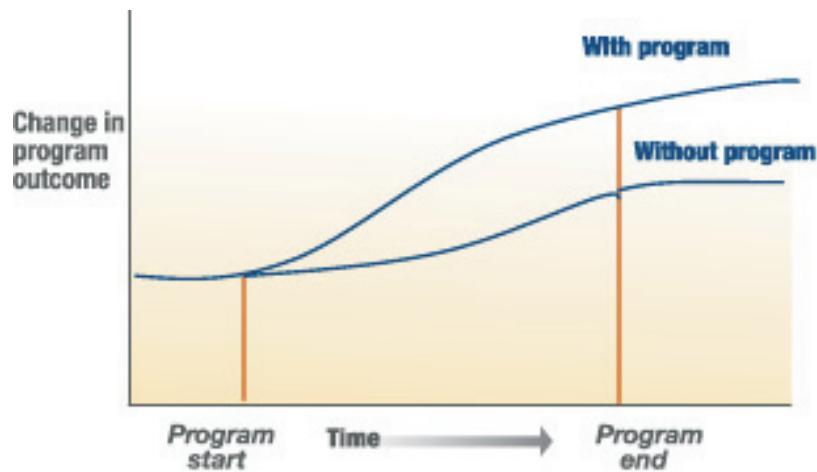
- ▲ is an ongoing, continuous process;
- ▲ requires the collection of data at multiple points throughout the program cycle, including at the beginning to provide a baseline; and
- ▲ can be used to determine if activities need adjustment during the intervention to improve desired outcomes.

WHAT IS EVALUATION?

Evaluation measures how well the program activities have met expected objectives and/or the extent to which changes in outcomes can be attributed to the program or intervention. The difference in the outcome of interest between having or not having the program or intervention is known as its “impact,” and measuring this difference and is commonly referred to as “**impact evaluation**.”

Did you know?

Evaluation is fundamentally an exercise to help decision-makers understand how, and to what extent, a program is responsible for particular, measured results.



A graphic illustration of program impact would look like this.

Evaluations require:

- ▲ data collection at the start of a program (to provide a baseline) and again at the end, rather than at repeated intervals during program implementation;
- ▲ a control or comparison group in order to measure whether the changes in outcomes can be attributed to the program; and
- ▲ a well-planned study design.

Check to see if you know whether the following situations call for “monitoring” or “evaluation.”

- ▲ The National Council of Population and Development wants to know if the programs being carried out in province A are reducing unintended pregnancy among adolescents in that province.
- ▲ USAID wants to know how many sex workers have been reached by your program this year.
- ▲ A country director is interested in finding out if the post-abortion care provided in public clinics meets national standards of quality.

Go to the next page for the answers.

MONITORING OR EVALUATION?

Here are the answers:

- ▲ The National Council of Population and Development wants to know if the programs being carried out in province A are reducing unintended pregnancy among adolescents in that province.

*This is **evaluation** because it is concerned with the impact of particular programs.*

- ▲ USAID wants to know how many sex workers have been reached by your program this year.

*This is **monitoring** because it is concerned with counting the number of something (sex workers reached).*

- ▲ A country director is interested in finding out if the post-abortion care provided in public clinics meets national standards of quality.

*This is **monitoring** because it requires tracking something (quality of care).*

WHY IS M&E IMPORTANT?

Highlights

Examples of questions M&E can answer:

- ◆ Was the program implemented as planned?
- ◆ Did the target population benefit from the program, and at what cost?
- ◆ Can improved health outcomes be attributed to program efforts?
- ◆ Which program activities were more effective, and which were less effective?

Monitoring and evaluation helps program implementers:

- ▲ make informed decisions regarding program operations and service delivery based on objective evidence;
- ▲ ensure the most effective and efficient use of resources;
- ▲ objectively assess the extent to which the program is having or has had the desired impact, in what areas it is effective, and where corrections need to be considered; and
- ▲ meet organizational reporting and other requirements, and convince donors that their investments have been worthwhile or that alternative approaches should be considered.

M&E is a continuous process that occurs throughout the life of a program.

To be most effective, M&E should be planned at the design stage of a program, with the time, money and personnel that will be required calculated and allocated in advance.

Monitoring should be conducted at every stage of the program, with data collected, analyzed and used on a continuous basis.

Evaluations are usually conducted at the end of programs. However, they should be planned for at the start because they rely on data collected throughout the program, with baseline data being especially important.

WHEN SHOULD M&E TAKE PLACE?

Did you know?

One rule of thumb is that 5-10% of a project budget should be allocated for M&E.

KNOWLEDGE RECAP

Answer the following questions to see how much you know about this topic. Go to page 10 to see the correct answers.

1. Monitoring is sometimes referred to as:

- ☐ a. Evaluation
- ☐ b. Impact Evaluation
- ☐ c. Process Evaluation
- ☐ d. Performance Evaluation

2. Evaluations measure:

- ☐ a. The timeliness of a program's activities
- ☐ b. The outcomes and impact of a program's activities
- ☐ c. How closely a program kept to its budget
- ☐ d. How well the program was implemented

3. At what stage of a program should monitoring take place?

- ☐ a. At the beginning of the program
- ☐ b. At the mid-point of the program
- ☐ c. At the end of the program
- ☐ d. Throughout the life of the program

4. As a general guide, what percentage of a program's budget should go toward M&E?

- ☐ a. 1-2%
- ☐ b. 5-10%
- ☐ c. 20-25%
- ☐ d. 70-80%

5. Which of the following is NOT considered "monitoring"?

- ☐ a. Counting the number of people trained
- ☐ b. Tracking the number of brochures disseminated
- ☐ c. Attributing changes in health outcomes to an intervention
- ☐ d. Collecting monthly data on clients served in a clinic.

KNOWLEDGE RECAP: ANSWERS

The correct answers are as follows:

1. Monitoring is sometimes referred to as:

c. Process Evaluation

Monitoring is sometimes referred to as process evaluation because it focuses on the implementation process of a project.

2. Evaluations measure:

b. The outcomes and impact of a program's activities

Evaluation measures the extent to which the changes that are monitored are attributable to the program; in other words, evaluation measures the impact of a program.

3. At what stage of a program should monitoring take place?

d. Throughout the life of the program

Monitoring should be conducted at every stage of the program, with data collected, analyzed and used on a continuous basis.

4. As a general guide, what percentage of a program's budget should go toward M&E?

b. 5-10%

As a general guide, 5-10% of a project budget should be allocated for M&E.

5. Which of the following is NOT considered "monitoring"?

c. Attributing changes in health outcomes to an intervention

Monitoring usually pertains to counting, tracking and collecting. Attributing changes to an intervention is usually a function of evaluation.

THE M&E PLAN

Every project or intervention should have a **monitoring and evaluation (M&E) plan**. This is the fundamental document that details a program's objectives, the interventions developed to achieve these objectives and describes the procedures that will be implemented to determine whether or not the objectives are met. It shows how the expected results of a program relate to its goals and objectives, describes the data needed and how these data will be collected and analyzed, how this information will be used, the resources that will be needed, and how the program will be accountable to stakeholders.

M&E plans should be created during the design phase of a program and can be organized in a variety of ways. Typically, they include:

- ▲ the **underlying assumptions** on which the achievement of program goals depend;
- ▲ the **anticipated relationships** between activities, outputs, and outcomes;
- ▲ well-defined conceptual **measures and definitions**, along with baseline values;
- ▲ the **monitoring schedule**;
- ▲ a list of **data sources** to be used;
- ▲ **cost estimates** for the M&E activities;
- ▲ a list of the **partnerships and collaborations** that will help achieve the desired results; and
- ▲ a plan for the **dissemination and utilization** of the information gained.

M&E plans:

- ▲ state how a program will measure its achievements and therefore provide accountability;
- ▲ document consensus and provide transparency;
- ▲ guide the implementation of M&E activities in a standardized and coordinated way; and
- ▲ preserve institutional memory.

Highlights

An M&E plan should be considered a living document and revised whenever a program is modified or new information is needed.

WHY ARE M&E PLANS IMPORTANT?

M&E PLAN COMPONENTS

Typically, the components of an M&E plan include:

- ▲ introduction
- ▲ program description and **framework**
- ▲ detailed description of the plan **indicators**
- ▲ data collection plan
- ▲ plan for monitoring
- ▲ plan for evaluation
- ▲ plan for the utilization of the information gained
- ▲ mechanism for updating the plan

M&E PLAN COMPONENTS: INTRODUCTION

The introduction to the M&E plan should include:

- ▲ information about the purpose of the program, the specific M&E activities that are needed and why they are important; and
- ▲ a development history that provides information about the motivations of the internal and external stakeholders and the extent of their interest, commitment and participation.

M&E PLAN COMPONENTS: PROGRAM DESCRIPTION AND FRAMEWORKS

The program description should include:

- ▲ a **problem statement** that identifies the specific problem to be addressed. This concise statement provides information about the situation that needs changing, who it affects, its causes, its magnitude and its impact on society;
- ▲ the program goal and objectives:
 - a program's **goal** is a broad statement about the desired long-term outcome of the program. For example, improvement in the reproductive health of adolescents or a reduction in unwanted pregnancies in X population would be goals
 - **objectives** are statements of desired specific and measurable program

results. Examples of objectives would be to reduce the total fertility rate to 4.0 births by year X or to increase contraceptive prevalence over the life of the program;

- ▲ descriptions of the specific interventions to be implemented and their duration, geographic scope and target population;
- ▲ the list of resources needed, including financial, human, and those related to the infrastructure (office space, equipment and supplies);
- ▲ the **conceptual framework**, which is a graphical depiction of the factors thought to influence the problem of interest and how these factors relate to each other; and
- ▲ the **logical framework** or **results framework** that links the goal and objectives to the interventions.

We will discuss frameworks in more detail in the next section of this course, which begins on page 23.

The objectives listed in the program description should be “SMART,” an acronym that stands for:

Specific: Is the desired outcome clearly specified?

