

Ensuring Relevance & Sustainability through Monitoring & Evaluation

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South Africa – particularly the domain of social services – has limited human and financial resources with which to address tremendous and often intractable social problems. Within such a context, it is imperative that every Rand that is spent makes a difference. The challenge is how to determine whether we are, in fact, making a difference.

Monitoring and evaluation (M&E) is an applied field that endeavours to answer this and other questions:

- ❖ What is our input into our social development programmes?
- ❖ Are they run according to process specifications? Are they of a high standard?
- ❖ Are we reaching the number of people and outputs that we hope to?
- ❖ Are we reaching our outcomes of changing people's behaviour and improving their quality of life?
- ❖ Are we having an impact on the foundation of society?

This paper will provide a practical introduction to M&E, based in part on the author's own experience of developing an M&E system for a national HIV programme. The value of M&E in ensuring that programmes are relevant (achieving the intended outcomes) and sustainable (ensuring the money and resources are well utilised) will be emphasised. The paper will highlight the centrality of partnerships, cooperation and alignment in M&E. The costs and expertise required for M&E will be mentioned.

The emphasis of the paper will be on equipping participants with sufficient core knowledge about M&E so that they will be able to design or refine an M&E plan in their domain of responsibility.

NOTE: This paper uses a *fictitious* case study as a vehicle for imparting content. The people, organisations and places referred to do not exist and are used solely to create an experiential framework for learning.

Dear Cynthia

MONITORING & EVALUATION: INTRODUCTORY CONCEPTS

After having visited your organisation a few weeks back, I feel that the best way forward to address your concerns is to establish a monitoring and evaluation (M&E) system. M&E is a helpful tool for managers, practitioners, partners and clients to determine what we are doing, how well we are doing it and what difference we are making.

As I understand it, you have the following four main concerns:

- ❖ You are unsure about the relationship between what goes into your programme and what you get out.
- ❖ You are unsure about the quality of services rendered.
- ❖ You are unsure what difference your programme is making – how relevant it is.
- ❖ You are unsure how sustainable your service is.

I think that M&E would be the most helpful way to address these concerns. M&E is not very familiar to everyone, so I wanted to briefly summarise the most important issues in M&E. The information is based on a document I prepared for a large national HIV M&E plan, but I hope that it will be relevant and meaningful to you.

I'm also including an annotated bibliography of references at the end of this letter. All of the documents are about HIV programmes – because this is where M&E is probably best developed. All the concepts, however, apply to the M&E of any programme. Also, all the documents are available on the Internet, so you can access the original texts online or even order them for free. Not often that we get that opportunity!

INTRODUCTION TO M&E

Monitoring and Evaluation (M&E) is a term that is broadly used to refer to activities that involve monitoring what is happening in a programme and evaluating the degree to which that programme is achieving its objectives.

M&E is widely accepted as an essential element of HIV programmes throughout the world, in both developed and developing countries. Donor organisations, such as UNAIDS, WHO, CDC's GAP, PEPFAR, FHI and USAID, all require M&E as part of their funding agreements, so as to ensure that the allocated funds are achieving the desired effects.

This section will provide a broad conceptual overview of M&E in the context of HIV programmes, specifically addressing the following questions:

- ❖ What is M&E, what does it achieve, and how is it different from programme evaluation?
- ❖ What is the accepted model for M&E?
- ❖ What are indicators and what role do they play in M&E?

M&E AND PROGRAMME EVALUATION

Definitions of M&E. Michael Quinn Patton provides the following descriptive definition of evaluation, which forms a foundation to this M&E Plan (Family Health International, 2001):

"I use the term evaluation quite broadly to include any effort to increase human effectiveness through systematic data-based inquiry. When one examines and judges accomplishments and effectiveness, one is engaged in evaluation. When this examination of effectiveness is conducted systematically and empirically through careful data collection and thoughtful analysis, one is engaged in evaluation research... Evaluation is applied research, or a type of 'action science.' This distinguishes evaluation research from basic academic research... The purpose of applied research and evaluation is to inform action, enhance decision-making, and apply knowledge to

solve human and societal problems... Applied evaluation research is judged by its usefulness in making human actions and interventions more effective and by its practical utility to decision makers, policymakers and others who have a stake in efforts to improve the world.”

