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Building Monitoring, Evaluation and Reporting Systems for HIV/AIDS Programs

This publication was made possible through support provided by the Office of HIV/AIDS, Bureau for Health, U.S. Agency for International Development, under the terms of Pact's Leader Award No. GPH-A-00-01-00007-00 and USAID South Africa Associate Award No. 674-A-00-04-00025-00025-00 under the above referenced Leader Award in addition to USAID/REDSO Mission Award No. 623-C-00-98-00026-00 and USAID Tanzania Mission Award No. 623-A-00-01-00123-00 under Pact Leader Award No. GEG-A-00-01-00005-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of Pact or the U.S. Agency for International Development.

Building Monitoring, Evaluation and Reporting Systems for HIV/AIDS Programs

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1200 18th Street, NW, Suite 350
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Printed in the United States of America

LOC 2005923421 2005

ISBN 1-888753-44-7

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Abbreviations

A and AB – Abstinence and abstinence/be faithful
ART – Antiretroviral therapy
BCC – Behavior change communication
CSW – Commercial sex workers
FBO – Faith-based organization
HBC – Home-based care
HMIS – Health Management Information System
IDU – Injecting drug user
IEC – Information, education, and communication
M&E – Monitoring and evaluation
MER – Monitoring, evaluation, and reporting
MOH – Ministry of Health
MOU – Memorandum of understanding
MSM – Men who have sex with men
NGO – Nongovernmental organization
PLWHA – People living with HIV/AIDS
PMTCT – Preventing mother-to-child transmission
OVC – Orphans and vulnerable children
STI – Sexually Transmitted Infection
TOT – Training of trainers
UNDP – United Nations Development Programme
USAID – United States Agency for International Development
USG – United States government
VCT – Voluntary counseling and testing

Foreword

One of the core values that guides Pact's work is stewardship of resources intended for the poor. Every dollar entrusted to us is our responsibility to manage efficiently and effectively so that the greatest proportion of funds moves from us directly to local organizations and institutions and the communities they serve. Providing monitoring, evaluation, and reporting (MER) tools to local organizations is critical to enabling them to account to their donors and ultimately to their beneficiaries. A good MER system frames the parameters of project activities, guides adjustments along the way, and enables measurement of changes and identification of lessons learned when the project ends so that funds are optimally used.

Demand for MER tools suitable for use at the local level has grown with the increased commitment of the U.S. government and other international donors to fund responses to the HIV/AIDS epidemic. I am pleased that Pact is able to publish this MER manual, which is one of the first manuals written to assist local nongovernmental organizations (NGOs) working in HIV/AIDS. To the greatest extent possible the authors have taken pains to eliminate jargon and simplify the structures that often defeat MER systems, even when in the hands of more experienced organizations.

The manual also presents the indicator reporting and monitoring requirements for the President's Emergency Plan for AIDS Relief. This program, more than any other single effort on the part of the U.S. government, is enabling hundreds of thousands of individuals to get urgently needed services for HIV/AIDS prevention, treatment, and care.

Local grassroots organizations represent the frontlines of the battle on HIV/AIDS and are the true unsung heroes in this long-waged battle. Empowered with effective MER tools, they will be able to strengthen their approaches and better capture the amazing results of their work. Through their efforts, I am confident we will reach the Millennium Development goal to halt and begin to reverse the spread of HIV/AIDS by 2015.

Sarah Newhall
President and CEO, Pact
March 2005

Preface

Organizations working in the HIV/AIDS sector today are incredibly busy, forced to respond to a growing demand for programs and activities that respond effectively to the pandemic. Development managers and motivated staff spend untold hours trying to deliver quality services to those in need. It is for this reason that HIV/AIDS programs need quality monitoring, evaluation, and reporting (MER) systems, to ensure they can more efficiently track and utilize their resources for enhanced effectiveness.

The goal of this workbook is to present MER in its most basic and useable form. It is geared particularly toward those local nongovernmental organizations (NGOs) already under pressure to meet the increase in demand for their programs. These organizations, which report that they do not have full-time staff dedicated to MER, may often see a frequent turnover in the staff they have and are limited in terms of both financial and human resources. These organizations (like most) tend to state that they find MER to be time-consuming, expensive, and sometimes externally but not internally important. Therefore, the goal is to provide materials to help organizations construct a quality system that is straightforward, affordable, efficient, and most importantly, useful to the management and operations of the organization itself. To that end, we have built on the basic principles of monitoring and evaluation, while limiting or streamlining technical jargon or excessive system design beyond the minimum required to maintain an institutional memory and ensure reliable and valid data collection and evaluation. Pact's approach to institutional system design is to help organizations build strong programming capacity so they can successfully implement, monitor, and manage complex field-based programs. In the past few years, Pact has supported hundreds of local NGOs across Africa, Asia, Latin America, and the Caribbean to design and implement successful HIV/AIDS response programs and ignite community-led responses to HIV/AIDS. To these organizations, we offer our deepest respect and a promise that improved MER systems are worth the effort as they will help achieve organizational goals as well as the larger goal of improving the quality of our joint response to the HIV/AIDS crisis.

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Acknowledgements

Several individuals should be acknowledged for their efforts in supporting the compilation of this workbook. In USAID's Office of HIV/AIDS we would like to thank Jason Heffner and Estelle Quain for their continuous support and encouragement of our vision and Cameron Wolf for his invaluable input and guidance on the President's Emergency Plan reporting requirements. In the South Africa Mission we offer thanks to Annie Latour, who graciously lent her time in helping us with protocol development.

In Pact we would like to thank William Polidoro for his leadership and unflagging encouragement; the entire Pact Community REACH team, particularly Allison Campbell, Sujata Rana, Dwan Dixon, Malika Magagula, and Polly Mott; Jeff Whisenant for his commitment to improving MER practice; Dan Craun-Selka and Nora Pendael-Mhina for support of the initial pretest; Evan Bloom, Sue Bloom, and Traer Sunley for publication support; and Paul Cowles, Irene Gathinji Nduta, and Georgia Beans for their sustained support and championing of our undertaking.

CHAPTER 1

PRINCIPLES

In this chapter, readers will learn:

- To identify the benefits and purposes of tracking performance, measuring results, and reporting the progress of an organization
- To define the terms monitoring, evaluation, and reporting (MER), as well as other key terms often used in the discussion of MER systems
- Essential elements in developing a successful MER program
- Four factors that contribute to the failure of a monitoring program
- To determine their organization's different audiences and their unique information needs.

In this chapter, readers will work on the following tasks in building their MER systems:

- Identify the reasons MER are beneficial to their organizations.
- Identify organization-specific audiences and information needs.
- Complete several practice activity sheets.

Introduction

Organizations and managers working in the HIV/AIDS field are often aware that in order to be effective they need to know on a regular basis how well their organizations are doing; in reality, however, they often base decisions on personal and staff judgment, anecdotal data, or haphazardly collected field information. Managers commonly state that they tend to place less emphasis on monitoring and evaluation because they perceive measuring performance as complex and time-intensive, and they do not see a benefit to investing in monitoring and evaluation systems. Many organizations and their management consider MER to be a requirement of the funding agencies that support them, an external rather than internal necessity. For instance, few managers consider MER to be a strategic system that they can adapt to assess their organizational capacity, judge their economic effectiveness, or predict their organization's future sustainability. This chapter aims to overcome some of these objections by discussing the principles of monitoring, evaluation, and reporting and analyzing the benefits and purposes of MER systems.

The Importance of Monitoring, Evaluating, and Reporting

Nongovernmental organizations (NGOs) exist in large part because they believe that change to the social, administrative, or ecological conditions of an area will occur as a result of natural and human factors. Organizations believe that if they intervene with initiatives and programs, change will be promoted in a positive manner. The overall goal of management, therefore, is to keep the character and rate of change due to human factors within acceptable (or preferable) levels. Management's challenge is not how to prevent any change in an area but to identify what management actions are needed to guide and control it.

WHY MER IS IMPORTANT: REASON 1

MER provides organizations with a tool to *evaluate* how effectively the organization promotes change.

A MER system is simply a tool that organizations and managers use to see if they are achieving change. MER is effective in the following ways:

Organizations define the most significant change they would like to see by developing vision statements and identifying how their organizations will affect change by defining a mission statement.

EXAMPLES	
VISION:	A just and equitable society
MISSION:	Empower the public to promote, reinforce, and safeguard human rights and good governance.
VISION:	A healthy society with low HIV prevalence rates
MISSION:	Provide quality health services to reduce morbidity and mortality of people living with HIV/AIDS (PLWHAs).

WHY MER IS IMPORTANT: REASON 2

MER provides organizations with a tool to *monitor* how efficiently the organization promotes change.

After developing vision and mission statements, organizations then lay out a realistic plan for influencing change by identifying implementation strategies, specific program objectives, and key activities.

EXAMPLES	
VISION:	A just and equitable society
MISSION:	Empower the public to promote, reinforce, and safeguard human rights and good governance.
STRATEGY:	Create legal and human rights awareness among the public and under-privileged sections of society.
OBJECTIVE:	By July 2005, conduct an advocacy campaign on the rights of the girl child.
KEY ACTIVITIES:	Sponsor a regional conference. Develop and promote communication messages for print, radio, and television.
VISION:	A healthy society with low HIV prevalence rates
MISSION:	Provide quality health services to reduce morbidity and mortality of PLWHAs.
STRATEGY:	Strengthen the district health system to enhance the quality of HIV/AIDS care and support services for PLWHAs.
OBJECTIVE:	Ensure health care workers providing care and support services for PLWHAs are knowledgeable in best practices by July 2008.
KEY ACTIVITIES:	Research best practices. Develop resource manual on best practices. Train service providers.

The strategies, objectives, and activities are based on the perceived skills and strengths of an organization, on the anticipated availability (current or future) of resources, and on certain time frames; in short, they outline how an organization will efficiently produce change.