Measurable: Can the achievement of the objective be quantified and measured?

Appropriate: Is the objective appropriately related to the program’s goal?

Realistic: Can the objective realistically be achieved with the available resources?

Timely: In what time period will the objective be achieved?

Here is a sample objective. Do you think it is SMART (i.e., meets all of the criteria above)?

Increase contraceptive prevalence by 15% in women 30-49 years of age

Go to the next page for the answer.

PROGRAM DESCRIPTION: SMART OBJECTIVES

Is this objective SMART?

Increase contraceptive prevalence by 15% in women 30-49 years of age

Specific: Yes, the intended outcome of the program is specified.

Measurable: Yes, contraceptive prevalence is measurable.

Appropriate: Unknown, because the program's goal would need to be provided in order to know whether the objective relates logically to it.

Realistic: Unknown, because the resources available to the program would need to be known.

Timely: No, the time within which the objective is to be achieved is not specified.

So this objective is not known to be “SMART” because, although it meets some of the criteria, it does not meet them all.

M&E PLAN COMPONENTS: INDICATORS

Highlights

Examples of indicators include:

- ◆ The number of health workers trained in IUD insertion in the past 12 months
- ◆ Percentage of women of reproductive age who are using a contraceptive method at a particular point in time
- ◆ The number of maternal deaths per 100,000 live births in a specified period

Indicators are clues, signs or markers that measure one aspect of a program and show how close a program is to its desired path and outcomes. They are used to provide benchmarks for demonstrating the achievements of a program.

One of the most critical steps in designing an M&E system is selecting appropriate indicators. The M&E plan should include descriptions of the indicators that will be used to monitor program implementation and achievement of the goals and objectives.

We will discuss the selection and use of indicators later in this course, beginning on page 35.

Data sources are sources of information used to collect the data needed to calculate the indicators.

The data collection plan should include diagrams depicting the systems used for data collection, processing, analysis and reporting. The strength of these systems determines the validity of the information obtained.

Potential errors in data collection, or in the data themselves, must be carefully considered when determining the usefulness of data sources. We will discuss data sources, data collection and data quality later in this course, beginning on page 51.

M&E PLAN COMPONENTS: DATA SOURCES AND DATA COLLECTION PLAN

Highlights

Examples of data sources include:

- ◆ Birth registers
- ◆ Sentinel or demographic surveillance
- ◆ Censuses
- ◆ Focus groups
- ◆ Household surveys

The monitoring plan describes:

- ▲ specific program components that will be monitored, such as provider performance or the utilization of resources;
- ▲ how this monitoring will be conducted; and
- ▲ the indicators that will be used to measure results.

Because monitoring is concerned with the status of ongoing activities, output indicators, also known as process indicators, are used. For example, these indicators might be the following:

- ▲ *How many children visit a child health clinic in one month?*

and

- ▲ *How many of these children are vaccinated during these visits?*

M&E PLAN COMPONENTS: MONITORING PLAN

M&E PLAN COMPONENTS: EVALUATION PLAN

The evaluation plan provides the specific research design and methodological approaches to be used to identify whether changes in outcomes can be attributed to the program.

For instance, if a program wants to test whether quality of patient care can be improved by training providers, the evaluation plan would identify a research design that could be used to measure the impact of such an intervention.

One way this could be investigated would be through a quasi-experimental design in which providers in one facility are given a pretest, followed by the training and a posttest. For comparison purposes, a similar group of providers from another facility would be given the same pretest and posttest, without the intervening training. Then the test results would be compared to determine the impact of the training.

M&E PLAN COMPONENTS: INFORMATION DISSEMINATION AND USE

How the information gathered will be stored, disseminated and used should be defined at the planning stage of the project and described in the M&E plan. This will help ensure that findings from M&E efforts are not wasted because they are not shared.

The various users of this information should be clearly defined, and the reports should be written with specific audiences in mind.

Dissemination channels can include written reports, press releases and stories in the mass media, and speaking events.

M&E PLAN COMPONENTS: IMPLEMENTATION AND MECHANISM FOR UPDATE

The capacities needed to implement the efforts described in the M&E plan should be included in the document.

A mechanism for reviewing and updating the M&E plan should also be included. This is because changes in the program can and will affect the original plans for both monitoring and evaluation.

STANDARDS FOR M&E PLANS

M&E plans should serve the information needs of the intended users in practical ways. These users can range from those assessing national program performance at the highest central levels to those allocating resources at the district or local level.

M&E plans should convey technically accurate information and should be realistic, prudent, diplomatic and frugal.

The activities described in M&E plans should be conducted legally, ethically, and with regard to those involved in and affected by them.

Answer the following questions to see how much you know about M&E plans. Go to page 21 to see correct answers.

1. M&E plans should include:
 - ☐ a. A detailed description of the indicators to be used
 - ☐ b. The data collection plan
 - ☐ c. A plan for the utilization of the information gained
 - ☐ d. All of the above
 - ☐ e. a and b only

2. The purpose of indicators is to:
 - ☐ a. Demonstrate the strength of the information system
 - ☐ b. Serve as benchmarks for demonstrating achievements
 - ☐ c. Provide program accountability
 - ☐ d. Describe the objectives of a project

3. The problem statement and goals and objectives of a project should be described in the M&E plan.
 - ☐ True
 - ☐ False

4. The results of M&E activities can be disseminated through:
- ☐ a. Written reports
 - ☐ b. Press releases
 - ☐ c. The mass media
 - ☐ d. Speaking events
 - ☐ e. All of the above
5. When should the M&E plan be created?
- ☐ a. During the design phase of a program
 - ☐ b. At the midpoint of the program
 - ☐ c. At the end of the program
 - ☐ d. After all of the data have been collected but before they are analyzed

The correct answers are as follows:

1. M&E plans should include:

- d. All of the above** (a detailed description of the indicators to be used, the data collection plan, and a plan for the utilization of the information gained)

Typically, the components of an M&E plan include the introduction, the program description and framework, a detailed description of the plan indicators, the data collection plan, a plan for monitoring, a plan for evaluation, a plan for the utilization of the information gained and a mechanism for updating the plan.

2. The purpose of indicators is to:

- b. Serve as benchmarks for demonstrating achievements**

Indicators provide benchmarks for demonstrating the achievements of a program.

3. The problem statement and goals and objectives of a project should be described in the M&E plan.

True

The M&E plan should include a problem statement that identifies the specific problem to be addressed, the goal that describes the desired long-term outcome of the program, and the objectives that describe the desired specific, measurable program results.

4. The results of M&E activities can be disseminated through:

- e. **All of the above** (written reports, press releases, the mass media, and speaking events)

Dissemination channels can include written reports, press releases and stories in the mass media, and speaking events.

5. When should the M&E plan be created?

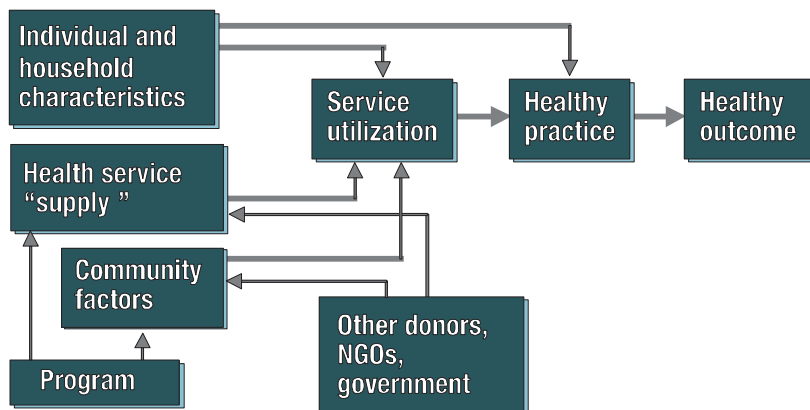
- a. **During the design phase of a program**

M&E plans should be created during the design phase of a program.

Frameworks are key elements of M&E plans that depict the components of a project and the sequence of steps needed to achieve the desired outcomes. They help increase understanding of the program's goals and objectives, define the relationships between factors key to implementation, and delineate the internal and external elements that could affect its success. They are crucial for understanding and analyzing how a program is supposed to work.

There is no one perfect framework and no single framework is appropriate for all situations, but three common types will be discussed here:

- ▲ **conceptual framework**
- ▲ **results framework**
- ▲ **logic model**



A **conceptual framework**, sometimes called a “research framework,” is useful for identifying and illustrating the factors and relationships that influence the outcome of a program or intervention.

Conceptual frameworks are typically shown as diagrams illustrating causal linkages between the key components of a program and the outcomes of interest. For instance, in this example (shown above), the program, in addition to other donors, is supplying health services, in order to increase service utilization, with the ultimate outcome of improved health.

WHAT ARE FRAMEWORKS?

Did You Know?

A fourth common type of framework, not discussed in this course, is a logical framework, a diagram or matrix that illustrates the linear relationships between key program inputs, activities, immediate results/outputs and desired outcomes.

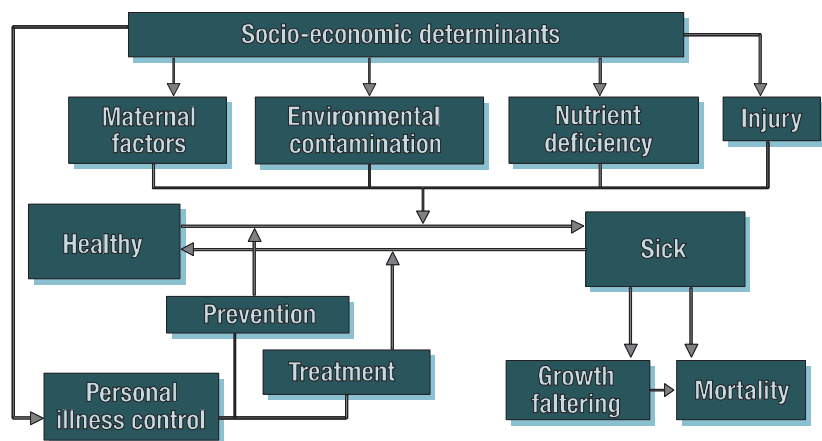
CONCEPTUAL FRAMEWORKS

By identifying the variables that factor into program performance and depicting the ways that they interact, the results that can reasonably be expected from program activities are outlined. Clarifying this process permits program designers to develop valid measures for evaluating the success of the outcomes and also guides the identification of appropriate indicators.