For the purposes of this document, the following working definition of M&E will be utilised:

Monitoring and evaluation (M&E) is the systematic, planned and replicable process of collecting critical data that generates management information about progress towards achieving defined programme outcomes in order to guide decision-making.

The terms ‘monitoring’ and ‘evaluation’ are often confused. “There is a simple distinction between monitoring and evaluation that may be helpful. Monitoring is routine, daily assessment of ongoing activities and progress. In contrast, evaluation is the episodic assessment of overall achievements. Monitoring looks at what is being done, whereas evaluation examines what has been achieved or what impact has been made” (UNAIDS/World Bank, 2002).

Rationale for M&E. There are several reasons for having an M&E plan, viz:

- ❖ To detect problems in the programme timeously, in order to address problems proactively, in such a way that project redesign and improvement become standard operating procedures (UNAIDS/World Bank, 2002).
- ❖ To provide early evidence of programme effectiveness (UNAIDS/World Bank, 2002).
- ❖ To generate information that can be used to communicate, in transparent and objective ways, to those who are infected with or affected by HIV/AIDS, “the effort being made to improve prevention, care, treatment and mitigation programmes” (UNAIDS/World Bank, 2002).
- ❖ To provide a credible foundation from which to make decisions regarding programme priorities (Family Health International, 2001).
- ❖ To account to funders and stakeholders, and potentially to draw additional funding and support (Family Health International, 2001).
- ❖ To provide performance incentives to those who are implementing HIV programmes (UNAIDS/World Bank, 2002).
- ❖ To allow for comparisons of performance data across elements within the organisation, and between organisations, and between countries.

M&E versus Programme Evaluation. M&E and formal programme evaluation have much in common – words, objectives, methodologies, intentions, etc. Much M&E literature uses the terms interchangeably, adding to the lack of distinction between them. However, in practice, they are quite different. Attempts to conduct M&E through programme evaluation can prove futile. It is thus important to distinguish between M&E and programme evaluation – the table below provides a contrast of these two approaches.

M&E	Programme Evaluation
Focus. M&E tends to focus on broad programmes, not usually on specific project elements.	Focus. Programme evaluation tends to focus on detailed project elements, such as a specific intervention.
Timing. M&E tends to be an ongoing and long-term activity.	Timing. Programme evaluation tends to be a short term, specific activity.
Target. M&E tends to be cross-sectional and longitudinal, with no control group.	Target. Programme evaluation involves time-series design, where the same people are tracked over time with personal identifiers, with a control group.
Study Design. M&E tends to utilise cross-sectional surveys with no control groups.	Study Design. Programme evaluation tends to utilise experimental and quasi-experimental designs, with control groups and often with randomisation.
Attribution. The results of M&E data cannot be attributed to a specific programme – improvements in condom use are not definitively attributable to the programme being evaluated.	Attribution. Programme results can be attributed, with reasonable confidence, to the specific programme being evaluated.
Intensity. M&E is less intensive and more broad (more people are involved).	Intensity. Programme evaluation is highly intensive and narrower in focus (fewer people are involved).
Utilisation. M&E tends to be used on an ongoing basis, for the duration of the programme's lifespan.	Utilisation. Programme evaluation tends to be used in the early stages of a new programme, in order to determine how effective the specific programme is, and is thereafter replaced with M&E processes.

In short, programme evaluation is a highly rigorous, costly, complex, scientific and usually small-scale approach to determining whether a specific intervention achieves the defined objectives, using an experimental design. M&E is a broad, on-going, systematic, large-scale approach to determining whether defined objectives are being achieved, using repeated data collection methods.