Once an organization identifies what it wants to change and how it plans to go about changing it, the organization may seek partners—like the government, other NGOs, community-based organizations (CBOs), and others—and donors—for example, the United States Agency for International Development (USAID), World Bank, and the United Nations Development Programme (UNDP)—with similar goals to implement and fund specific programs. These partners and donors are all interested in promoting change but have different ways of working and different ways of accessing money and resources. An organization has to interest partners and donors in joining a cause; when they do join, the organization has to provide them with information about its programs in a manner that supports their particular method of operation. When your organization does this successfully, public and political support is fostered.

WHY MER IS IMPORTANT: REASON 3

MER fosters public and political cooperation and supports particular information needs for target audiences (such as donors, board members, etc.).

The Information Circle

Here is an example of how the information collected about a program fosters donor support:

1. A donor (for instance, USAID) wants to promote a change—to reduce the incidence of HIV/AIDS.
2. They provide (through Pact) a grant to a local NGO that has a similar goal.
3. The NGO reports to Pact on how efficient and effective it has been in promoting a certain change.
4. Pact condenses this information and reports to USAID.
5. USAID condenses this information and sends it to U.S. and local government partners such as the Congressional appropriations committees.
6. The government's partners read the information, measure the results, and possibly clear support for more programs relating to HIV/AIDS response.

WHY MER IS IMPORTANT: REASON 4

MER provides managers with a tool to gain timely information on the progress of project activities, allowing them to compare what was planned to what is actually occurring.

Once an organization is in the process of implementing a particular project, managers want to know how things are progressing. Managers recognize that the organization is responsible for and will be held accountable for the completion of certain tasks. To ensure the completion of tasks, they need to be able to compare what was planned to what is actually going on in the field.

WHY MER IS IMPORTANT: REASON 5

MER promotes organizational learning and encourages adaptive management—action in response to learning.

At key stages in the life of an organization or program, it is important to step back and ask: What have we learned? What are our lessons? What have been our successes and what have been our failures? This type of analysis allows organizations to better their systems and implementation practices and encourages institutional memory. Armed with this type of data, managers can ensure that successful program elements are replicated and mistakes are minimized. Organizations prosper when they capture new knowledge and support learning.

Using new knowledge and learning is known as adaptive management, an approach to monitoring, evaluation, and management decision-making involving a cycle of planning, implementation, monitoring, research, and subsequent re-examination of management decisions based on new information. In its simplest form, adaptive management is action in response to learning.

Definitions

A MER system is based on three separate but interrelated concepts: monitoring, evaluation, and reporting.

Monitoring is a systematic process of collecting and analyzing information to track the *efficiency* of the organization in achievement of goals. Monitoring provides regular feedback that helps an organization track costs, personnel, implementation time, organizational development, and economic and financial results to compare what was planned to actual events. In its simplest terms, monitoring is collection and analysis of information to track project implementation.

Evaluation is a systematic process of collecting and analyzing information to assess the *effectiveness* of the organization in the achievement of goals. Evaluation provides regular feedback that helps an organization analyze the consequences, outcomes, and results of its actions. Evaluation also provides regular feedback that helps organizations assess their relevance, scope, and sustainability. In its simplest terms, evaluation is the collection and analysis of information to assess the impact of the organization's work.

Reporting is the systematic and timely provision of useful information at periodic intervals. Reporting provides regular feedback that helps organizations inform themselves and others (stakeholders, partners, donors, etc.) on the progress, problems, successes, and lessons of program implementation.

Efficiency and effectiveness are two key terms used when discussing MER systems.

Effectiveness measures the degree to which results/objectives have been achieved. An effective organization is one that achieves its results and objectives.

Efficiency measures how productively inputs (money, time, equipment, personnel, etc.) were used in the creation of outputs (products, outcomes, results). An efficient organization is one that achieves its objectives with the most resourceful expenditures of resources.

Definitions of the concepts and five key benefits of having a functional MER system have been listed in this chapter to help organizations think about why and how MER systems are useful. There are numerous benefits, many of which are unique to the individual institutions implementing the systems. Without monitoring and evaluation, it is impossible to judge if work is going in the right direction, whether progress and success can be claimed, and how future efforts might be improved. The strength of a quality MER system lies not in its ability to produce data but rather in its ability to provide useful information for managing results.

ACTIVITY #1 WORKSHEET ▶ DESCRIBING WHY MER IS USEFUL

Beyond the five reasons cited in this chapter, please list why having a functional MER system could be useful to your organization:

1. _____

2. _____

3. _____

4. _____

5. _____

Essential Elements in Developing a Successful MER Program

Building a MER system begins with development of a MER plan, which documents data collection, evaluation, and reporting procedures to be undertaken by the organization. The MER plan builds from the organization's strategic plan proposal (which outlines the mission, strategies, objectives, and key activities of the organization) or original funding proposal. The MER plan identifies:

1. The organization's mission and strategies and need for a MER system
2. Who needs information and data from the organization, why, and when
3. What data (management information and indicators) will be collected by the organization
4. The source, method, frequency, and schedule of data collection
5. The team or individuals responsible for data collection
6. How data will be analyzed, compared, reviewed, and presented, and associated tools to be utilized
7. Plans, schedules, and tools for evaluating information
8. Plans, schedules, and tools for communicating information
9. Related budgetary information.

Determining Audiences and Information Needs

One of the first steps in developing a MER plan is to determine who will be using the information that you will be collecting and what it is they would like to know. You may collect the best information in the world but if nobody cares about it or it is in a form that people cannot or will not use, then all your hard work will be wasted.

Identify Your Audiences

Almost any project will have multiple audiences (stakeholders). To begin the process of determining your audiences, sit down with your project team and make a list of the various groups who you think might be interested in the results of your project and monitoring work. Differentiate between those audiences who just need to know about your organization versus those audiences who actually require information or data from your organization. In almost all cases, the first audience listed should be your own project team. Other possible internal audiences include the board, the membership, partner organizations, potential future donors, among others. Potential external audiences include the stakeholders or community members with whom your project is working (may also be defined as an internal audience), donors, and policy and decision-makers in government and other agencies.

Determine What Data/Information Your Audience Needs

Any project will have hundreds of possible questions that could potentially be asked about it. Your primary challenge in designing a MER plan is to focus on only the most important ones. The hard work and thinking you have invested in identifying and developing a strategic plan and/or work plan will make it much easier to determine what to monitor, so review the strategic and/or workplan when you develop information needs.

Determine Why They Need Data/Information

Think about why your stakeholders need the data. Review any reporting requirement communications they may have sent. How will they use the information? Understanding why a partner needs data increases your ability to provide useful information and helps build a sense of teamwork among stakeholders.

Identify When Your Audience Needs Data/Information

If you are aware of specific time frames when stakeholders need data, be sure to document these dates. This will help you when you are scheduling your activities and reporting procedures. Be as exact as possible.

AUDIENCE	THE DATA THEY NEED	WHY THEY NEED THE DATA	WHEN THEY NEED THE DATA
INTERNAL			
Board members	Updates on: • Activities, projects and programs • Management issues • Financial issues Lessons learned and info on program impacts	To monitor the efficiency and effectiveness of the organization, its people, products and impacts To provide guidance To problem solve To help us fundraise	Monthly memo and financial statement to CEO Quarterly meeting (Jan., April, July, Oct.) Annual report and financial statement (Dec.)
EXTERNAL			
Donor: Pact/USAID	Progress of grant activities Results of grant activities Financial data Lessons learned	To approve transfer of funds To monitor our grant progress To learn about our grant impacts To monitor and evaluate their program To enable them to report to their donors	Quarterly reports Monthly financial reports Mid-term evaluation report Final program report and evaluation
Community leaders in project area	Results of HIV/AIDS prevention campaign: • Number of people reached in campaign • Incidences of infections averted	To be able to report back to the community and get feedback To monitor community health To ensure quality relations between the project and the community	Twice a year (Jan. and July)
Ministry of Health	Number of HIV/AIDS cases averted	To count our contribution in a national HIV/AIDS prevention effort To show efforts being made in country to improve standards of HIV/AIDS prevention To compare incidence rates to level of illness in a target area To approve our annual certificate of medical provision	Twice a year (June and Dec.)

ACTIVITY #2 WORKSHEET ▶ AUDIENCE AND INFORMATION NEEDS ANALYSIS

WITHIN MY ORGANIZATION, WHO NEEDS INFORMATION ABOUT THE PROGRESS AND RESULTS/PERFORMANCE OF PROGRAMS?	WHAT INFORMATION DO THEY NEED?	WHY DO THEY NEED THE INFORMATION? WHAT WILL THE DATA HELP THEM DO?
WHO ARE THE EXTERNAL AUDIENCES THAT NEED INFORMATION ABOUT THE PROGRESS AND RESULTS/PERFORMANCE OF OUR PROGRAMS?	**WHAT INFORMATION DO THEY NEED?**	**WHY DO THEY NEED THE INFORMATION? WHAT WILL THE DATA HELP THEM DO?**

CHAPTER 2

RESULTS-BASED MER

In this chapter, readers will learn:

- The importance of results-based management and monitoring
- Levels of results
- How to refine strategic plan elements into results statements to clarify linkages and hierarchy
- How to draft an implementation plan for a United States government (USG) grant

In this chapter, readers will complete the following tasks in building their MER systems:

- Develop a results framework.
- Implement a plan for a USG grant.

The Shift Toward Results-Based Management and Monitoring

Traditionally, monitoring focused simply on the implementation of projects: tracking basic inputs (resources) and outputs (products or services). For example: We were given x amount of money and we trained 12 organizations, issued 300 press releases, tested 1,200 people, etc. Data collection was often completed haphazardly and not as part of a systematic, comprehensive, and long-term plan. When a project ended, the monitoring ended too.