We will discuss the selection and use of indicators in the next section of this course, beginning on page 35.

Highlights

There is no standard format for conceptual frameworks, but the two examples shown here are typical.

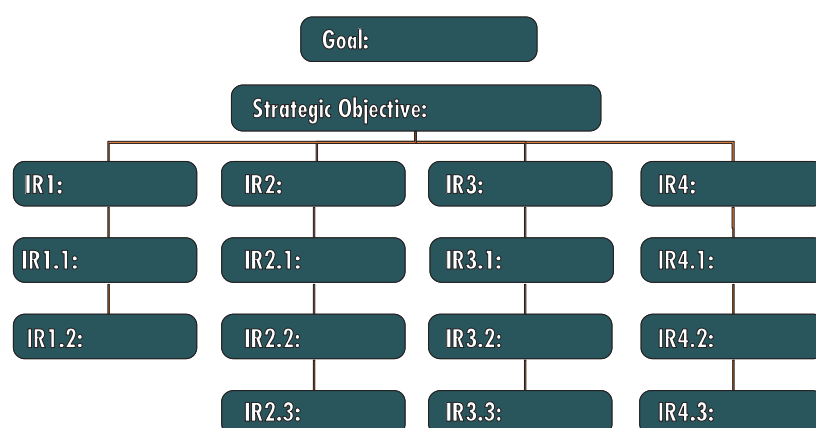


Source: Mosley & Chen, 1984

Another example of a conceptual framework, the Mosley-Chen Framework, is commonly used in the study of child survival. In this framework, socio-economic determinants act through the following five “proximate” or biological determinants to impact child health.

- ▲ maternal factors (age, parity, birth interval)
- ▲ environmental contamination (air, food, water, soil, insect vectors)
- ▲ nutrient deficiency (calories, proteins, vitamins, minerals)
- ▲ injury (accidental or intentional)
- ▲ personal illness control (preventive measures and medical treatment)

RESULTS FRAMEWORKS



Results frameworks, sometimes called “strategic frameworks,” diagram the direct causal relationships between the incremental results of the key activities all the way up to the overall objective and goal of the intervention. This clarifies the points in an intervention at which results can be monitored and evaluated.

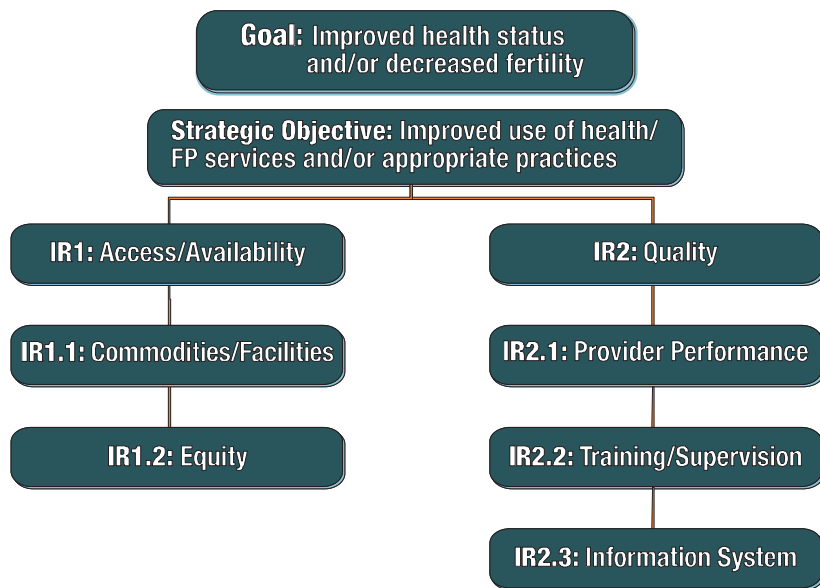
As can be seen in this example, results frameworks include an overall goal, a **strategic objective (SO)** and **intermediate results (IRs)**.

- ▲ An SO is an outcome that is the most ambitious result that can be achieved and for which the organization is willing to be held responsible.
- ▲ An IR is a discrete result or outcome that is necessary to achieve an SO.

Notice that the goal and strategic objective appear at the top of the framework. Before achieving this broader strategic objective, a set of “lower level” intermediate results must first be reached. Under each IR are subordinate intermediate results, or sub-IRs that relate directly to the intermediate results. For example, under IR1, you will see IR1.1 and IR 1.2. IR1.1 and IR 1.2 are sub-IRs.

Did You Know?

Results frameworks are the type of framework used by USAID in what is called Performance Monitoring Plans, or PMPs.



Source: Marsh, 1999

Did You Know?

Please note that actual frameworks contain more information than appears here in these abbreviated examples.

Here is a portion of the same results framework with the information filled in. For example, as you can see under IR2, the information system, training and supervision of clinicians, and provider performance are factors that lead to improved quality of health services.

Notice that IRs and sub-IRs need to be measurable; in other words, indicators can be developed for them and data can be collected to calculate them.

LOGIC MODELS

A **logic model**, sometimes called an “M&E framework,” provides a streamlined linear interpretation of a project’s planned use of resources and its desired ends.

Logic models have five essential components:

inputs – the resources invested in a program, for example, technical assistance, computers, condoms or training;

processes – the activities carried out to achieve the program’s objectives;

outputs – the immediate results achieved at the program level through the execution of activities;

outcomes – the set of short-term or intermediate results at the population level achieved by the program through the execution of activities; and

impacts – the long-term effects, or end results, of the program, for example, changes in health status (in this context, the term “impact” refers to the health status or conditions that the program is intended ultimately to influence [mortality, morbidity, fertility, etc.], as measured by appropriate **indicators**; measuring “impact” in this way, however, should be distinguished from **impact evaluation**, which is a specific type of evaluation activity that focuses on examining how much of an observed change in outcomes or “impact” can be attributed to the program).

In other words, inputs (or resources) are used in processes (or activities) which produce immediate intermediate results (or outputs), ultimately leading to longer-term or broader results (or outcomes) and impacts.

The example above presents a straightforward view of a project designed to reduce population morbidity by increasing the number of clients served by trained health-care providers. As you can see, it does not try to account for all factors that may be influencing operations and results as a conceptual framework would, but instead focuses specifically on the project’s activities and impacts. This narrow focus assists program managers and M&E planners as they clarify the direct relationships between elements of particular interest within a particular program effort.

INPUT

Develop clinical training curriculum

PROCESS

Conduct training events

OUTPUT

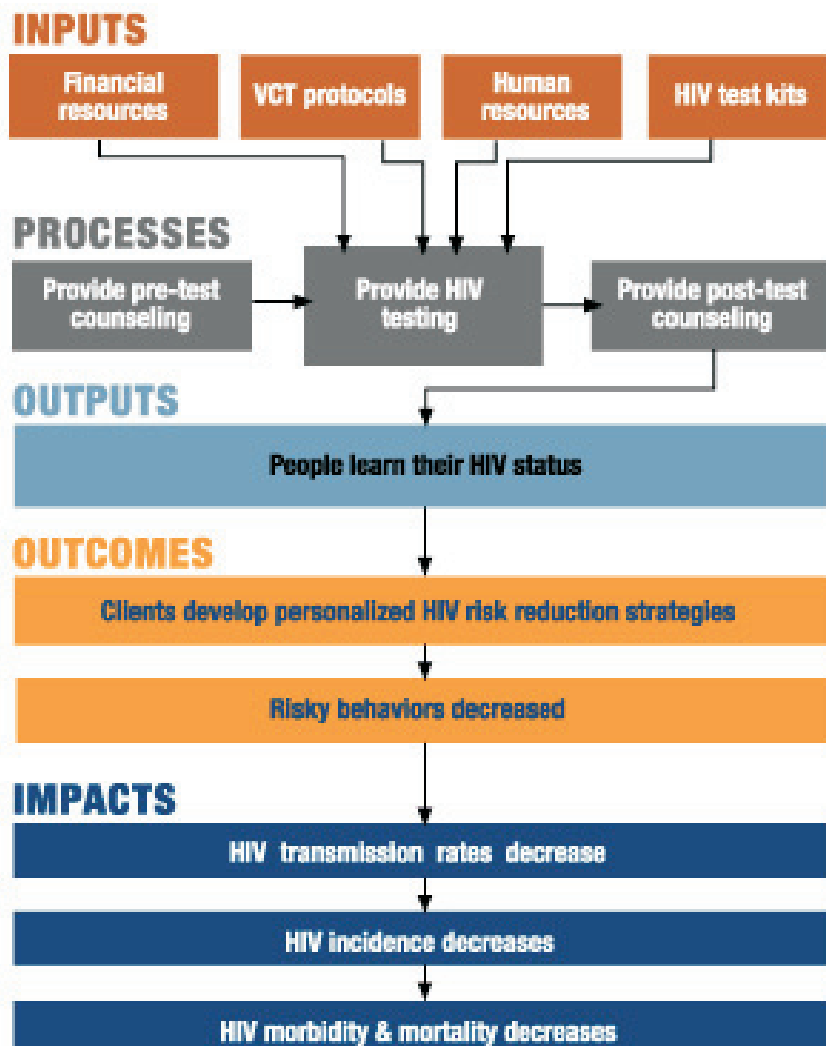
Practitioners trained in new clinical techniques

OUTCOME

Increase in clients served by (newly) trained providers

IMPACT

Declining morbidity levels in target population



This is a small portion from a logic model for an HIV voluntary counseling and testing (VCT) program.