A crucial implication of the above is that M&E creates what is termed the 'attribution dilemma', viz, "are observed changes a result of prevention interventions?" (Family Health International, 2001). Ideally, M&E should generate data that can be linked with confidence to the specific programme being evaluated. This is, however, rarely the case – hence the artificial distinction that has been drawn above between M&E and programme evaluation.

Some of the literature (UNAIDS/MEASURE, 2000) distinguishes between outcome *monitoring* (which "tracks changes in outcomes following the implementation of a programme, but is not able to attribute those changes directly to the intervention") and outcome *evaluation* (which "is designed specifically with the intention of being able to attribute the changes to the intervention itself"). In M&E, the focus is typically on outcome monitoring.

The cost of formal programme evaluation is great. It is not practical to use programme evaluation on a wide scale. M&E data are thus collected on a larger scale. However, changes in trend (eg a reduction of HIV incidence) cannot be attributed with confidence to the specific programme.

M&E philosophy, however, suggests that attribution is less salient than the change that is detected – a reduction in seroincidence is good news, regardless of which programme components caused it. Indeed, there is a growing conviction that it is a confluence of various programmes that creates the most significant behaviour change, and not a single intervention.

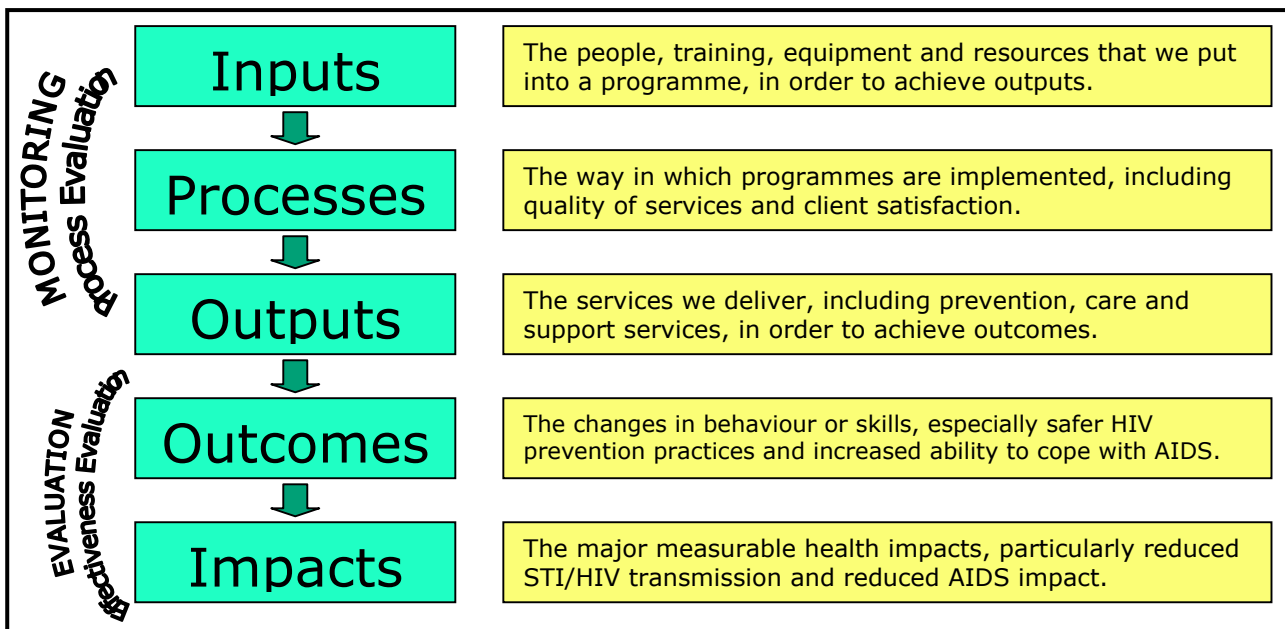
A good approach to follow in such cases is to conduct rigorous programme evaluation of new interventions on a small scale. Once the intervention has been demonstrated to be effective, M&E should be used on a broader scale.