Today, given the increasing complexity of development issues and increasing competition for resources, organizations must think about (and present) the results of their programs as contributing to a larger strategic objective. A strategic objective is the overall and long-term effect of an intervention. In other words, it is the highest level of impact an organization anticipates having. Some examples include:

- Reduction in incidence of HIV
- Reduced number and percentage of HIV-infected infants born to HIV-infected mothers
- Reduced number and percentage of young people (ages 15–24) that are HIV-infected
- Increased survival/decreased mortality of PLWHAs
- Increased quality of life for PLWHAs
- Increased quality of life for AIDS orphans and vulnerable children (OVCs).

Organizations plan, present, and monitor how they contribute to the attainment of a strategic objective in the short-term, intermediate, and long-term.

When you were developing your organization's strategic plan or proposal, you were probably thinking about what your organization wants to do in terms of development objectives (results you want to see and make happen). In creating that plan or proposal, you were laying out the structure for results-based management. Results-based management is a management approach by which an organization ensures that its processes, products, and services contribute to the achievement of clearly stated results. A result is a consequence of a particular activity, project, or program that an organization can affect and for which it is willing to be held accountable. Simply put, a result is a change in condition attributable in whole or part to the organization.

A result is:

- A broad term used to refer to the effects of a program
- The most ambitious impact that an organization can effect and for which it is willing to be held accountable
- A describable or measurable change in state that is derived from a cause-and-effect relationship
- The consequences of a particular program/project/activity
- The outcome, output, or impact (There can be several levels of results for a large complex program.)

A good results statement:

- States the most ambitious impact that an organization can effect
- Expresses the highest level for which the project can reasonably be expected to be held accountable
- May need to be qualified by using terms such as facilitated, improved, and supported to ensure that it is a realistic result of the project
- Does not include the means of achieving them
- Is as specific as possible.

In its simplest form, a result is:

the objective restated as an accomplishment

If you are practicing results-based management, then it makes sense that your MER would mirror the same structure so that you have information about whether you are meeting your results. This is referred to as results-based monitoring (also known as performance monitoring or outcome monitoring). In addition to tracking general project implementation information (for example, how much money the organization spent on an activity), the MER system also measures the organization's contribution of processes, products, and services to broader development objectives.

Levels of Results

One way to present the short, intermediate, and long-term results and associated indicators is to think about what the project is achieving at four levels:

1. Inputs and processes
2. Outputs
3. Outcomes
4. Impacts.

Inputs and processes are the resources and methods employed to conduct an activity, project, and/or program. Inputs can be physical, such as equipment rental or purchase; material, such as supplies and provisions; human, such as labor costs for salaries, technical assistance, and staff; or financial, such as travel costs, per diem costs, direct and indirect costs. Processes are the methods or courses of action selected to conduct the work, such as training, capacity building, service provision, and message promotion. Inputs usually produce a result immediately (0–1 years).

Outputs are information, products, or results produced by undertaking activities or projects. Outputs relate to completion of activities and are the type of results over which managers have a high degree of influence. Outputs reflect what you hoped to produce from a particular input (or set of inputs). For example: You decide the process you want to use is to train people. People trained is the result at the input/process level while knowledge level increased would be the result at an output level, the assumption being that if you train people, they will increase their knowledge on a given subject. Outputs usually reflect a result achieved in a relatively short time period (0–2 years).

Outcomes are broad changes in development conditions. Outcomes help us answer the "so what?" question. (For example: We trained 100 people and increased their knowledge but did or did they not change their behavior?). Outcomes often reflect behavior or economic change and help us analyze how our activities and projects scale up or contribute toward development outcomes. Outcomes usually reflect a result achieved over an intermediate time period (2–5 years).

Impacts are the overall and long-term effects of an intervention. Impacts are the ultimate result attributable to a development intervention over an extended period, such as improvement in HIV/AIDS incidence rates and higher standards of living for PLWHAs. Impacts usually reflect a result achieved over a longer time period (5–10+ years).

The Results Chain

INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Resources and processes utilized to produce a change/result Examples of resources and processes include: • Staff • Mentoring/technical assistance • Funds • Materials • Facilities/ infrastructure • Training • Community mobilization • Development of advocacy or communication messages • Establishment of services • Establishment of networks • Establishment of websites • Identification of best practices or lessons • Research *Which lead to...* ➡	Short-term change, effects, and results Examples of outputs include: • Knowledge/ awareness, understanding change • Service change (more people receiving services) • Access change (improved or expansion of access to services, programs, networks, materials or information) • Quality change (improved programs, services) • Capacity change (improved skills and abilities, improved capacity to address specific needs) *Which lead to...* ➡	Intermediate change, effects, and results Examples include: Increased coverage of target populations by interventions leading to: • Behavior change (increased participation, improved HIV/AIDS prevention practice, increased media coverage, increased partnership and collaboration) • Attitude change (percentage of the general population with accepting attitudes toward PLWHAs) • Individual economic change (increased financial benefits, increased household income, etc.) • Percentage of people with advanced HIV infection receiving antiretroviral therapy (ART) • Individual educational level change • Intermediate policy change/policy drafted *Which lead to...* ➡	Long-term change, effects, and results Examples include: • Quality of life change • Overall health status change (increased survival, decreased mortality, decreased morbidity, reduced infection rate, percentage of people still alive at six,12, and 24 months after initiation of treatment) • Political change (human rights policies affecting PLWHAs developed, transparency and accountability among Ministry of Health (MOH) clinics achieved, etc.) • Legal change (legislation enacted and rule of law improved, etc.) • Human rights, sociocultural and empowerment change, socioeconomic status change (reduction in poverty, increased livelihoods, etc.) • Resource management change
PROJECT LEVEL (TRACKING EFFICIENCY) (IMPLEMENTATION MONITORING)		PROGRAM LEVEL	
		STRATEGIC LEVEL (EVALUATING EFFECTIVENESS) (OUTCOME MONITORING)	

This example illustrates how one organization presented its contribution toward one development objective by capturing the anticipated levels of results:

Program Area: AIDS Education

INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Improved message promotion	Improved knowledge	Reduced number of partners	Reduction of HIV incidence

The Role of Hypotheses and Assumptions

The results chain or framework represents the development hypothesis of an organization. A hypothesis illustrates the cause-and-effect linkage that is believed to exist by the organization. The framework is simply an "if…then" approach to planning and implementation— "If we improve message promotion…then people will improve their knowledge about HIV…and then people will change their behaviors…and then HIV prevalence will be reduced." Results in the framework are linked to each other. The hypotheses are usually based on an in-depth understanding of the economy, political situation, social and demographic factors, and potential factors outside the project's context that may affect achievement of development outcomes. The results framework is also based on critical assumptions (conditions that are assumed will or will not take place outside the control of an organization that are likely to affect results); some examples might be the continued existence of a positive policy environment, a relatively free press, absence of severe drought or natural catastrophe and political turmoil. Building a results framework helps identify linkages and important external factors that might require monitoring.

RESULTS CHAIN/FRAMEWORK EXAMPLE

INPUTS/PROCESSES (RESOURCES, PROCESSES, AND METHODS UTILIZED)

- Funding for programs, facilities, and materials provided
- Training/mentoring for key stakeholders and service providers funded
- Staff hired and organizational structures in place
- Needs identified
- Materials and messages developed
- Community mobilization conducted
- Networks, websites, memorandums of understanding (MOUs), and partnerships established
- Curriculum/best practices/lessons identified and disseminated

Leading to... ➡

OUTPUTS (SHORT-TERM CHANGE, EFFECTS, AND RESULTS SOUGHT)

- Increased number of facilities/expansion of services sites and/or programs operating
- Increased number of individuals being served (having access to services)
  - Increased number of clients served
  - Increased number of new clients served by service providers
  - Increased number of current clients in continuous services for more than 12 months
- Increased capacity of service providers (increased knowledge and skills) in service provision
- Increased capacity of health facilities and organizations to provide HIV/AIDS care
- Increased quality of services
- Increased understanding and knowledge about HIV/AIDS and related issues

Leading to... ➡

OUTCOMES (INTERMEDIATE CHANGE EFFECTS AND RESULTS SOUGHT)
Increased proportion of the population covered by intervention leading to: • Changed/improved attitudes • Changed/improved behaviors/practices • Improved economic standing of targeted individuals/households • Improved emotional well-being of PLWHAs, OVCs, families, and/or care providers • Improved heath of targeted PLWHAs, OVCs, and families • Improved educational status of OVCs or PLWHAs • Improved policy environment—a commitment to HIV/AIDS and related issues *Leading to...* ➡
IMPACTS (LONG-TERM CHANGE, EFFECTS, AND RESULTS SOUGHT)
• Improved well-being, care, and support for the chronically ill and families affected by HIV/AIDS • Reduced number and percentage of HIV-infected individuals ◦ Increased survival/decreased mortality/decreased morbidity of PLWHAs ◦ Improved quality of life for PLWHAs, OVCs, families and/or care providers

Below are some examples of results chain/frameworks for specific areas of HIV programming:

OVCs:

RESULTS CHAIN/FRAMEWORK FOR OVCS
INPUTS/PROCESSES (RESULTS RELATING TO PROVISION OF RESOURCES AND PROCESSES)
• Funding for programs, facilities, and materials provided • Human resources hired/available • Training/mentoring for key stakeholders and service providers offered • Materials, plans, and guidelines produced/provided • Facilities produced/provided • Networks established, coordination undertaken • Curriculum/best practices/lessons identified and disseminated *Leading to...* ➡
OUTPUTS (RESULTS RELATING TO SHORT-TERM CHANGE EFFECTS AND RESULTS SOUGHT)
• Increased/strengthened capacity of communities to address the needs of OVCs • Increased number of facilities, services, and programs available to OVCs • Increased access to services • Increased number of OVCs served • Increased quality of service/care • Increased knowledge and understanding of HIV/AIDS prevention transmission and care *Leading to...* ➡

OUTCOMES (RESULTS RELATING TO INTERMEDIATE CHANGE AND EFFECTS SOUGHT)

A majority of the targeted population is covered by the intervention, resulting in improvement in:

- Health of OVCs
- Educational levels of OVCs
- Economic capacity of OVCs and/or their care providers
- Emotional well-being of OVCs
- Protection of OVCs (reduced exploitation)
- HIV/AIDS prevention practices by OVCs

Leading to... ➡

IMPACTS (RESULTS RELATING TO LONG-TERM CHANGE AND EFFECTS SOUGHT)

- Improved quality of life for AIDS orphans and other vulnerable children

PLWHA care and support:

RESULTS CHAIN/FRAMEWORK FOR CARE AND SUPPORT OF PLWHAs

INPUTS/PROCESSES (RESULTS RELATING TO PROVISION OF RESOURCES AND PROCESSES)

- Recruitment/selection of volunteers/staff
- Partnerships/MOUs developed with faith-based organizations (FBOs)/CBOs/government sector
- New support groups established
- PLWHAs identified who require care and support
- PLWHAs' needs in respect to care and support identified
- Training needs identified
- Training materials developed
- PLWHAs/FBOs/CBOs/home-based care (HBC) service providers trained
- Networks within geographic locations established
- Networks for nutritional support established
- Database populated
- Basic care and support service package enhanced
- Other resource providers/support mechanism for referral identified

Leading to... ➡

OUTPUTS (RESULTS RELATING TO SHORT-TERM CHANGE EFFECTS AND RESULTS SOUGHT)

- Increased knowledge among service providers and support groups as to the needs of PLWHAs
- Increased number of targeted stakeholders knowledgeable about quality care and support
- Increased capacity/skills of support groups, service providers, HBC workers to provide service
- Increased quality of services offered to PLWHAs
- Increased access to information/networking among support groups
- Increased access to care and support services (including nutrition services, home-based care, palliative care, and basic care and support package)
- Increased support base for PLWHAs to care and support services
- Increased number of visits (by type of service)

Leading to... ➡

OUTCOMES (RESULTS RELATING TO INTERMEDIATE CHANGE AND EFFECTS SOUGHT)

Increased proportion of clients being served by knowledgeable care providers so that an increased proportion of PLWHAs and affected families have:

- Improved health
- Improved medical support—symptoms diagnosed and treated correctly/referrals made
- Positive living is being undertaken
- Pain and suffering appropriately treated
- Spiritual and emotional support provided
- Grief counseling provided

Leading to... ➡

IMPACTS (RESULTS RELATING TO LONG-TERM CHANGE AND EFFECTS SOUGHT)

- Improved quality of life of both the infected and affected
- Extended life span

Palliative care:

RESULTS CHAIN/FRAMEWORK FOR PALLIATIVE CARE

INPUTS/PROCESSES (RESULTS RELATING TO PROVISION OF RESOURCES AND PROCESSES)

- Staff hired and organizational structures in place
- Officers acquired, equipped and infrastructure in place
- Mapping exercise completed
- Palliative care expertise, services, and resources identified in targeted regions
- Coordination/networking mechanisms established
- Standards for palliative care, training, good governance, and management developed
- Policies and procedures for management and good governance established including MER
- Capacity assessment of service providers conducted
- Approval of palliative care services/training providers
- Technical assistance for palliative care program development provided
- Facilitation of training courses, training of trainers (TOT), and technical assistance in palliative care
- Partnership, twinning, and mentorship encouraged/formed
- Knowledge, lessons, and best practices identified and disseminated
- Adequate financing for sustaining key programs secured

Leading to... ➡

OUTPUTS (RESULTS RELATING TO SHORT-TERM CHANGE EFFECTS AND RESULTS SOUGHT)

- Palliative care association functional with increased oversight, networking, advocacy, and financial capacity
- Increased number of governments and health care practitioners aware of palliative care
- Increased knowledge as to the needs of service providers and palliative care patients
- Increased number of targeted stakeholders trained and knowledgeable in quality palliative care services
- Increased number of service sites providing palliative care
- Increased number of service sites accredited
- Increased capacity and skills among service providers in palliative care
- Increased quality of service/implementation of standards of practice
- Increased number of clients served (by accredited or trained palliative care providers)
- Spiritual and emotional support and grief counseling are provided
- Increased number of families providing care to palliative family members at home

Leading to... ➡

OUTCOMES (RESULTS RELATING TO INTERMEDIATE CHANGE AND EFFECTS SOUGHT)

• Increased proportion of palliative care patients and families receiving quality palliative care, for example:
  ◦ Symptoms are diagnosed correctly
  ◦ Pain and suffering is appropriately treated
  ◦ Access to essential palliative care drugs is provided, including morphine
  ◦ Spiritual and emotional support and grief counseling provided
• Increased political commitment by governments to quality palliative care
• Increased commitment among service providers to sustainably provide quality palliative care
• Increased proportion of families and patients successfully coping with death, bereavement, and planning for the future
Leading to... ➡

IMPACTS (RESULTS RELATING TO LONG-TERM CHANGE AND EFFECTS SOUGHT)
• Improved well-being, care, and support for the chronically ill and families affected by HIV/AIDS

HIV Voluntary Counseling and Testing:

RESULTS CHAIN/FRAMEWORK FOR COUNSELING AND TESTING
INPUTS/PROCESSES (RESULTS RELATING TO PROVISION OF RESOURCES AND PROCESSES)
• Partnerships/MOUs developed with voluntary counseling and testing (VCT) service providers • Existing sites that provide VCT services assessed • Materials for VCT training enhanced • Risk reduction counseling implemented in terms of the protocols • Database populated • Networks established • Communities sensitized *Leading to...* ➡
OUTPUTS (RESULTS RELATING TO SHORT-TERM CHANGE EFFECTS AND RESULTS SOUGHT)
• Increased capacity/skills of target groups to deliver VCT (Increased number of service providers trained) • Increased access to information/networking among target groups • Community access to VCT services increased/broadened • Increased number of service outlets providing VCT (by type of service provider) • Increased number of individuals who receive counseling and testing *Leading to...* ➡
OUTCOMES (RESULTS RELATING TO INTERMEDIATE CHANGE AND EFFECTS SOUGHT)
• Increased community demand for VCT services • Increased proportion of targeted population being tested *Leading to...* ➡
IMPACTS (RESULTS RELATING TO LONG-TERM CHANGE AND EFFECTS SOUGHT)
• Reduced HIV/AIDS infection rate

Youth Behavior Change Communication (BCC):

RESULTS CHAIN/FRAMEWORK FOR BEHAVIOR CHANGE COMMUNICATION (BCC) PROGRAM TARGETING YOUTH (AGES 10–24)

INPUTS/PROCESSES (RESULTS RELATING TO PROVISION OF RESOURCES AND PROCESSES)

- Funding and grants provided
- Root cause/issue analysis conducted
- Technical expertise provided
- Materials and communication messages developed
- Schools and communities selected
- Child-to-child mentoring and peer groups formed (in school and out of school)
- Adult-to-child mentoring programs established
- Training provided, including in creation and delivery of A and AB messages
- Mentoring provided
- Best practices and lessons captured and distributed
- Limited commodity support provided

Leading to... ➡

OUTPUTS (RESULTS RELATING TO SHORT-TERM CHANGE EFFECTS AND RESULTS SOUGHT)

- Increased capacity and skills of targeted HIV/AIDS organizations, community leaders, and youth mentors so they may better craft and deliver optimal A and AB communication messages among targeted populations (individuals ages 10–24):
  - Capacity/skills increased to promote A and AB messaging through improved peer mentoring
  - Capacity/skills increased to promote A and AB messaging through quality adult-to-child community programming
  - Capacity/skills increased to promote A and AB messaging in quality in-school program settings
  - Capacity/skills increased to promote A and AB messaging in quality out-of-school/alternative education settings
  - Capacity/skills increased to promote A and AB messaging in quality mass media campaigns
- Capacity/skills of journalists and media staff increased so they may better formulate, cover, and program stories relating to A and AB messaging in mass media settings
- Increase capacity of targeted HIV/AIDS organizations so they are more effective in improving knowledge and increasing the number of individuals ages 10–24 who hear targeted A and AB communication messages so the individuals have:
  - Increased knowledge of what HIV/AIDS is and how it is and is not contracted and reduce prevalence of misconceptions regarding HIV/AIDS
  - Increased knowledge of the best way to protect oneself from HIV (abstinence)
  - Increased awareness of youth on the importance of delay of sexual initiation, having one-to-one sexual relations, avoiding premarital sex
  - Increased knowledge that multiple sex partners increases the chances of contracting HIV while being faithful and/or having fewer partners may help decrease the chances of contracting HIV
  - Increased knowledge among adolescent males that engaging in sexual relations with young girls or virgins does not mean HIV-free relations

- Increased knowledge of young girls regarding their security and the existing risk of rape
- Increased awareness of parents on the importance of early communication with children on the issues of sexuality
- Increased awareness among targeted populations on the impact of harmful traditional practices
- Increased awareness of the role of both males and females in sharing sexual decision-making
- Increased knowledge and skill in sexual communication practices

- Increased capacity among targeted organizations to sustainably deliver communication and HIV/AIDS messages and function successfully as an organization

Leading to... ➡

OUTCOMES (RESULTS RELATING TO INTERMEDIATE CHANGE AND EFFECTS SOUGHT)

- Larger proportion of targeted populations (ages 10–24) who report:
  - Delayed onset of sexual activity, both boys and girls ages 10–24
  - Reduced number of sexual partners (increase in percentage of young people who are faithful)
  - Increased parent-to-child communication on sexual matters
  - Increased proportion of young people who have positive attitudes toward men and women being jointly involved in and communicating about sexual matters/decision-making
  - Increased proportion of young people (particularly males) who have negative attitudes towards rape
  - Young men and women protected from acquiring STDs and HIV and/or unwanted pregnancy

Leading to... ➡

IMPACTS (RESULTS RELATING TO LONG-TERM CHANGE AND EFFECTS SOUGHT)

- Reduced number and percentage of young people (ages 10–24) that are HIV-infected

ACTIVITY #3A WORKSHEET ▶ REFINING RESULTS STATEMENTS AND FRAMEWORKS

Put the following results statements in the correct results level categories:

Example: *Improved knowledge and understanding on HIV/AIDS on prevention practices; reduction of HIV incidence; communication messages developed; reduced number of partners. (See answer in chart.)*

1. Access increased to food/nutrition sources; resource centers built (including kitchens); increased quality of life for OVCs; improved nutrition of targeted OVCs
2. Improved quality of life of persons living with HIV/AIDS; reduced stigma and discrimination; increased knowledge and understanding of how HIV/AIDS is (and is not) transmitted; course curriculum developed for secondary schools.