It is important to remember that, within a program, several activities can have their own inputs and outputs. Collectively the outputs of the activities contribute to the program outcomes and impacts.

In some cases the output of one program activity could be an input for another activity. For example, if an activity is to develop guidelines, the output of that activity is the guidelines, which can then be an input (VCT protocols) in this overall logic model for VCT-service delivery.

SUMMARY OF FRAMEWORKS

Using frameworks is one way to develop a clearer understanding of the goals and objectives of a project, with an emphasis on identifying measurable objectives, both short-term and long-term.

Frameworks, such as the three types discussed in this course, also help define the relationships between factors key to the implementation and success of a project, both internal and external to the program context. This design process deepens the understanding of managers, implementers, and other partners in many practical ways, including serving as the foundation for selecting appropriate, useful M&E indicators.

Type of Framework and Brief Description	Program Management	Basis for Monitoring and Evaluation?
Conceptual- Interaction of various factors	Determines which factors the program will influence	No. Can help to explain results.
Results- Logically linked program objectives	Shows the causal relationship between program objectives	Yes – at the objective level
Logic model- Logically linked inputs, processes, outputs, and outcomes	Shows the causal relationship between inputs and the objectives	Yes – at all stages of the program from inputs to process to outputs to outcomes/objectives

Highlights

USAID-funded programs tend to use results frameworks, but many other donors, such as the UK Department for International Development (DFID) and the United Nations, use other types of frameworks.

The **conceptual framework** places the health problem in a wider context, one that considers the various factors that can affect the program or intervention, clarifies the causal relationships between these factors and identifies those that the intervention may affect. It is used for program design rather than for program M&E.

Results frameworks show the causal relationships between the various intermediate results that are critical to achieving the strategic objective. The effectiveness of these activities can be measured at each step along the way.

Logic models help to show the logical connections between the inputs, processes and outputs of an activity, and how they link to the program's objectives (outcomes) and goals (impacts). They also clarify the linear relationships between program decisions, activities and products.

Programs should use the types of frameworks that best suit their needs.

KNOWLEDGE RECAP

Answer the following questions to see how much you know about frameworks. Go to page 32 to see the correct answers.

1. Frameworks can:
 - ☐ a. Help increase understanding of a project's goals and objectives
 - ☐ b. Define the relationships between factors key to project implementation
 - ☐ c. Delineate the internal and external elements that could affect a project's success
 - ☐ d. All of the above
 - ☐ e. b and c only

2. The five key components of logic models are:
 - ☐ a. Inputs, processes, outputs, outcomes, impacts
 - ☐ b. Conceptual, results, logical, logframe, logic
 - ☐ c. Conceptual, indicators, outputs, outcomes, impacts
 - ☐ d. Indicators, inputs, processes, outputs, results

3. Conceptual frameworks are useful for identifying the factors that influence the outcome of programs.

- ☐ True
- ☐ False

4. Frameworks that diagram the direct causal relationships between the incremental results of key project activities and the overall objective and goal of the intervention are called:

- ☐ a. Conceptual frameworks
- ☐ b. Results frameworks
- ☐ c. Logic models
- ☐ d. All of the above

5. In some cases, the output of one activity depicted in a logic model could be an input for another activity.

- ☐ True
- ☐ False?

KNOWLEDGE RECAP: ANSWERS

The correct answers are as follows:

1. Frameworks can:

d. All of the above

Frameworks help increase understanding of a project's goals and objectives, define the relationships between factors key to project implementation and delineate the internal and external elements that could affect a project's success.

2. The five key components of logic models are:

a. Inputs, processes, outputs, outcomes, impacts

Logic models have five essential components: inputs, processes, outputs, outcomes and impacts.

3. Conceptual frameworks are useful for identifying the factors that influence the outcome of programs.

True

Conceptual frameworks are useful for identifying and illustrating the factors and relationships that influence the outcome of a program or intervention.

4. Frameworks that diagram the direct causal relationships between the incremental results of key project activities and the overall objective and goal of the intervention are called:

d. Results frameworks

Results frameworks diagram the direct causal relationships between the incremental results of key project activities all the way up to the overall objective and goal of the intervention.

5. In some cases, the output of one activity depicted in a logic model could be an input for another activity.

True

In some cases, the output of one program activity depicted in a logic model could be an input for another activity. For example, if an activity is to develop guidelines, the output of that activity is the guidelines, which can then be an input for a service delivery intervention that uses those guidelines.

An indicator is a *variable* that *measures one aspect* of a program or project that is directly related to the program's objectives.

Let's take a moment to go over each piece of this definition.

An indicator is a *variable* whose value changes from the baseline level at the time the program began to a new value after the program and its activities have made their impact felt. At that point, the variable, or indicator, is calculated again.

Secondly, an indicator is a *measurement*. It measures the value of the change in meaningful units that can be compared to past and future units. This is usually expressed as a percentage or a number.

Finally, an indicator focuses on a *single aspect* of a program or project. This aspect may be an input, an output or an overarching objective, but it should be narrowly defined in a way that captures this one aspect as precisely as possible.

A reasonable guideline recommends one or two indicators per result, at least one indicator for each activity, but no more than 10-15 indicators per area of significant program focus.

WHAT IS AN INDICATOR?

Highlights

Examples of indicators include:

- ◆ Percentage of clinic personnel who have completed a particular training workshop
- ◆ Number of radio programs about family planning aired in the past year
- ◆ Percentage of clinics that experienced a stockout of condoms at any point during a given time period

Did You Know?

A full, complete, and appropriate set of indicators for a given project or program should include at least one indicator for each significant aspect of the program's activities.

QUANTITATIVE AND QUALITATIVE INDICATORS

Indicators can be either be quantitative or qualitative.

Quantitative indicators are numeric and are presented as numbers or percentages.

Qualitative indicators are descriptive observations and can be used to supplement the numbers and percentages provided by quantitative indicators. They complement quantitative indicators by adding a richness of information about the context in which the program has been operating. Examples include “availability of a clear, strategic organizational mission statement” and “existence of a multi-year procurement plan for each product offered.”

WHY ARE INDICATORS IMPORTANT?

Indicators provide M&E information crucial for decision-making at every level and stage of program implementation.

- ▲ Indicators of program **inputs** measure the specific resources that go into carrying out a project or program (for example, *amount of funds allocated to the health sector annually*).
- ▲ Indicators of **outputs** measure the immediate results obtained by the program (for example, *number of multivitamins distributed or number of staff trained*).
- ▲ Indicators of **outcomes** measure whether the outcome changed in the desired direction and whether this change signifies program “success” (for example, *contraceptive prevalence rate or percentage of children 12-23 months who received DTP3 immunization by 12 months of age*).

WHAT IS A METRIC?

Highlights

Defining good metrics is crucial to the usefulness of any M&E plan because it clarifies the single dimension of the result that is being measured by the indicator.

An important part of what comprises an indicator is the **metric**, the precise calculation or formula on which the indicator is based. Calculation of the metric establishes the indicator’s objective value at a point in time. Even if the factor itself is subjective or qualitative, like the attitudes of a target population, the indicator metric calculates its value at a given time objectively.

For example, an indicator might measure the percentage of urban facilities that score 85-100% on a quality of care checklist. Note that because this indicator calls for a percentage, a fraction is required to calculate it. Possible metrics for this indicator are:

- ▲ numerator, or top number of the fraction: number of urban facilities scoring 85-100% on a *quality of*

care checklist; and

- ▲ denominator, or bottom number of the fraction:
total number of urban facilities checked and scored.

In many cases, indicators need to be accompanied by clarifications of the terms used. For instance, let's look at the indicator: *number of antenatal care (ANC) providers trained.*

If such an indicator were used by a program, definitions would need to be included. For example, *providers* would need to be defined, perhaps as *any clinician providing direct clinical services to clients seeking ANC at a public health facility.* For the purposes of this indicator then, *providers* would not include clinicians working in private facilities.

Trained would also need to be defined, perhaps as *those staff who attended every day of a five-day training course and passed the final exam with a score of at least 85%.*

Another indicator for this program could be percentage of facilities with a provider trained in ANC.

In this example, because the indicator is a proportion or fraction, a numerator and a denominator are needed to calculate it.

- ▲ The numerator would be the number of public facilities with a provider who attended the full five days of the ANC training and scored at least 85% on the final exam. Note that the numerator must still specify that the facilities are public and that the providers must have attended all five days and passed the exam in order to be counted. This information need not be included in the indicator itself as long as it is in the definitions that accompany it.
- ▲ The denominator would be the total number of public facilities offering ANC services. This requires that this number be obtainable. If it is not known and it is not possible to gather such information, this percentage cannot be calculated.

In this example, it is also necessary to know at which facility each trained provider works. This information could be obtained at the time of the training. If it is not, all facilities would have to be asked if they have any providers who attended the training.

CLARIFYING INDICATORS

You Decide ...

To calculate the indicator in this example, let's say there were 100 public facilities with an ANC provider who completed the five-day training and scored at least 85% on the exam out of 500 facilities total. What would the indicator show?

ANSWER: The indicator would be 100 facilities with a trained provider/500 facilities total, which means 1/5 or 20% of public facilities have a provider trained in ANC.

CHARACTERISTICS OF INDICATORS

A good indicator should:

- ▲ produce the same results when used repeatedly to measure the same condition or event;
- ▲ measure only the condition or event it is intended to measure;
- ▲ reflect changes in the state or condition over time;
- ▲ represent reasonable measurement costs; and
- ▲ be defined in clear and unambiguous terms.