Triangulation, however, is one way to increase the quality of M&E data (Family Health International, 2001), and involves collecting data from multiple sources and with multiple methods. For example, "process evaluation data on condom sales, the intensity of peer education, or the quality and coverage of media campaigns can be combined with an analysis of behavioural outcome data to provide an understanding of the process through which an intervention has achieved its effects" (Family Health International, 2001).

The Cost of Science. Science is expensive. A balance needs to be struck between science and affordability/feasibility. M&E should gather the best possible data, given the constraints of time, personnel and funds, in order to be realistic, feasible and sustainable.

M&E MODEL

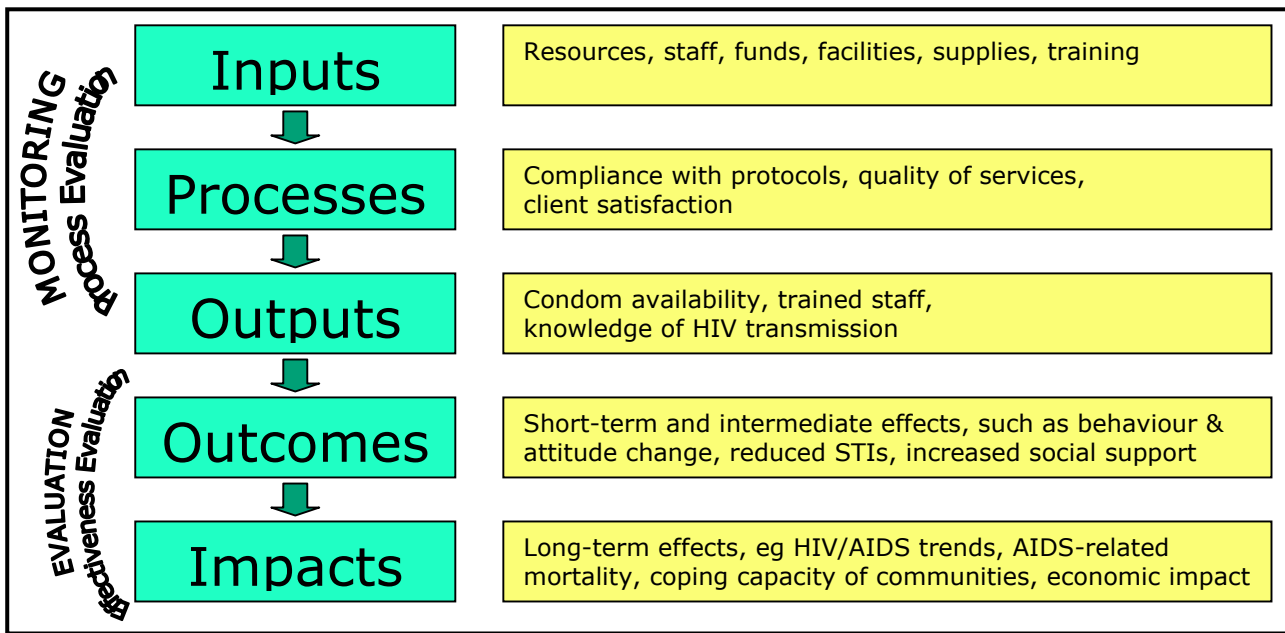
M&E Model Components. Most literature on M&E utilises the following model (Family Health International, 2001; UNAIDS/MEASURE, 2000; UNAIDS/World Bank, 2002), which has been adapted for use as the M&E framework for the SA DOD HIV/AIDS Programme.