INPUTS	OUTPUTS	OUTCOMES	IMPACTS
Example: Communication messages developed	**Example:** Improved knowledge and understanding of HIV/AIDS prevention practices	**Example:** Reduced number of partners	**Example:** Reduction of HIV incidence
1.			
2.			

ACTIVITY #3B WORKSHEET ▶ REFINING RESULTS STATEMENTS AND FRAMEWORKS

A quality MER plan starts with quality results statements and reflects your strategic plan.

1. Impact-Level Results—Your Long-Term Development Objective

a. Review the precise wording and intention of your vision statement. (You may also want to review your mission statement and objectives.)

b. In the box below, re-write your vision as a results statement describing the overall and long-term effects of your organization's interventions. Make sure that:

- The result is an effect or consequence of a particular activity, project, or program of your organization for which you are willing to be held accountable (perhaps in partnership with others).
- The statement is one-dimensional (you may have more than one strategic outcome).
- The statement is written as an accomplishment.

Do not include how you will achieve results. Focus on describing the results you hope your intervention will accomplish. Do not include extemporaneous factors, just critical outcomes.

Example:

Vision as written in plan: *OVCs in South Africa are socially and physically healthy and live in economically stable conditions.*

Vision as written as an impact-level results statement: *Improved quality of life of OVCs (health, education, and economic stability).*

Results Framework

LEVEL OF RESULTS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Key results sought				• Improved quality of life of OVCs (health, education, and economic stability)

ACTIVITY #3B WORKSHEET ▶

Your vision statement: _____

Your vision statement written as an impact-level results statement(s): _____

Your Results Framework

LEVEL OF RESULTS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Key results sought				

2. Outcome-Level Results—Your Intermediate Results

a. Review the precise wording and intention of your mission statement. You may also want to review your objectives and strategies.

b. In the box below, re-write your mission as results statements. Make sure that:

- The result is an effect or consequence of a particular activity, project, or program of your organization for which you are willing to be held accountable (perhaps in partnership with others).
- The statement is one-dimensional. You may find that you have more than one development outcome.
- The statement is written as an accomplishment.

c. Look at the results statements you have drafted and then determine if they describe the intermediate outcomes of your organization's interventions. They should answer the "so what?" question of why you are undertaking a series of activities and are often related to behavior or economic change, or they describe the outputs or products of a series of activities. Capture each statement in the appropriate boxes. If more detail is needed to clarify the linkages, add it and refine your results statements.

ACTIVITY #3B WORKSHEET ▶

d. Do not include how you will achieve results. Focus on describing the results you hope your intervention will accomplish. Do not include extemporaneous factors, just critical outcomes.

Example:

Mission as written in plan:
Improve the quality of life of all OVCs through provision of services (or referrals) to improve the health, education, and economic capacity of OVCs and/or their care providers and to ensure the emotional well-being and protection of OVCs, including HIV/AIDS prevention/care.

Mission written as results statements:

- *All OVCs covered*
- *Improved health of OVCs*
- *Improved educational levels of OVCs*
- *Improved economic capacity of OVCs and/or their care providers*
- *Improved emotional well-being of OVCs*
- *Improved protection of OVCs (reduced exploitation)*
- *Improved HIV/AIDS prevention practices by OVCs.*

Results Statements Organized by Level

LEVEL OF RESULTS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Key results sought in program area			• A majority of OVCs receiving care and support services • Improved health of OVCs • Improved educational levels of OVCs • Improved economic capacity of OVCs and/or their care providers • Improved emotional well-being of OVCs • Improved protection of OVCs (reduced exploitation) • Improved HIV/AIDS prevention practices by OVCs	• Improved quality of life of OVCs (health, education, and economic stability)

ACTIVITY #3B WORKSHEET ▶

Your mission statement: _____

Your results statements: _____

Your Results Statements Organized by Level

LEVEL OF RESULTS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Key results sought in program area				

ACTIVITY #3B WORKSHEET ▶

3. Output-Level Results – Your Short-Term Results

a. Review the wording and intention of your objectives and strategies.

b. In the box below, draft results statements describing the short-term outputs of your organization's interventions from the objectives, strategies, and activities draft. Remember these are project-oriented results and often relate to knowledge change, access change, service change, or quality change.

c. Make sure that:

- The result is an effect or consequence of a particular activity, project, or program of your organization for which you are willing to be held accountable (perhaps in partnership with others).
- The statement is one-dimensional. You may find that you have more than one development outcome.
- The statement is written as an accomplishment.

d. Do not include how you will achieve results. Focus on describing the results you hope your intervention will accomplish. Do not include extemporaneous factors, just critical outcomes.

e. Repeat the process with other objectives.

Example:

Objectives and strategies as written in plan:

- *Increase/strengthen capacity of communities to address the needs of OVCs*
- *Increase number of facilities, services, and programs available to OVCs*
- *Increase access to services*
- *Increase number of OVCs served*
- *Increase quality of service/care*
- *Increase knowledge and understanding of HIV/AIDS transmission prevention and care.*

Objectives and strategies written as results statements:

- *Increased/strengthened capacity of communities to address the needs of OVCs*
- *Increased number of facilities, services, and programs available to OVCs*
- *Increased access to services*
- *Increased number of OVCs served*
- *Increased quality of service/care*
- *Increased knowledge and understanding of HIV/AIDS transmission prevention and care.*

ACTIVITY #3B WORKSHEET ▶

Results Statements Organized by Level

LEVEL OF RESULTS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Key results sought in program area		• Increased/strengthened capacity of communities to address the needs of OVCs • Increased number of facilities, services, and programs available to OVCs • Increased access to services • Increased number of OVCs served • Increased quality of service/care • Increased knowledge and understanding of HIV/AIDS prevention, transmission, and care	• A majority of OVCs receiving care and support services • Improved health of OVCs • Improved educational levels of OVCs • Improved economic capacity of OVCs and/or their care providers • Improved emotional well-being of OVCs • Improved protection of OVCs (reduced exploitation) • Improved HIV/AIDS prevention practices by OVCs	• Improved quality of life of OVCs (health, education, and economic stability)

Your objectives and strategies: _____

Your objectives and strategies written as results statements: _____

ACTIVITY #3B WORKSHEET ▶

Your Results Statements Organized by Level

LEVEL OF RESULTS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Key results sought in program area				

4. Input/Process-Level Results—Your Immediate Results

a. In the box below, develop results statements describing the immediate inputs of your organization's interventions from your activities. Remember, these are project-oriented results and relate to process and resources utilized to undertake an activity (for example: training, services, staff, materials, etc.).

b. Make sure that:

- The result is an effect or consequence of a particular activity, project, or program of your organization for which you are willing to be held accountable (perhaps in partnership with others).
- The statement is one-dimensional. You may find that you have more than one development outcome.
- The statement is written as an accomplishment.

c. Do not include how you will achieve results. Focus on describing the results you hope your intervention will accomplish. Do not include extemporaneous factors, just critical outcomes.

d. Repeat the process with other outcomes.

ACTIVITY #3B WORKSHEET ▶

Example:

Activities as written in plan:

- *Secure funding*
- *Train service providers in needs of OVCs*
- *Provide mentoring of OVCs' care givers*
- *Develop materials for service providers*
- *Identify best practices*
- *Disseminate best practices to service providers*

Activities written as results statements:

- *Funding for programs, facilities, and materials provided*
- *Training/mentoring programs for key stakeholders and service providers funded*
- *Materials and facilities provided*
- *Curriculum/best practices/lessons identified and disseminated*

Results Statements Organized by Level

LEVEL OF RESULTS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Key results sought in program area	• Funding for programs, facilities, and materials provided • Training/mentoring programs for key stakeholders and service providers funded • Materials and facilities provided • Curriculum/best practices/lessons—identified and disseminated	• Increased/strengthened capacity of communities to address the needs of OVCs • Increased number of facilities, services, and programs available to OVCs • Increased access to services • Increased number of OVCs served • Increased quality of service/care • Increased knowledge and understanding of HIV/AIDS prevention, transmission, and care	• 50% of OVCs receiving care and support services • Improved health of OVCs • Improved educational levels of OVCs • Improved economic capacity of OVCs and/or their care providers • Improved emotional well-being of OVCs • Improved protection of OVCs (reduced exploitation) • Improved HIV/AIDS prevention practices by OVCs	• Improved quality of life of OVCs (health, education, and economic stability)

ACTIVITY #3B WORKSHEET ▶

Your activities: _____

Your related activities written as results statements: _____

Your Results Statements Organized by Level

LEVEL OF RESULTS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Key results sought in program area				

Information to Assist Your Organization to Develop a Results Framework

How to Write a Results Statement

1. Review the precise wording and intention of the activities, objectives, and project hypothesis. What exactly do they say? Sometimes objectives and results are so broadly stated it is difficult to identify the right indicators. Instead, specify those aspects believed to make the greatest difference to improve performance. Avoid overly broad results statements. For example, rather than using a broad statement like, "Reduced stigma and discrimination in xx community," clarify those aspects that program activities actually emphasize such as, "Fewer incidences of stigma and discrimination requiring documentation of human rights abuses of PLWHAs in xx community."
2. Clarify what type of change is implied. Because a result is a describable or measurable change, you need to be clear about what type of change is implied. What is expected to change? Is it a situation, a condition, the level of knowledge, attitude, a behavior? Changing a country's law about discrimination toward PLWHAs is very different from changing PLWHAs' awareness of their rights. And that is different from the amount of stigma and discrimination that PLWHAs receive. Each type of change is measured by different types of indicators.
3. Clarify whether the change being sought is an absolute change, a relative change, or no change.
    - Absolute changes involve the creation or introduction of something new.
    - Relative changes involve increases, decreases, improvements, strengthening, or weakening in something that currently exists, but at a higher or lower level than is considered optimum.
    - No change involves the maintenance, protection, or preservation of something that is considered fine as is.
4. Identify precisely the specific target for change. Be clear about where change should appear. Is change expected to occur among individual, families, groups, communities, regions? Clearly, a change in behavioral practices of the general population will be quite different than for a particular sector of the community, such as youth. This is known as identifying the "unit of analysis" for the indicators. Who or what are the specific targets for the change? If individuals, which individuals?
5. Determine what changes are reasonable to expect in relation to the project objectives and timeline. Before appropriate statements can be developed, it is necessary to be clear about the expected relationship between activities and their intended outcomes over a specific time frame, in order to understand exactly what changes are reasonable to expect.