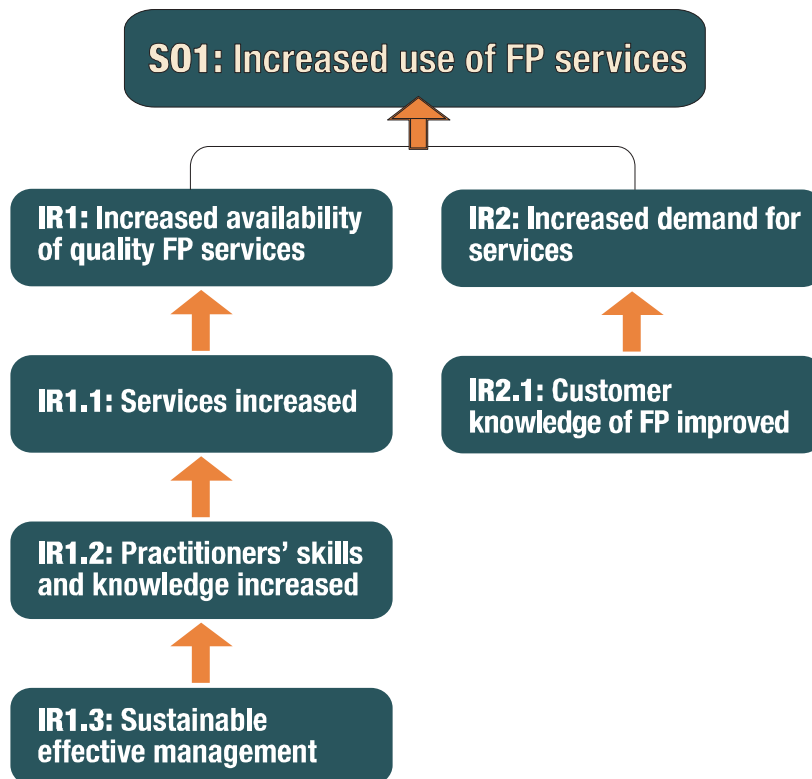
Indicators should be consistent with international standards and other reporting requirements. Examples of internationally recognized standardized indicators include those developed by UNAIDS and those included in the UNDP Millennium Development Goals.*

Indicators should be **independent**, meaning that they are non-directional and can vary in any direction. For instance, an indicator should measure the number of clients receiving counseling rather than an increase in the number of clients receiving counseling. Similarly, the contraceptive prevalence rate should be measured, rather than the decrease in contraceptive prevalence.

Indicator values should be easy to interpret and explain, **timely**, **precise**, **valid** and **reliable**. They should also be **comparable** across relevant population groups, geography, and other program factors.

* The Joint United Nations Programme on HIV/AIDS (UNAIDS) guidelines on core indicators may be obtained at:
http://data.unaids.org/publications/irc-pub06/jc1126-constrcoreindic-ungass_en.pdf

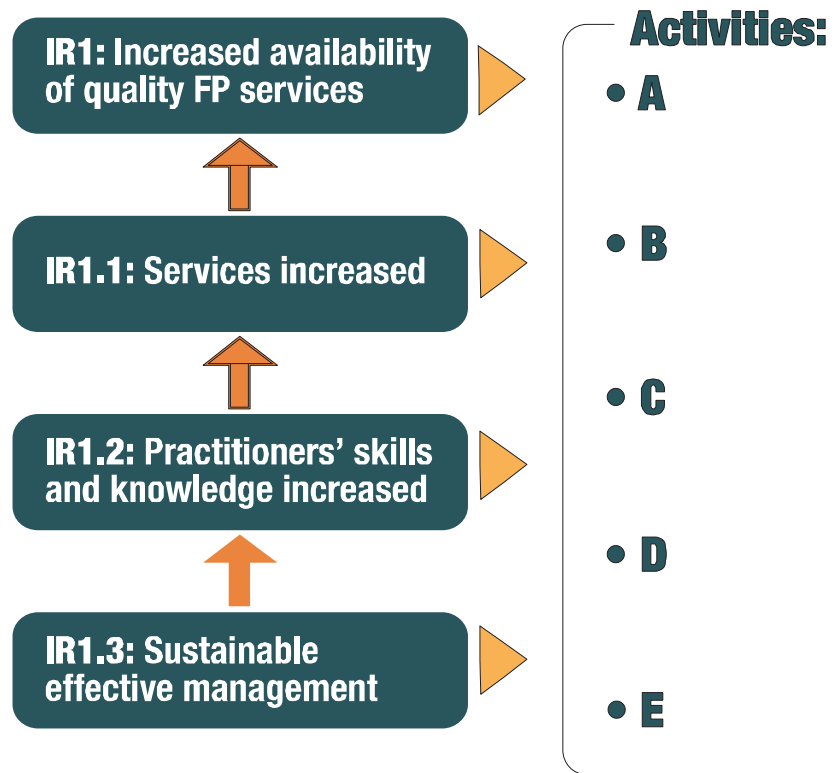
The United Nations Development Programme (UNDP) Millennium Development Goals may be obtained at:
<http://mdgs.un.org/unsd/mdg/default.aspx>



Let's use this generic results framework for a family-planning program to demonstrate how indicators are linked to frameworks.

For this program, the strategic objective (SO) is to increase the use of family-planning services. There are two intermediate results (IRs) feeding into this objective.

- ▲ Under the IR of increasing availability of quality services, there are three sub-intermediate results (sub-IRs): services increased, practitioners' skills and knowledge increased, and sustainable effective management.
- ▲ Under the other IR (increasing demand for services), the only sub-IR listed is to improve customer knowledge of family planning.



In order to develop indicators for this framework, the activities to be undertaken by the program must first be recognized.

This portion of the results framework shows what activities are planned in order for the program to achieve IR1 and its sub-IRs. These activities are:

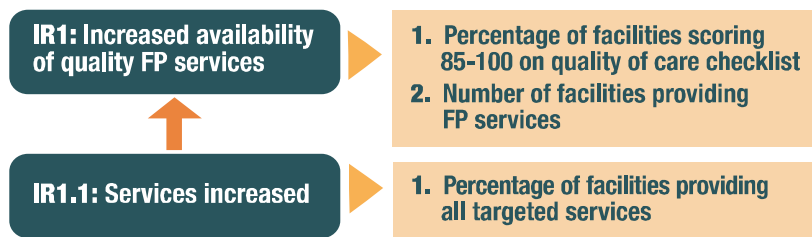
A. Provision of support and supplies to community-based distributors

B. Expanding family-planning services to additional clinics

C. Clinical training for providers

D. The development of a checklist to monitor the quality of care

E. Management training for supervisors



Note that some of these activities can affect several of the sub-IRs.

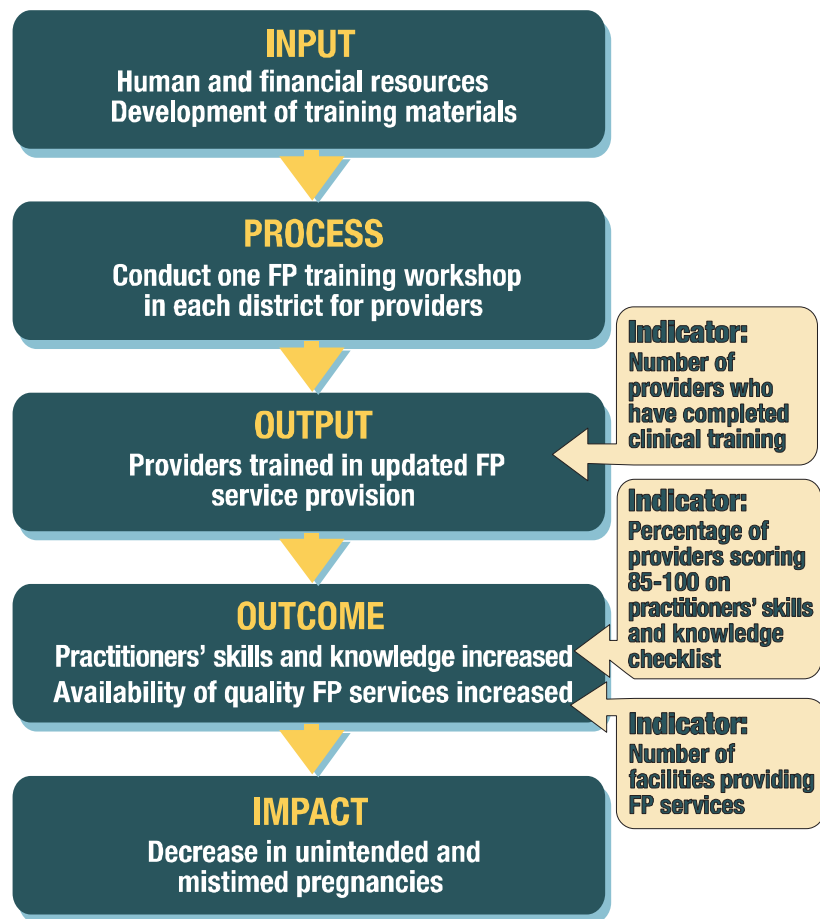
Next, indicators that measure these activities would be identified. Here you can see the indicators that are linked to the IR and sub-IR1. Other indicators would be linked to the other sub-IRs.

Although it is important to avoid assigning so many indicators that their measurement becomes unachievable, it is risky to rely on a single indicator to measure the significant effects of a project. If the data for that one indicator became unavailable for some reason, it would be difficult to document a significant impact on that result. Therefore, some diversification of indicators tends to strengthen M&E plans.

Did You Know?

Note that the indicators in these examples are not necessarily “perfect” indicators, just examples to suggest the connections between activities, results and possible indicators.

LINKING INDICATORS TO LOGIC MODELS



This example depicts how indicators are related to logic models. Here is a logic model for the same activity that was just depicted in the results framework.

Three indicators are linked with this activity:

- ▲ *Number of providers who have completed clinical training* is linked to the output of having trained providers. This indicator can provide information about whether the program is meeting its targets for training providers.
- ▲ *Percentage of providers scoring 85-100 on the practitioners' skills and knowledge checklist* relates to the intended outcome of improving the knowledge and skills of practitioners.
- ▲ *Number of facilities providing family planning services* links to the intended outcome of increasing the availability of services. The assumption is that increasing the skills and knowledge of more providers will result in more facilities being able to offer services.