The first three components of the model – inputs, processes and outputs – collectively measure *what we are doing*, and thus refer to the *monitoring* component of M&E. They are also referred to as *process evaluation* – evaluating what we are doing. (The second component, 'process', is usually incorporated as part of 'output' in the literature, but has been separated out for the purposes of this M&E Plan, in order to highlight process compliance which is a concern of the SA DOD.)

The last two components of the model – outcomes and impact – collectively measure *what we are achieving*, and thus refer to the *evaluation* component of M&E. They are also referred to as *effectiveness evaluation* – evaluating how effective we are at achieving our objectives.

M&E Model Measurements. The graphic below provides examples of what can be measured in each component.



Logic Modelling. The M&E model has a distinct logic that must be utilised when conducting M&E and when interpreting M&E data. Inputs are used to execute processes that produce outputs, which create outcomes in the short to medium term, culminating in impacts in the long term. Each component must be measured and interpreted in light of preceding components (UNAIDS/MEASURE, 2000).

For example, it is illogical to:

- ❖ Measure what is being done (process), if no resources (input) are available for the doing.
- ❖ Measure how many people have been trained as Peer Educators (output), if we are not confident that the HIV Peer Educators course is being run as prescribed in the training manual (process).
- ❖ Measure how many people have access to ARVs (output), if we are not providing ARVs (process).
- ❖ Measure whether people are using condoms more consistently (outcome), if we are not sure whether sufficient condoms are available and accessible (output).
- ❖ Measure whether the incidence of HIV is decreasing (impact), if we are not sure whether people's risk behaviour has decreased (outcome).

A logic model is thus required for each programme component, addressing each of the five components of the M&E model, before measurement and data interpretation takes place. In principle, nothing should be measured that is not logically located within a logical conceptual framework.

Notwithstanding this caveat, outcome and impact data should be collected from the very beginning in order to establish baselines from which to track trends over the medium and long-term.

INDICATORS

What is an Indicator? Indicators are typically the type of data measured within M&E systems. Indicators are somewhat different from other data types, in that they usually refer to a percentage of something over something else, such as the percentage of people who used a condom with their last non-regular sex partner over the number of people who had a non-regular sex partner in the past 12 months.

Strictly speaking, the number of condoms distributed during the past year is not an indicator because it is not reflected as a percentage. It could be converted into an indicator by placing the number of condoms over the number of potential users of condoms.

Furthermore, the average score on an HIV-knowledge scale is not an indicator. It could, however, be converted into an indicator by placing the number of people who got all the answers correct over the number of respondents.

In practice, however, many indicators provided in the literature are not percentages, but often Yes/No questions (eg is there a policy on prevention, recruitment and discrimination?) or simply numbers (eg median age at first sex).

The Nature of Indicators. Indicators are two dimensional – they simply tell one whether something has become more or less (UNAIDS/MEASURE, 2000). They provide no insight into the nature or cause of such a change.

An indicator can be likened to a thermometer. The thermometer tells us what a person's temperature is. If the temperature is 39 degrees, we have an indication that the person is ill, but this does not tell us why the person is ill nor what should be done about it. The temperature is, however, an indication that we should do further investigation and some kind of action is needed.

Similarly, HIV indicators will simply tell us that something has (or has not) changed, but provide no insight into why it has changed nor what we should do about it. Only smaller (usually qualitative) studies will provide answers to these 'why' and 'how' questions (UNAIDS/MEASURE, 2000). Conversely, such small, explanatory studies cannot be used for broad M&E purposes – they are, by definition, situation-specific.

Characteristics of Good Indicators. Indicators need to be of a high quality, which implies that they should have the following seven characteristics (quoted verbatim from Family Health International, 2001):

- ❖ **Valid.** They should measure the condition or event they are intended to measure.
- ❖ **Reliable.** They should produce the same results when used more than once to measure the same condition or event.
- ❖ **Specific.** They should measure only the condition or event they are intended to measure.
- ❖ **Sensitive.** They should reflect changes in the state of the condition or event under consideration.
- ❖ **Operational.** It should be possible to measure or quantify them with developed and tested definitions and reference standards.
- ❖ **Affordable.** The costs of measuring the indicators also should be reasonable.
- ❖ **Feasible.** It should be possible to carry out the proposed data collection.