QUESTIONS TO ASK WHEN WRITING RESULTS STATEMENTS

- Do the results reflect the highest desired achievements of the grant program that you can realistically be held accountable for delivering?
- Are the results realistic for the program to achieve during its lifetime?
- Are there any results that are unnecessary in terms of achieving the program purpose?
- Is there a set of practical strategies and actions that can be carried out to achieve each key result?
- Do the results lend themselves to being a clear and simple way of explaining what the project is all about?
- Are the results understandable to project stakeholders and expressed as plainly and succinctly as possible?

If you still need help in clarifying results, try answering (in point form) the following questions:

1. Specifically, who (people) or what (environment) will benefit from the result?
2. Specifically, what are the benefits?
3. What changes would have occurred if this result is achieved (what differences would you be able to observe)?
4. How do activities contribute to achieving results?

Implementation Planning

Once you have been provided a grant, and you have a results framework, you need to complete an implementation plan that lays out your activities over a time frame and refines results particularly anticipated at the input and output levels. While you may have included an implementation plan in your proposal, this is the time to finalize it reflecting the grant negotiations and final award (refer to your grant document "program description" and "special conditions" sections). This is also a time to ensure you have written high-quality goal and objective statements. The clearer these statements are, the easier it will be to select appropriate indicators for specific programs. Goals and objectives reflect results statements but are more specific and detailed, as they present the strategy you have selected for attaining results.

Hints For Writing Quality Goals

- Present the desired outcomes, accomplishments, results, or purposes sought (but not the process!). Capture broad changes in conditions, answering the "so what?" question (So…we trained 100 people and increased their knowledge but did or did they not change their behavior?).
- Goals reflect behavior, attitude, or economic change and show how activities contribute toward a larger development impact. They usually reflect a result achieved in an intermediate time period (2–5 years).

To write a goal statement, review your results frameworks at the outcome and impact levels, then mentally picture what you want specifically to accomplish in a particular program or period of time related to those results and say:

(We want) to _____ the _____ of/among _____

(action verb, like improve, increase, reduce, etc.)

(what behavior/practice/attitude or economic change is sought, though sometimes just the knowledge, capacity or access change is sought)

(whom)

Goals should not be a restatement of the development objective or impact-level results but present more detail in what you plan to accomplish under a specific program without presenting information on how you will accomplish it. Do not present your process/methods in a goal statement.

NO	YES
To reduce incidence of HIV/AIDS	To reduce the number of sexual partners among men 15–49
To improve health	To improve the pre-natal health practices of women living in targeted communities
To improve quality of life of OVCs	To increase the percentage of households receiving basic external support in caring for OVCs

Hints for Writing Quality Objectives

- Link them directly to the goals and make sure they state the outputs—information, products, processes, services or results you hope to produce that will support attainment of the goal.
- Reflect what you hope to produce by undertaking a specific activity. For example: you decide you want to train people (the activity). The objective should relate to the knowledge you seek to increase.
- Objectives usually reflect a result achieved in a relatively short time period (0–2 years).

Remember that all objectives should be SMART:

- **Specific:** The objective states a specific output to be accomplished—in numbers, percentages, frequency, reach, scientific outcome. The object is defined.
- **Measurable:** The objective can be measured and the measurement source is identified.
- **Achievable:** The objective or expectation of what will be accomplished is realistic given the time period, working conditions, resources, etc.
- **Relevant:** The output of the objective supports the goals sought in the project.
- **Time-bound:** The objective clearly states when the objective will be accomplished.

To write an objective, review your goal statement and results frameworks at the input and output levels, then mentally picture what you need to do/accomplish to achieve your goal and say:

(I want) to _____ the _____ in _____ by _____
(direction of change) *(what will be changed)* *(target area of change)* *(results to be achieved)*

_____ [as measured by _____] by _____ .
(how measured) *(time frame)*

Example

To increase *(direction of change)* the number of OVCs households receiving government supported stipends *(what will be changed)* in the greater Nairobi area *(target area of change)* by 25 percent *(results to be achieved)* as measured by Department of Social Services records *(how measured)* by December 30, 2006 *(time frame)*.

Another way to write objectives is to review your goal statement and results frameworks at the input and output levels, then mentally picture what you need to do/accomplish to achieve your goal and say:

(I want) to _____ _____ to _____ by _____
(action taken) *(object of action)* *(to whom/recipient)* *(by when)*

_____ [as measured by _____.]
(how measured)

Example

To provide four workshops *(action taken)* on how to care for OVCs at home *(object of action)* to 100 OVCs' household members *(to whom/recipient)* by December 30, 2005 *(by when)* as measured by attendance registers *(how measured)*.

Implementation Format

Use this form to develop your implementation plan. Repeat the process with each goal and for all your objectives under each goal.

IMPLEMENTATION PLAN SECTION	DESCRIPTION	EXAMPLE
PROGRAM NAME/ORGANIZATION NAME	Enter the name of your grant program and the name of your organization.	HIV/AIDS Palliative Care Association
GRANT GOAL #___ (OUTCOME LEVEL RESULT)	Enter the number and list your goal (*i.e.,* the first goal is goal #1). Ideally, the goals are reflective of either the impact, outcome, or output-level results.	**Goal #1:** Improve the standards of quality palliative care practice among Palliative Care Association members.
OBJECTIVE #___ (OUTPUT LEVEL RESULT/ACTIVITY/STRATEGY AREA)	Number and list your objectives (or activity/strategy areas). Ideally, the objectives are reflective of your input- or output-level results.	**Objective #1:** Increase the capacity in oversight, management, and advocacy, of the national body of the Palliative Care Association by Dec. 2006 (as measured by members' perceptions).
KEY ACTIVITIES	List (and number) the key activities you need to undertake to achieve your objective.	**1–1:** Establish a management team. **1–2:** Develop standards for palliative care good governance and management. **1–3:** Develop a communication strategy.
TARGET BENEFICIARIES	For each activity, list who will most directly benefit from completion of the activity, often this is the direct recipient targeted.	**1–1:** National Hospice **1–2:** Palliative Care Association and member organizations **1–3:** Palliative care professionals

IMPLEMENTATION PLAN SECTION	DESCRIPTION	EXAMPLE
TIME FRAME (STARTING ON/ENDING ON)	Note when the activity is scheduled to start and when you plan to have it completed. Be as exact as possible.	**1–1:** April 2004 – July 2004. **1–2:** May 2004 – July 2004 **1–3:** May 2004 – Aug. 2004
PERSON/PARTNER RESPONSIBLE	Identify who is taking the lead on completing or following the activity. Is it executive staff, a consultant, a partner, or someone else?	**1–1:** Executive staff **1–2:** Management team **1–3:** Public relations consultant
RESULTS ANTICIPATED (TARGET INPUTS/OUTPUTS)	List the results you will bring about once the activity is completed, (*i.e.,* information, products, or results produced that are attributable to your efforts.) Normally, these relate to your input and output level results. Be as exact as possible and use numbers. If this activity has to do with training, services offered, or number of patients served, be exact as to how many people you plan to train, how many people will receive services, or how many programs/services you plan to offer.	**1–1:** One committee established; management capacity improved **1–2:** Standards published; increased oversight capacity/quality defined **1–3:** One strategy developed. Information materials and media activities developed and distributed; increased knowledge on standards of care among professionals
BUDGET	Pulling the data from your finalized budget, estimate the cost for the activity or the related series of activities. The budget can either be in local currency or U.S. dollars.	**1–1:** through **1–3:** $30,000 USD
COMMENTS	List any other information that is essential to understanding the information in the plan. Some examples might be geographic area of coverage, more detail on materials to be purchased, developed, or distributed, etc.	**1–1:** Executive staff will ensure member organizations from each province are represented on the management committee.

Implementation Plan Example

PROGRAM NAME/ORGANIZATION NAME: **HIV/AIDS** PALLIATIVE CARE ASSOCIATION

GRANT GOAL **#1:** IMPROVE THE STANDARDS OF QUALITY PALLIATIVE CARE PRACTICE AMONG PALLIATIVE CARE ASSOCIATION MEMBERS.

OBJECTIVE **#1:** INCREASE THE CAPACITY IN OVERSIGHT, MANAGEMENT, AND ADVOCACY, OF THE NATIONAL LEVEL BODY OF THE PALLIATIVE CARE ASSOCIATION BY **12/06** (AS MEASURED BY MEMBERS' PERCEPTIONS).