We will now look at some common challenges to selecting indicators.

Choosing an indicator that the program activities cannot affect

For instance, imagine a program that planned to train health-care providers in AIDS prevention and treatment services in an effort to expand access to these services.

The authors of the M&E plan selected the UNAIDS indicator *the proportion of health-care facilities with adequate conditions to provide care*. However, many elements can affect this indicator, such as supervision, availability of supplies and equipment, and the drafting of appropriate treatment protocols. None of these factors would be addressed by the planned training program. In using this global indicator, the planners overlooked the fact that it did not accurately reflect their program activities.

Better indicators would be *the number of clinicians trained* or *the number of facilities with a trained provider*.

Choosing an indicator that is too vague

For example, imagine a radio campaign aimed at dispelling specific myths about HIV/AIDS transmission. Although the goal of the campaign is ultimately to increase knowledge about HIV/AIDS, the indicator *percentage of the population with knowledge about HIV/AIDS* does not specify the exact area of knowledge in question.

A better indicator would be one that measured precisely the objective of the campaign: *percentage of the population not believing myths X and Y about HIV/AIDS transmission*.

Selecting an indicator that relies on unavailable data

For instance, a program working on drug-supply issues selected an indicator that stated *percentage of days per quarter that service delivery points have stockouts of drugs*. However, information on stockouts may not be collected often enough to provide this information.

A better indicator would be *percentage of service delivery points that experienced a stockout of drugs at some time during the last quarter*.

Population-level data may also be unavailable or difficult to

collect. For example, baseline numbers for immunization coverage in a certain population may be unknown.

Selecting an indicator that does not accurately represent the desired outcome

For instance, if an IR states *expanded access to antiretroviral (ARV) treatment for pregnant women to prevent mother-to-child transmission (PMTCT) of HIV*, what would an appropriate indicator be?

Would the indicator *percentage of women on ARVs who are pregnant* be appropriate?

Answer:

No, this would not be an appropriate indicator because it tells us how many women are pregnant out of all women on ARVs, rather than how many HIV-positive pregnant women are on ARVs.

In other words, the numerator for this indicator is the number of women on ARVs who are pregnant and the denominator is the number of women who are on ARVs. Let's say that there were 100 pregnant women on ARVs and a total of 400 women on ARVs. The percentage would be $100/400$, which simplifies to $1/4$ or 25%.

If the denominator increased, that is, if more non-pregnant women received treatment for HIV but the number of pregnant women receiving treatment stayed the same, the indicator would decrease. For instance, if 1000 women were on ARVs, the percentage would become $100/1000$, which simplifies to $1/10$ or 10%. The indicator would reflect this change, but this change is irrelevant to the desired outcome of the program, which is increasing the number of pregnant women on ARVs.

Similarly, if the indicator increased, for instance if the percentage of women on ARVs who were pregnant out of all women on ARVs went from 25% to 50%, this may be because more pregnant women received ARV treatment (the desired outcome) but it also could be because fewer non-pregnant women were on ARVs, which would not be related to the desired outcome of the program. Because it is not clear which change occurred, this would not be a good indicator to use.

Let's try another example. Would the indicator *percentage of people on ARVs who are pregnant women* be appropriate?

Answer:

No, this also would not be an appropriate indicator.

Here the numerator is the number of pregnant women on ARVs (let's say it is 100 again), and the denominator is the total number of people on ARVs, including all men and women and children receiving treatment (let's say it's 5,000). In other words, this indicator would tell us, of all the people on ARVs, the percentage who are pregnant women is $100/5000$ or $1/50$ or 2%.

If this indicator increased over time, say from 2% to 20%, it could be because more pregnant women were receiving ARV treatment ($1000/5000$, the desired effect of the program) but it could also be because fewer people overall were receiving this treatment ($100/500$) and the number of pregnant women receiving treatment did not actually change.

Similarly, if the indicator decreased, it might be because more people overall were receiving treatment, because fewer women were HIV-positive or because there were fewer pregnant women. So the information provided by this indicator would be difficult or impossible to interpret accurately.

Let's try one more example: Would the indicator *percentage of HIV-positive pregnant women who are on ARVs* be appropriate?

Answer:

Yes, this indicator would provide the needed information.

Here the numerator is the number of HIV-positive pregnant women who are on ARVs, and the denominator is the total number of HIV-positive pregnant women.

With this indicator, interpretation is not complicated by factors unrelated to the IR, such as a decrease in HIV prevalence among pregnant women or the number of non-pregnant women receiving ARVs.

GUIDELINES FOR SELECTING INDICATORS

Some general guidelines for the selection of indicators are:

- ▲ Select indicators requiring data that can realistically be collected with the resources available.
- ▲ Select at least one or two indicators (ideally, from different data sources) per key activity or result.
- ▲ Select at least one indicator for each core activity (e.g., training event, social marketing message, etc.).
- ▲ Select no more than 8-10 indicators per area of significant program focus.
- ▲ Use a mix of data collection sources whenever possible. (We will discuss data sources in the next section of this course, beginning on page 45.)

KNOWLEDGE RECAP

Answer the following questions to see how much you know about indicators. Go to page 48 to see the correct answers.

1. The success of a program should be measured by a single indicator.
 - ☐ True
 - ☐ False

2. Indicators do NOT need to be directly related to the program's objectives.
 - ☐ True
 - ☐ False

3. Indicators should be vague so that people can interpret them to meet their own needs, making them more useful.
- ☐ True
 - ☐ False
4. Which of the following is a characteristic of a good indicator?
- ☐ a. It is clearly defined in unambiguous terms.
 - ☐ b. It produces the same results when used repeatedly to measure the same condition or event.
 - ☐ c. It measures only the condition or event it is intended to measure.
 - ☐ d. All of the above.
5. When selecting an indicator, care must be taken to ensure that it is one that program activities can affect.
- ☐ True
 - ☐ False

KNOWLEDGE RECAP: ANSWERS

The correct answers are as follows:

1. The success of a program should be measured by a single indicator.

False

A complete and appropriate set of indicators for a given project or program should include at least one indicator for each significant aspect of the program's activities.

2. Indicators do NOT need to be directly related to the program's objectives.

False

An indicator is a variable that measures one aspect of a program or project that is directly related to the program's objectives.

3. Indicators should be vague so that people can interpret them to meet their own needs, making them more useful.

False

A good indicator should be defined in clear and unambiguous terms.

4. Which of the following is a characteristic of a good indicator?

d. All of the above are characteristics of good indicators

A good indicator should produce the same results when used repeatedly to measure the same condition or event, measure only the condition or event it is intended to measure, reflect changes in the state or condition over time, represent reasonable measurement costs, and be defined in clear and unambiguous terms.

5. When selecting an indicator, care must be taken to ensure that it is one that program activities can affect.

True

When selecting an indicator, care must be taken to ensure that it is one program activities can affect.

Data sources are the resources used to obtain data for M&E activities. There are several levels from which data can come, including client, program, service environment, population, and geographic levels. Regardless of level, data are commonly divided into two general categories: routine and nonroutine.

Routine data sources provide data that are collected on a continuous basis, such as information that clinics collect on the patients utilizing their services. Although these data are collected continuously, processing them and reporting on them usually occur only periodically, for instance, aggregated monthly and reported quarterly.

- ▲ Data collection from routine sources is useful because it can provide information on a timely basis. For instance, it can be used effectively to detect and correct problems in service delivery.
- ▲ However, it can be difficult to obtain accurate estimates of catchment areas or target populations through this method, and the quality of the data may be poor because of inaccurate record keeping or incomplete reporting.

Nonroutine data sources provide data that are collected on a periodic basis, usually annually or less frequently.

- ▲ Depending on the source, nonroutine data can avoid the problem of incorrectly estimating the target population when calculating coverage indicators. This is particularly the case with representative population-based surveys, such as a Demographic Health Survey (DHS).
- ▲ Nonroutine data have two main limitations: collecting them is often expensive, and this collection is done on an irregular basis. In order to make informed program decisions, program managers usually need to receive data at more frequent intervals than nonroutine data can accommodate.

TYPES OF DATA SOURCES

Highlights

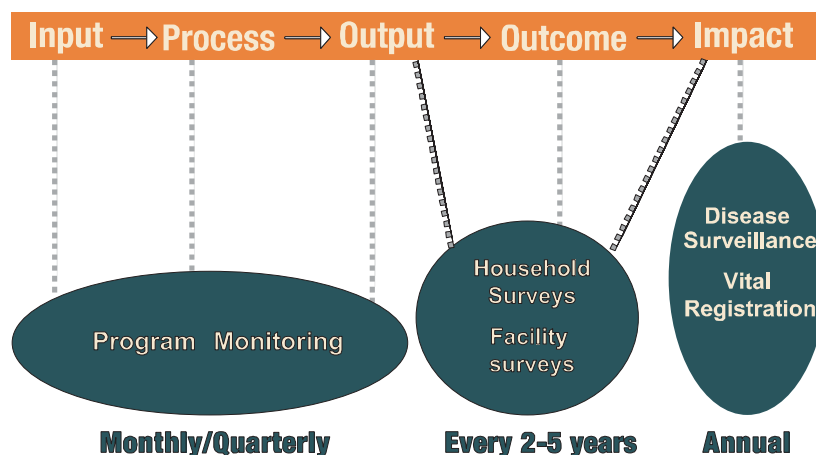
Examples of routine data sources:

- ◆ Vital registration records
- ◆ Clinic service statistics
- ◆ Demographic surveillance

Examples of non-routine data sources:

- ◆ Household surveys, such as DHS
- ◆ National censuses
- ◆ Facility surveys

DIFFERENT SOURCES, SAME INDICATORS



Data from different sources can be used to calculate the same indicator, although changes to the metric may be necessary. This illustration depicts one way that routine and nonroutine data can be used together to provide for an effective M&E system.