Global, National and Programme Indicators. One of the values of indicators is that they can be used not only for M&E within a particular programme, but also to make comparisons across programmes at both national and global levels. This comparability is important to international organisations and funders, but also to programme managers who desire to benchmark their programme against other programmes.

Such comparability requires indicators to be defined and utilised consistently across sites, programmes and countries. Fortunately, numerous HIV indicators have been developed and adopted for standard use by large international agencies, such as UNAIDS, WHO, USAID, CDC, FHI and the World Bank (Family Health International, 2000; UNAIDS/World Bank, 2002).

Standard international practice is now to measure the dozen or so 'core' global HIV indicators, the standardised national HIV indicators, as well as additional indicators that are specific to one's own programme. This provides all users with key information and ensures standardisation at those levels where it is most important.

Sources of Indicator Data. One of the complexities of M&E is that indicator data come from multiple sources and are collected through multiple methods. Consequently, at least some indicator data is often available, but in a very fragmented and incoherent form. There is a great need for such data to be integrated into a coherent and meaningful form.

Indicator data are typically collected through the following means:

- ❖ Behavioural surveillance surveys with the general population or specific vulnerable subpopulations (eg commercial sex workers, men who have sex with men, military personnel, truck drivers, etc).
- ❖ HIV and STI serosurveillance, usually through antenatal clinics or representative surveys of vulnerable subpopulations.
- ❖ Site inspections or facility surveys.
- ❖ Key stakeholder interviews.
- ❖ Routine programme monitoring data.
- ❖ Budgets and expenditure records.
- ❖ Document review.
- ❖ Direct observation.

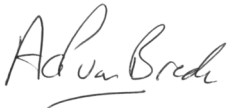
CONCLUSION

Well, it is my hope that you will find this information helpful and interesting. M&E is not complicated science, but it does require one to think in a structured and systematic way about what we do.

Although most of the information here is about HIV, I hope that you will see how you can easily apply it to the field of social development. The annotated bibliography on the following pages will give you more detailed and technical information about M&E.

I look forward to speaking with you shortly.

Yours truly,



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ANNOTATED BIBLIOGRAPHY

Centers for Disease Control and Prevention. (1999). Framework for program evaluation in public health. *MMWR (Morbidity and Mortality Weekly Report)*, 48(RR-11). Retrieved 2004, July 18, from <http://www.cdc.gov/mmwr/PDF/rr/rr4811.pdf>

This is a really helpful document. It provides a step-by-step guide to setting up an M&E system. The steps are: engaging stakeholder; describing the programme; focusing the evaluation design; gathering credible evidence; justifying conclusions; ensuring use and sharing lessons learned. It is very detailed - perhaps a bit pedantic - and provides helpful information about what goes on behind the actual M&E. It can be downloaded for free from the internet.

Family Health International. (2000). *Behavioral surveillance surveys (BSS): Guidelines for repeated behavioral surveys in populations at risk of HIV*. Arlington, VA: FHI. Retrieved 2004, May 25, from <http://www.fhi.org/en/aids/wwdo/wwd12a.html#anchor545312>

This is a terrific manual if you intend to conduct Behavioural Surveillance Surveys (also known as KAP or KAPB studies). BSS involves measuring primarily outcome indicators - especially knowledge (actually an output), attitudes and behaviours - repeatedly over time. BSS is a source of many outcome indicators that can only be measured through surveys. The manual addresses the entire process - setting up the survey, identifying the population, taking a representative sample, adapting a questionnaire, analysing data and utilising the data. If you plan to conduct behavioural surveys, this is the book to have. You can download it or order it over the internet for free!