KEY ACTIVITIES	TARGET BENEFICIARIES	TIME FRAME STARTING ON	ENDING ON	PERSON/PARTNER RESPONSIBLE	RESULTS ANTICIPATED (TARGET INPUTS/OUTPUTS)	BUDGET	COMMENTS
1–1: Appoint personnel to key positions.	National Hospice Palliative Care Association and member organizations; palliative care professionals	April 2004	Jan. 2005	Executive staff/ management team	I43 staff recruited. Increased human resource capacity.	$15,000	Project management, national coordinators, administrative assistant, eight provincial palliative care coordinators, 16 mentors at mentor hospices, 12 training coordinators
1–2: Establish management team.		April 2004	July 2004	Executive staff	One committee established; management capacity improved		Member organizations from each province are represented on the mgmt committee

Implementation Plan Example

PROGRAM NAME/ORGANIZATION NAME: HIV/AIDS PALLIATIVE CARE ASSOCIATION

GRANT GOAL #1: IMPROVE THE STANDARDS OF QUALITY PALLIATIVE CARE PRACTICE AMONG PALLIATIVE CARE ASSOCIATION MEMBERS.

OBJECTIVE #1: INCREASE THE CAPACITY IN OVERSIGHT, MANAGEMENT, AND ADVOCACY, OF THE NATIONAL LEVEL BODY OF THE PALLIATIVE CARE ASSOCIATION BY 12/06 (AS MEASURED BY MEMBERS' PERCEPTIONS).

KEY ACTIVITIES	TARGET BENEFICIARIES	TIME FRAME STARTING ON	ENDING ON	PERSON/PARTNER RESPONSIBLE	RESULTS ANTICIPATED (TARGET INPUT/OUTPUTS)	BUDGET	COMMENTS
1–3: Equip national office.	National Hospice Palliative Care Association and member organizations; palliative care professionals	April 2004	Sept. 2004	Management team	Increased networking/ administration capacity	$15,000	
1–4: Recruit members.		April 2004	Ongoing	Management team	Ten new members		
1–5: Develop standards for palliative care good governance and management.		May 2004	July 2004	Management team	Standards published; increased oversight capacity/quality defined		
1–6: Establish policies and procedures for hospice management and good governance.		April 2004	Dec. 2004	Management team	Policies and procedures published; increased oversight capacity/quality defined		
1–7: Establish accreditation program.		April 2004	Aug. 2004	Management team	Accreditation program developed; increased oversight capacity/quality defined	$5,000	
1–8: Conduct accreditation of member hospices.		Aug. 2004	March 2005	Management team	Ten hospices fully accredited; 42 in process evaluated		
1–9: Develop communication strategy.		May 2004	Aug. 2004	Public relations consultant	One strategy developed; information materials and media activities developed; knowledge among professionals increased	$10,000	
1–10: Promote access to essential palliative care drugs including morphine.	Patients, members, patients, providers, government	July 2004	Ongoing	Management team	Access to appropriate drugs improved		
1–11: Liaise with key DOH officials at national and provincial level.		Ongoing throughout grant		HPCA	Knowledge and understanding of palliative care issues increased		
1–12: Raise awareness among community members and health professionals in respect of palliative care.	Community members and health care professionals.	Ongoing throughout grant		HPCA	Knowledge and understanding of palliative care issues increased	$8,000	

ACTIVITY #4 WORKSHEET ▶ DEVELOPING AN IMPLEMENTATION PLAN

Implementation Plan							
PROGRAM NAME/ORGANIZATION NAME:							
GRANT GOAL # ____:							
OBJECTIVE # ____ :							
KEY ACTIVITIES	TARGET BENEFICIARIES	TIME FRAME		PERSON/PARTNER RESPONSIBLE	RESULTS ANTICIPATED (TARGET INPUTS/OUTPUTS)	BUDGET	COMMENTS
		STARTING ON	ENDING ON				

CHAPTER 3

INDICATORS

In this chapter, readers will learn:

- To identify what indicators are and why they are important
- How to select indicators
- Ten criteria for assessing the quality of indicators
- How (and why it's necessary) to develop indicator protocols
- What the Emergency Plan indicators are and which are required for their organization

In this chapter, readers will complete the following tasks in building their MER systems:

- Identify some of the indicators for their organizations at the strategic level.
- Assess the quality of indicators selected.
- Develop an indicator protocol.
- Identify the Emergency Plan indicators used to report on a grant.

Introduction

Because you cannot afford either in terms of time or money to monitor every aspect of your program, you need to select indicators to identify what you will measure to know if conditions have or have not changed. Using indicators enables you to reduce a large amount of data down to its simplest form while retaining the essential information you need to make decisions.

What Is an Indicator?

- An indicator is a unit of information, measured over time, that documents change.
- An indicator provides evidence of how much has been or has not been achieved.
- Indicators are usually quantitative (number-related) measures but may also be qualitative (narrative-related) observations.
- Indicators enable a large amount of data to be reduced down to its simplest form.

Why Are Indicators Important?

Indicators serve as tools to examine trends and highlight problems and can act as early warning signals to predict future conditions. When compared with targets, indicators can signal the need for corrective management action, evaluate the effectiveness of various management actions, and help determine if objectives are being achieved. Indicators, by themselves, do not tell managers whether an observed change is acceptable or unacceptable nor do they necessarily identify the cause of the change.

It is important to note that there is no requirement to develop an indicator for every possible issue. Even the most ambitious program is likely to include a limited number of indicators. Many do not lend themselves to being easily monitored and can be addressed in a different manner. Indicators represent the elements that are most important for monitoring, but usually no single indicator constitutes a comprehensive measure. Managers will need to select a number of complementary indicators to adequately assess whether a particular objective is being achieved. Several donors request indicators and measure their performance closely.

INDICATORS ARE NOT:

- Anything that can be measured. They should reduce a large amount of data down to its simplest form.
- Objectives, targets, or results. They do not specify a particular level of achievement. The words "improved," "increased," "gained," etc. do not belong in an indicator.

Indicators Are Not….

Indicators are not just anything you can think of to measure. Every measure is not an indicator. Indicators are meant to reduce a large amount of data down to its simplest form. For example, say you wanted to buy a used car and you wanted to know what condition the car was in. You could look at or "measure" many things when you go to see the car, including the amount of gas in the car, the amount of tread on the tires, the number of dents in the car, the level of oil pressure, among many others. These measures are all associated with the car but they probably aren't the best gauge or indicator of the car's condition. The best indicator of a car's condition is likely to be the mileage (how many kilometers the car has been driven). This data reduces a large amount of data down to its simplest form. The odometer reading tells you how much the car has been driven, indicating how much wear the engine has undergone, thus providing a useful indication to help you evaluate the condition of the car.

Another more relevant example might be developing indicators to measure the percentage of OVCs who are receiving support. You could measure many things: the number of OVCs residing in households that received health care support within the past 12 months; emotional support within the past three months; school-related assistance within the past 12 months; other social support, including material support, within the past three months. All four types of support can be used as measures. However, combining two of the measures, such as OVCs residing in households that received health care and emotional support within the past 12 months, may be the measurement that reduces a large amount of data down to its simplest form.

TARGETS: MAGNITUDE OR LEVEL OF OUTPUT EXPECTED TO BE ACHIEVED. TARGETS ARE VALUES AGAINST WHICH THE ACTUAL PROJECT ACHIEVEMENTS ARE COMPARED. TARGETS SHOULD BE REALISTIC.

THEY ARE NORMALLY QUANTITATIVE. IF THE TARGETS ARE QUALITATIVE, THEY DESCRIBE A STATEMENT OF THE EXPECTED STATE OF AFFAIRS AT THE END OF A PROJECT PERIOD.

Indicators are not objectives, targets, goals, or results. Indicators do not specify a particular level of achievement. The words "improved," "increased," "gained," etc., do not normally belong in an indicator. Rather, indicators describe the unit of information to be measured over time. For example, if you want to increase knowledge level, that is a goal. The indicator is the change in knowledge, which can be measured. Objectives, targets, and results statements are used when you want to explicitly define what exactly you hope to accomplish. If you hope to train 100 people, then 100 people trained is your target. The indicator of whether you have achieved that target would be the number of people actually trained.

A result, goal, or objective may require measuring several indicators. For example, if your objective is "to increase the skills of 100 care providers through palliative care training," you might measure both the number of care providers trained and their skill levels (for example, the percentage of individuals trained who report integrating new palliative care skills into their work).

Targets reflect the magnitude or level of output an organization expects to achieve. Indicators are measurements. When looked at alone, they do not tell managers whether what is measured is acceptable or unacceptable nor do they necessarily identify the cause of the change.

However, when compared with targets, indicators signal the need for corrective management action, evaluate the effectiveness of various management actions, and help determine if objectives are being achieved.

Counting Measures Versus Proxy Indicators

An indicator is ideally meant to provide indicative evidence of change in conditions in a relatively simple form. Often, organizations use simple counting measures (or deliverables), such as number of meetings held, number of people trained, number of vehicles purchased, as indicators. While, generally, they should not be used as indicators, there are cases when measures like those can be used as proxy indicators: alternate or indirect measures used to stand in for another indicator when obtaining direct information is too difficult, time-consuming, or sensitive. For example, the number of people trained could be seen as an indirect measure for level of knowledge, if it is assumed that if people were trained their level of knowledge will always be increased. Another example would be using household consumption of maize as a proxy indicator for household income if it is known that maize consumption always rises with income gain. Other times, these counting measures are no more than just measures. The number of vehicles you have usually only represents the number of vehicles you have; it does not indicate your capacity. When choosing a set of key data by which to evaluate your results, select lower-level counting measures sparingly.

Indexed Measures

Some results are complex enough or have enough identifiable steps that they lend themselves to being measured by an index. An index value is derived by measuring a compilation of discreet variables across a scale (*i.e.,* key elements or a series of steps are identified, points assigned as to the level of completion of each, and then the total added to determine the level of measurement).

Example

Indicator: Level of CBO Capacity in HIV/AIDS Advocacy (advocacy index)

Directions: Score the following statements on a scale of 1 to 5, with 1 indicating little or no capacity and 5 indicating extensive capacity. Average the score to determine the organization's advocacy capacity.