For example, when calculating the coverage rate for the first dose of a diphtheria-tetanus-pertussis (DTP) vaccine:

If *population-based survey* data are used, the definition could be *proportion of children age 12-23 months who were immunized with the first dose of DTP vaccine before age 12 months*.

- ▲ numerator: *Number of children age 12-23 months who were immunized with the first dose of DTP vaccine before age 12 months*
- ▲ denominator: *Total number of children age 12-23 months surveyed*

If a *routine data source* is used, such as service statistics (e.g. clinic records, outreach records, etc.), the definition could be *proportion of infants 0-11 months of age in a specified calendar year who were immunized with the first dose of DTP vaccine in that calendar year*.

- ▲ numerator: *Number immunized by age 12 months with the first dose of DTP vaccine in a given year*
- ▲ denominator: *Total number of surviving infants less than 12 months of age in the same year*

Highlights

Whenever several options for data sources exist, the advantages and disadvantages of each should be weighed when selecting which to use.

DATA COLLECTION

The M&E plan should include a data collection plan that summarizes information about the data sources needed to monitor and/or evaluate the program.

The plan should include information for each data source, such as:

- ▲ the timing and frequency of collection;
- ▲ the person or agency responsible for the collection;
- ▲ the information needed for the indicators; and
- ▲ any additional information that will be obtained from the source.

DATA QUALITY

Throughout the data collection process it is essential that data quality be monitored and maintained. Data quality is important to consider when determining the usefulness of various data sources; the data collected are most useful when they are of the highest quality.

It is important to use the highest quality data that are obtainable, but this often requires a trade-off with what it is feasible to obtain. The highest quality data are usually obtained through the triangulation of data from several sources. It is also important to remember that behavioral and motivational factors on the part of the people collecting and analysing the data can also affect data quality.

Some types of errors or biases common in data collection include:

- ▲ *sampling bias*: occurs when the sample taken to represent the population of interest is not a representative sample;
- ▲ *non-sampling error*: all other kinds of mismeasurement, such as courtesy bias, incomplete records, incorrect questionnaires, interviewer errors, or non-response rates; and
- ▲ *subjective measurement*: occurs when the data are influenced by the measurer.

Here are some data quality issues to consider:

- ▲ *Coverage*: Will the data cover all of the elements of interest?
- ▲ *Completeness*: Is there a complete set of data for each element of interest?
- ▲ *Accuracy*: Have the instruments been tested to ensure validity and reliability of the data?
- ▲ *Frequency*: Are the data collected as frequently as needed?
- ▲ *Reporting Schedule*: Do the available data reflect the time periods of interest?
- ▲ *Accessibility*: Are the data needed collectable or retrievable?
- ▲ *Power*: Is the sample size big enough to provide a stable estimate or detect change?

DATA USE

The term data refers to raw, unprocessed information while information, or strategic information, usually refers to processed data or data presented in some sort of context.

Collecting data is only meaningful and worthwhile if it is subsequently used for evidence-based decision-making. To be useful, information must be based on quality data, and it also must be communicated effectively to policy makers and other interested stakeholders.

M&E data need to be manageable and timely, reliable, and specific to the activities in question. Additionally, the results need to be well understood.

The key to effective data use involves linking the data to the decisions that need to be made and to those making these decisions.

The decision-maker needs to be aware of relevant information in order to make informed decisions. For example, if sales data from a program to provide insecticide-treated bednets show that the program is successfully increasing bednet distribution, the decision-maker may decide to maintain the program as is. Alternatively, the data may prompt the implementation of a new distribution system and could spur additional research to test the effectiveness of this new strategy compared to the existing one.

When decision-makers understand the kinds of information that can be used to inform decisions and improve results, they are more likely to seek out and use this information.

KNOWLEDGE RECAP

Answer the following questions to see how much you know about data use. Go to page 58 to see the correct answers.

1. Which of the following is an example of a routine data source?

- ☐ a. Clinic service statistics
- ☐ b. Household surveys
- ☐ c. National censuses
- ☐ d. All of the above

2. Population-based surveys, such as a Demographic and Health Survey (DHS) or a national population census, are examples of nonroutine data sources. These sources are useful because:

- ☐ a. They provide information on a timely basis.
- ☐ b. They can be used for calculating coverage indicators.
- ☐ c. They include health outcomes for only those using health facilities.
- ☐ d. All of the above

3. A data collection plan should include the following:
- ☐ a. The timing and frequency of collection
 - ☐ b. The person or agency responsible for the collection
 - ☐ c. The types of information needed for the indicators
 - ☐ d. All of the above
4. Data should be collected whenever possible, for the reason that they could perhaps be used some day.
- ☐ True
 - ☐ False
5. The highest quality data are usually obtained through the triangulation of data from several sources.
- ☐ True
 - ☐ False

KNOWLEDGE RECAP: ANSWERS

The correct answers are as follows:

1. Which of the following is an example of a routine data source?

a. Clinic service statistics

Routine data sources provide data that are collected on a continuous basis, such as information that clinics collect on the patients utilizing their services. Examples include vital registration records, clinic service statistics and demographic surveillance.

2. Population-based surveys, such as a Demographic and Health Survey (DHS) or a national population census, are examples of nonroutine data sources. These sources are useful because:

b. They can be used for calculating coverage indicators

Nonroutine data sources can avoid the problem of incorrectly estimating the target population when calculating coverage indicators, especially representative population-based surveys, such as a Demographic and Health Survey (DHS).

3. A data collection plan should include the following:

d. All of the above

The plan should include information for each data source, such as the timing and frequency of collection, the person/agency responsible for the collection, the information needed for the indicators and any additional information that will be obtained from the source.

4. Data should be collected whenever possible, for the reason that they could perhaps be used some day.

False

Collecting data is only meaningful and worthwhile if it is subsequently used for evidence-based decision making.

5. The highest quality data are usually obtained through the triangulation of data from several sources.

True

Data quality is important to consider when determining the usefulness of various data sources. Throughout the data collection process it is essential that data quality be monitored and maintained. The highest quality data are usually obtained through the triangulation of data from several sources.

Congratulations — you have nearly completed this course!

The final exam will test your understanding of the material presented.

Answer the following questions to see how much you know about M&E fundamentals. Go to page 67 to see the answers.

1. Frameworks that diagram the direct causal relationships between the incremental results of key project activities and the overall objectives and goal of the intervention are called:
 - ☐ a. Conceptual frameworks
 - ☐ b. Results frameworks
 - ☐ c. Logic models
 - ☐ d. All of the above

2. Indicators should be vague so that people can interpret them to meet their own needs, making them more useful.
 - ☐ True
 - ☐ False

3. Which of the following is an example of a routine data source?
- ☐ a. Clinic service statistics
 - ☐ b. Household surveys
 - ☐ c. National censuses
 - ☐ d. All of the above
4. Population-based surveys, such as a Demographic and Health Survey (DHS) or a national population census, are examples of nonroutine data sources. These sources are useful because:
- ☐ a. They provide information on a timely basis.
 - ☐ b. They can be used for calculating coverage indicators.
 - ☐ c. They include health outcomes for only those using health facilities.
 - ☐ d. All of the above
5. A data collection plan should include the following:
- ☐ a. The timing and frequency of collection
 - ☐ b. The person or agency responsible for the collection
 - ☐ c. The types of information needed for the indicators
 - ☐ d. All of the above

6. When should a program's M&E plan be created?

- ☐ a. During the design phase of a program
- ☐ b. At the midpoint of the program
- ☐ c. At the end of the program
- ☐ d. After all of the data have been collected but before they are analyzed

7. Evaluations measure:

- ☐ a. The timeliness of a program's activities
- ☐ b. The outcomes and impact of a program's activities
- ☐ c. How closely a program kept to its budget
- ☐ d. How well the program was implemented

8. At what stage of a program should monitoring take place?

- ☐ a. At the beginning of the program
- ☐ b. At the mid-point of the program
- ☐ c. At the end of the program
- ☐ d. Throughout the life of the program

9. Which of the following is NOT considered “monitoring”?

- ☐ a. Counting the number of people trained
- ☐ b. Tracking the number of brochures disseminated
- ☐ c. Attributing changes in health outcomes to an intervention
- ☐ d. Collecting monthly data on clients served in a clinic

10. The M&E plan should never be changed once the program begins.

- ☐ True
- ☐ False

11. When it is said that objectives should be SMART, the “S” in the acronym stands for:

- ☐ a. Simple
- ☐ b. Strategic
- ☐ c. Silly
- ☐ d. Specific

12. Monitoring and evaluation both require knowledge of baseline values.

- ☐ True
- ☐ False

13. Which of the following is a characteristic of a good indicator?

- ☐ a. Is clearly defined in unambiguous terms
- ☐ b. Produces the same results when used repeatedly to measure the same condition or event
- ☐ c. Measures only the condition or event it is intended to measure
- ☐ d. All of the above are characteristics of good indicators

14. Data quality can be negatively affected by:

- ☐ a. Sampling bias (the sample taken is not a representative sample)
- ☐ b. Non-response rates
- ☐ c. Subjective measurement (data influenced by measurer)
- ☐ d. All of the above
- ☐ e. a and b only

15. In some cases, the output of one activity depicted in a logic model could be an input for another activity.

- ☐ True
- ☐ False

16. Frameworks can:

- ☐ a. Help increase understanding of a project's goals and objectives
- ☐ b. Define the relationships between factors key to project implementation
- ☐ c. Delineate the internal and external elements that could affect a project's success
- ☐ d. All of the above
- ☐ e. b and c only

The correct answers to the final exam are as follows:

1. Frameworks that diagram the direct causal relationships between the incremental results of key project activities and the overall objective and goal of the intervention are called:

b. Results frameworks

2. Indicators should be vague so that people can interpret them to meet their own needs, making them more useful.

False

3. Which of the following is an example of a routine data source?

a. Clinic service statistics

4. Population-based surveys, such as a Demographic and Health Survey (DHS) or a national population census, are examples of nonroutine data sources. These sources are useful because:

b. They can be used for calculating coverage indicators.