Family Health International. (2001). *Evaluating programs for HIV/AIDS prevention and care in developing countries: A handbook for program managers and decision makers*. Arlington, VA: FHI. Retrieved 2004, May 25, from <http://www.fhi.org/en/aids/impact/impactpdfs/evaluationhandbook.pdf>

This 300 page manual is probably the 'bible' of monitoring and evaluation, addressing all aspects. It can be downloaded for free from the FHI website or ordered in paper over the internet (for free). It addresses the theory of M&E, provides practical applications in various types of HIV programmes, addresses the methodological issues involved in M&E and discusses the measurement of impact. If you only have one M&E reference, this is the one to have!

UNAIDS/MEASURE. (2000). *National AIDS programmes: A guide to monitoring and evaluation*. Geneva, Switzerland: UNAIDS. Retrieved 2004, May 25, from <http://www.cpc.unc.edu/measure/guide/guide.html>

This is a helpful, short book on M&E within the HIV field. It addresses the theory and process of conducting M&E, and addresses some of the background issues that need to be worked out before implementing M&E. It provides some detailed information about a set of core HIV indicators that many are using around the world. It can be downloaded or ordered for free over the internet.

UNAIDS/World Bank. (2002). *National AIDS Councils: Monitoring and evaluation operations manual*. Geneva, Switzerland: UNAIDS. Retrieved 2004, October 18, from <http://www.unaids.org/html/pub/publications/irc-pub02/jc808-moneval-en-pdf.pdf>

This is an interesting manual that focuses on how to manage an M&E system at national level, in terms of who should do what. It is perhaps too macro for most agencies, but will give some valuable insights into the various roles that need to be addressed. At national level, these roles are fulfilled by different people or departments, while at agency level they may be fulfilled by a single person. It can be downloaded or ordered for free over the internet.

Rural Care FY03/04 Report

Introduction. *Rural Care* is a community-based organisation, established in 1999, providing a range of social development services to five rural communities in the Eastern Cape. Our mission is to provide a needs-based, relevant and sustainable service that enhances the quality of life for families living in rural communities.

Rural Care has three primary focus areas::

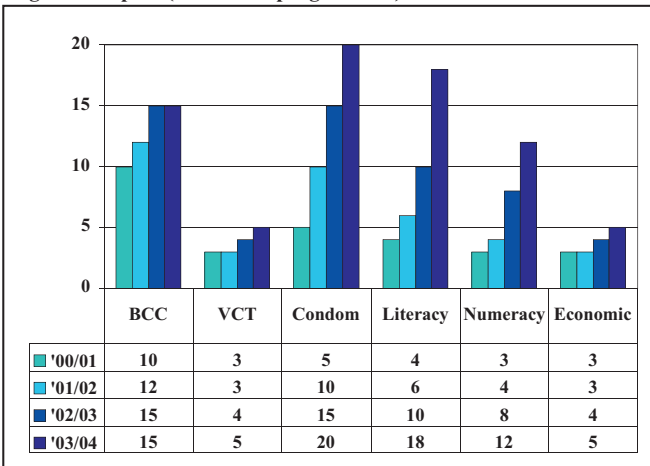
- * **HIV Prevention.** The reduction of HIV infections through condom promotion and distribution (CPD); behaviour change communications (BCC); and voluntary counselling and HIV testing (VCT).
- * **Literacy/Numeracy Training.** The promotion of literacy and numeracy, as a foundation for self-sufficiency.
- * **Economic Empowerment.** The promotion of economic empowerment of families, in order to develop self-sufficiency, primarily through the development of ecotourism.

This document serves to report on activities and results achieved during the 2003/2004 Financial Year, based on monitoring and evaluation data.

Inputs. These are the funds and services that were put into the programme during FY03/04:

- * **Budget.** The budget for FY03/04 was R4.5 million, up from R3.8 million in FY02/03.
- * **Service Outlets.** Services are provided from five dedicated sites, located in five rural communities.
- * **Programmes.** The graph below shows the increase in the number of programmes offered over the past five years.

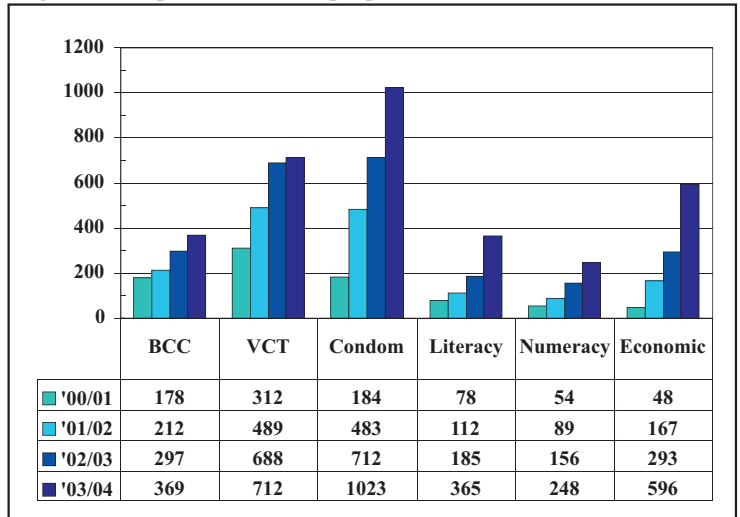
Figure 1: Inputs (number of programmes)



Processes. The average satisfaction of clients who have participated in our programmes increased from 78% in FY02/03 to 83% in FY03/04.

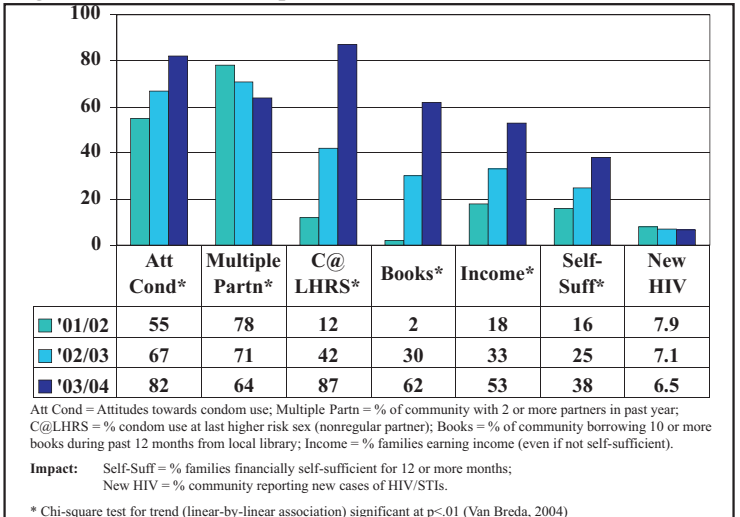
Outputs. The outputs achieved during FY03/04, compared with previous years, are illustrated in the graph below. There is clearly a tremendous increase in the number of people reached through *Rural Care*.

Figure 2: Outputs (number of people served)



Outcomes. Outcomes refer to medium term accomplishments in achieving the goals of *Rural Care*. Figure 3 illustrates the increases achieved in all outcomes.

Figure 3: Outcomes & Impact



Impact. Finally, the long-term impact of *Rural Care* is beginning to be felt, with an increase in the number of families who are able to sustain self-sufficiency and a reduction in the incidence of HIV and STIs (Figure 3).

Conclusion. *Rural Care* is working hard to improve the lives of families in rural Eastern Cape. With continued financial support, we hope to increase our efforts and reach yet more people in FY04/05.

Rural Care is a fictitious organisation. This report serves to illustrate the use of monitoring & evaluation (M&E) data in reporting organisational results to stakeholders and funders. Created by Adrian Van Breda (adrian@vanbreda.org).