5. A data collection plan should include the following:

d. All of the above (the timing and frequency of collection, the person or agency responsible for the collection, and the types of information needed for the indicators)

6. When should the M&E plan be created?

a. During the design phase of a program

7. Evaluations measure:

b. The outcomes and impact of a program's activities

8. At what stage of a program should monitoring take place?

d. Throughout the life of the program

9. Which of the following is NOT considered “monitoring”?

c. Attributing changes in health outcomes to an intervention

10. The M&E plan should never be changed once the program begins.

False

11. When it is said that objectives should be SMART, the “S” in the acronym stands for:

d. Specific

12. Monitoring and evaluation both require knowledge of baseline values.

True

13. Which of the following is a characteristic of a good indicator?

- d. All of the above are characteristics of good indicators** (is clearly defined in unambiguous terms, produces the same results when used repeatedly to measure the same condition or event, and measures only the condition or event it is intended to measure)

14. Data quality can be negatively affected by:

- d. All of the above** (sampling bias [the sample taken is not a representative sample], non-response rates, and subjective measurement [data influenced by measurer])

15. In some cases, the output of one activity depicted in a logic model could be an input for another activity.

True

16. Frameworks can:

- d. All of the above** (help increase understanding of a project's goals and objectives, define the relationships between factors key to project implementation and delineate the internal and external elements that could affect a project's success)

Glossary of Terms

Conceptual framework — A diagram of a set of relationships between factors that are believed to impact or lead to a target condition. It is the foundation of project design, management, and monitoring.

Synonym: **conceptual model**

Data sources — The resources used to obtain the data needed for M&E activities. These sources may include, among many others, official government documents, clinic administrative records, staff or provider information, client-visit registers, interview data, sentinel-surveillance systems, and satellite imagery.

Evaluation — A process that attempts to determine as systematically and objectively as possible the relevance, effectiveness, and impact of activities in light of their objectives.

Framework — An open set of tools for project planning, design, management, and performance assessment. Frameworks help to identify project elements (goals, objectives, outputs, outcomes), their causal relationships, and the external factors that may influence success or failure of the project. A framework matrix provides an easy overview of key project information that allows assessment of project logic as well as performance monitoring and evaluation.

Goal — A broad statement of a desired, long-term outcome of a program. Goals express general program intentions and help guide a program's development. Each goal has a set of related, more specific objectives that, if met, will collectively permit program staff to reach the stated goal.

Impact — The anticipated end results or long-term effects of a program. For example, changes in health status such as reduced disease incidence or improved nutritional status.

Impact evaluation — A set of procedures and methodological approaches that show how much of the observed change in intermediate or final outcomes, or "impact," can be attributed to the program. It requires the application of evaluation designs to estimate the difference in the outcome of interest between having or not having the program.

Indicators — Quantitative or qualitative measures of program performance that are used to demonstrate change and that detail the extent to which program results are being or have been achieved. Indicators can be measured at each level: input, process, output, outcome, and impact.

Inputs — The human and financial resources, physical equipment, clinical guidelines, and operational policies that are the core ingredients of programs and enable programs to be delivered.

Intermediate result (IR) — An important, measurable result that is an essential step to achieving a strategic objective (SO) in a results framework. IRs themselves may capture a number of other discrete or more specific results. IRs may also help to achieve other IRs.

Logic model — A program design, management, and evaluation tool that describes the main elements of a program and how these elements work together to reach a particular goal. The basic elements in describing the implementation of a program and its effects are: inputs, activities or processes, outputs, outcomes, and impacts. A logic model graphically presents the logical progression and relationship of these elements.

Logical framework — A dynamic planning and management tool that logically relates the main elements in program and project design and helps ensure that an intervention is likely to achieve measurable results. It helps to identify strategic elements (inputs, outputs, purposes, goal) of a program, their causal relationships, and the external factors that may influence success or failure. It can provide the basis for monitoring progress achieved and evaluating program results.

Metric — The precise calculation or formula that provides the value of an indicator.

Monitoring — Monitoring is the routine process of data collection and measurement of progress toward program objectives. It involves tracking what is being done and routinely looking at the types and levels of resources used; the activities conducted; the products and services generated by these activities, including the quality of services; and the outcomes of these services and products.

Monitoring and evaluation (M&E) plan — A comprehensive planning document for all monitoring and evaluation activities within a program. This plan documents the key M&E questions to be addressed: what indicators will be collected, how, how often, from where, and why; baseline values, targets, and assumptions; how data are going to be analyzed/interpreted; and how/how often reports will be developed and distributed.

Nonroutine data sources — Resources that provide data collected on a periodic basis, usually annually or less frequently. In addition to large-scale household surveys, they may include small-scale, ad-hoc household surveys, special studies and national censuses.

Objectives — Significant development results that contribute to the achievement of goals and provide a general framework for more detailed planning for specific programs. Several objectives can contribute to each goal. Examples: “to reduce the total fertility rate to 4.0 births by Year X” or “to increase contraceptive prevalence over the life of the program.”

Outcomes — The changes measured at the population level in the program’s target population, some or all of which may be the result of a given program or intervention. Outcomes refer to specific knowledge, behaviors, or practices on the part of the intended audience that are clearly related to the program, can reasonably be expected to change over the short-to-intermediate term, and that contribute to a program’s desired long-term goals. Examples would be “the percentage of clients in a stop smoking program who are nonsmokers six months after the program ends” or “the percentage of married women, 15-44, using contraception one year after a family planning intervention.”

Outputs — The results of activities achieved at the program level, in two forms: the number of activities performed (e.g., number of service providers trained) and measures of service utilisation (e.g., number of contraceptives distributed).

Problem statement — A statement in an M&E plan that describes the nature and extent of the problem to be addressed by an intervention. It clearly states the specific problem and includes a quantitative element that describes the magnitude of the problem and its impact on society. The statement should also include a description of other efforts that are addressing the problem and definitions of relevant terms.

An example of a problem statement is:

A recent situation analysis of District A demonstrated limited access to young adult reproductive health services. Young adults (ages 15-24) account for 30% of the population in District A, yet reproductive health service statistics show that only 5% of the people using the services were in this age range. Anecdotal evidence from district health workers suggests a high incidence of unwanted pregnancies and a high prevalence of HIV/AIDS among young adults. As part of the national commitment to improve the reproductive health of young adults, the Ministry of Health will implement a five-year project aimed at increasing access to youth-friendly health services by improving the infrastructure necessary to deliver such services, and in partnership with the Ministry of Education and Youth, focusing on reproductive health education for youth ages 10-24.

Process evaluation — A type of evaluation that focuses on program implementation. Process evaluations usually focus on a single program and use largely qualitative methods to describe program activities and perceptions, especially during the developmental stages and early implementation of the program. These assessments may also include some quantitative approaches, such as surveys about client satisfaction and perceptions about needs and services. In addition, a process evaluation might provide understanding about a program's cultural, socio-political, legal, and economic contexts that affect the program.

Synonyms: **formative evaluation, mid-term evaluation**

Processes — The multiple activities, both planning and implementation, carried out to achieve the program's objectives.

Reliable — Results that are accurate and consistent through repeated measurement.

Results framework — Frameworks that explain how a project's strategic objective (SO) is to be achieved, including those results that are necessary and sufficient, as well as their causal relationships and underlying assumptions. It is usually

depicted with the main program goal at the top, each of the main objectives in its own box under the goal, and the results feeding into each objective from the bottom to the top.

Routine data sources — Resources that provide data collected on a continuous basis, such as information that clinics collect on the patients utilizing their services.

Strategic objective (SO) — In a results framework, the most ambitious result that an intervention can materially affect and for which it is willing to be held accountable.

Valid — A term used to describe an objective, methodology or instrument that measures what it is supposed to measure.

Bertrand JT, Escudero G. *Compendium of Indicators for Evaluating Reproductive Health Programs. MEASURE Evaluation Manual Series No. 6.* Chapel Hill, NC: MEASURE Evaluation project, Carolina Population Center; 2002.

Marsh D. Results framework & performance monitoring [online slides]. Save the Children, 1999. Accessed January 5, 2007 at <http://www.childsurvival.com/tools/Marsh/sld001.htm>.

MEASURE Evaluation. *A Trainer's Guide to the Fundamentals of Monitoring and Evaluation for Population, Health, and Nutrition Programs. MEASURE Evaluation Manual Series No. 5.* Chapel Hill, NC: MEASURE Evaluation project, Carolina Population Center; 2002. Available at: <http://www.cpc.unc.edu/measure/publications/html/ms-02-05.html>.

Mosley WH, Chen LC. An analytical framework for the study of child survival in developing countries. *Popul Devel Rev.* 1984;10(Suppl):25-45.

Rossi PH, Freeman HE, Lipsey M. *Evaluation: A Systematic Approach.* Thousand Oaks, CA: Sage Publications; 1999.

International Fund for Agricultural Development. Annex A. Glossary of M&E Concepts and Terms. *A Guide for Project M&E.* Available at:

<http://www.ifad.org/evaluation/guide/annexa/index.htm>

United Nations Development Programme. Glossary. *Handbook on M&E for Results.* Available at:

http://stone.undp.org/undpweb/eo/evalnet/docstore3/yellowbook/glossary/glossary_d_e.htm

United Nations Population Fund. Programme Manager's Planning, Monitoring & Evaluation Toolkit. Tool Number 1: Glossary of Planning, M&E Terms. March 2004. Available at:

<http://www.unfpa.org/monitoring/toolkit/glossary.pdf>

**ONLINE GLOSSARIES OF
M&E TERMINOLOGY**

MEASURE Evaluation
Carolina Population Center
University of North Carolina at Chapel Hill
206 W. Franklin St.
Chapel Hill, NC 27516 USA

Telephone: 919-966-7482