Little or no capacity 1 2 3 4 5 Extensive capacity

CBO can formulate a policy position on the issue:

1. Policy formulation is done in a participatory manner.
2. Policy being advocated exists in writing, with formats and levels of detail that are appropriate for various audiences and policy makers.
3. Policy position is clearly and convincingly articulated.
4. Rationale for policy is coherent and persuasive.

Indexed measures are very useful in many field programs when a complex series of activities that jointly respond to an anticipated result—for instance, quality of life of OVCs and quality of patient care—need to be measured.

Steps in Selecting Indicators

Selecting appropriate and useful indicators is a fairly straightforward process, but requires careful thought, interactive refining, collaboration, and consensus-building. The following suggestions can be helpful in the selection process. Although presented as sequential steps, some can be effectively undertaken simultaneously.

Step 1: Clarify the results statements; identify what needs to be measured. Good indicators start with good results statements that people can understand and agree on. Carefully consider the results desired. Review the precise wording and intention of the objectives and hypothesis. Avoid overly broad results statements. Be clear about what type of change is implied. What is expected to change—a situation, a condition, the level of knowledge, attitude, a behavior? Each type of change is measured by different types of indicators. Be clear about where change should appear. Is change expected to occur among individual, families, groups, communities, regions? Identify more precisely the specific targets for change. Who or what are the specific targets for the change? If individuals, which individuals? Before appropriate indicators can be developed, you must be clear about the expected relationship between activities and their intended results, in order to understand exactly what changes are reasonable to expect.

USE A PARTICIPATORY APPROACH

Collaborate closely with development partners, counterparts, and beneficiaries at each step of the indicator selection process. This has many benefits as it calls on the experience of others and obtains their consensus throughout the process.

Step 2: Develop a list of possible indicators for your results through brainstorming and research. Look at one of your results statements and ask yourself what could be measured to see if this result has been achieved or not, or if conditions have at least changed. Many possible indicators exist for any desired outcome, but some are more appropriate and useful than others. In selecting indicators, do not settle too quickly on the first that come most conveniently or obviously to mind. A better approach is to start with a list of alternative indicators that can then later be assessed against a set of selection criteria.

Create an initial list of possible indicators by:

- Internal brainstorming
- Identifying and building on the experience of other similar organizations
- Consulting with beneficiaries and experts
- Identifying existing secondary data sources (data collected by someone else but that you use to measure a result)
- Referring to existing indicators developed by UNAIDS, USG, Global Fund, etc.

The key to creating a useful initial list of indicators is to be inclusive. Allow sufficient opportunity for a free flow of ideas and creativity.

Step 3: Assess each possible indicator. Assess each possible indicator on the initial list. Experience suggests using ten basic criteria for judging an indicator's appropriateness and utility.

Ten Criteria for Assessing Indicators

CRITERIA	EXAMPLES YES! = MEETS CRITERIA NO! = DOES NOT MEET THE CRITERIA
1. ***Measurable:*** It can be quantified and measured by some scale. Quantitative indicators are numerical. Qualitative indicators are descriptive observations. While quantitative indicators are not necessarily more objective, their numerical precision lends them to more agreement on interpretation of results data and are thus usually preferable. However, even when effective quantitative indicators are being used, qualitative indicators can supplement them to provide a richness of information that brings a program's results to life.	**NO!** Types of human rights violations recorded by PLWHAs **YES!** Number of human rights violation reported by PLWHAs
2. ***Practical:*** Data can be collected on a timely basis and at reasonable cost. Managers require data that can be collected frequently enough to inform them of progress and influence decisions. Organizations should expect to incur reasonable but not exorbitant costs for obtaining useful information. A general rule is to plan on allocating 3 to 10 percent of total program resources for monitoring and evaluation.	**NO!** % of targeted population who understand their voting rights (census) **YES!** % of targeted population who understand their voting rights (representative sample)
3. ***Reliable:*** Data can be measured repeatedly with precision by different people. While the data that a program manager needs to make reasonably confident decisions about a program does not have to be held to the same rigorous standards a scientist uses, all indicators should be able to be measured repeatedly with relative precision by different people.	**NO!** Number of people receiving quality care and support services through workplace programs **YES!** Number of people who were tested for HIV at work (by the visiting doctor)
4. ***Relevant—attributable at least in part to your organization:*** A result is caused to some extent by grant-sponsored activities. Attribution exists when the links between the outputs produced by grant-financed activities and the results being measured are clear and significant.	**NO!** National HIV/AIDS infection rates **YES!** HIV/AIDS infection rates in targeted communities
5. ***Useful to management:*** Information provided by the measure is critical to decision-making. Avoid collecting and reporting information that is not used to support program management decisions.	EXAMPLE INDICATOR: LEVEL OF INSTITUTIONAL CAPACITY **NO!** Number of computers; number of staff meetings **YES!** Amount by type of resources mobilized **YES!** Number by type of critical organizational systems fully operational

CRITERIA	EXAMPLES YES! = MEETS CRITERIA NO! = DOES NOT MEET THE CRITERIA
6. ***Direct:*** The indicator closely tracks the result it is intended to measure. An indicator should measure as closely as possible the result it is intended to measure. For example, condom use is a direct measure of the result of increased use of condoms. But number of service providers trained would not be a direct measure of a result of improved service delivery. Just because people are trained does not necessarily mean they will deliver service better. If using a direct measure is not possible, one or more proxy indicators might be appropriate. For example, sometimes reliable data on direct measures are not available at a frequency that is useful. Proxy measures are indirect measures that are linked to the result by one or more assumptions. In rural regions, for example, it is often very difficult to measure income levels directly. Measures such as percentage of village households with roofs (or radios or bicycles) may be a useful, if somewhat rough proxy. The assumption is that when villagers have higher income, they tend to purchase certain goods. If convincing evidence exists that the assumption is sound (for instance, it is based on research or experience elsewhere), then the proxy may be an adequate indicator, albeit second-best to a direct measure	RESULT: INCREASED HIV/AIDS PREVENTION PRACTICES AMONG YOUNG ADULTS **NO!** Number of youth counselors trained in HIV/prevention messages **YES!** Number of teenagers who report delaying sexual activity
7. ***Sensitive:*** The indicator serves as an early warning of changing conditions. A sensitive indicator will change proportionately and in the same direction as changes in the condition or item being measured, thus sensitive proxy indicators can be used as an indication (or warning) of results to come. For example, household rice consumption is a sensitive proxy indicator for income if the amount of rice consumed always rises with the level of income.	**NO!** Number of human rights violations recorded **NO!** Number of people killed in violent conflict **YES!** Number of reports from communities warning of impending conflicts (utilizing the early warning mechanisms established by community)
8. ***Responsive:*** The indicator can be changed by management control. Indicators should reflect change as a result of project activities and thus indicators reflect results that are responsive to management control.	**NO!** Level of behavior change **YES!** Number of communities who have implemented at least one BCC methodology
9. ***Objective:*** The measure is operationally precise and one-dimensional. An objective indicator has no ambiguity about what is being measured. That is, there is a general agreement on the interpretation of the results. It is both one-dimensional and operationally precise. To be one-dimensional means that it measures only one phenomenon at a time. Avoid trying to combine too much in one indicator. For example, while number of PLWHA support groups is ambiguous, something like the number of PLWHA support groups with an increase of 5 percent membership is operationally precise.	**NO!** Number of expanding and successful PLWHA support groups **YES!** Number of PLWHA support groups experiencing an annual increase in membership of at least 5%
10. ***Capable of being disaggregated:*** Data can be broken down by gender, age, location, or other category where appropriate. Disaggregating data by gender, age, location, or some other category is often important from a management or reporting point of view. Experience shows that development activities often require different approaches for different groups and affect those groups in different ways. Disaggregated data help track whether or not specific groups participate in and benefit from activities intended to include them.	**YES!** Gender, age, location, ethnic group

Step 4: Select the best indicators. Based on your analysis, narrow the list to the final indicators that will be used in the monitoring system. They should be the optimum set that meets management needs at a reasonable cost. Be selective and remember the cost associated with data collection and analysis. Limit the number of indicators used to track each objective or result to two or three. Select only those that represent the most basic and important dimensions of your objectives.

Step 5: Draft indicator protocols. Protocols are instruction sheets that capture the reason for selecting indicators, describe the indicator in precise terms, and identify the plans for data collection, analysis reporting and review.

Step 6: Collect baseline data. The baseline is a record of what exists in an area prior to an action. The baseline values establish the starting point from which change can be measured.

Step 7: Refine indicators and protocols and finalize your selection. Based on initial data collection efforts, refine your indicators and/or your data collection instructions.

Examples of Results Chains and Indicators

Example: OVCs Results Chain

LEVEL OF RESULTS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Key results sought in program area	Funding for programs, facilities, and materials provided	Increased number of facilities, services, and programs available to OVCs	Improved health of OVCs	Increased quality of life for AIDS orphans and other vulnerable children
Indicators	Amount of funds made available for communities using USG funds, cost share, and/or contributions, subsidies (time/money)	Number of resource centers operating	Proportion of targeted OVCs who have improved their nutritional well-being	Proportion of OVCs with improved quality of life due in whole or part to our efforts (total number of OVCs who have increased their nutritional status, their educational level, and their economic status and who have accessed psycho-social care)

Example: Results Chain and Indicators

INPUTS/PROCESSES (RESULTS RELATING TO PROVISION OF RESOURCES AND PROCESSES)	
Results Sought • Funding for programs, facilities, and materials provided • Training/mentoring programs for key stakeholders and service providers funded • Materials and facilities provided • Curriculum/best practices/lessons identified and disseminated *Leading to...* ➡	**Indicators Selected** • Amount of funds made available for communities using USG funds, cost share, and/or contributions, subsidies (time/money) • Number by type of training offered • Number by type of materials generated • Lessons identified (list)
OUTPUTS (RESULTS RELATING TO SHORT-TERM CHANGE EFFECTS AND RESULTS SOUGHT)	
• Increased/strengthened capacity of communities to address the needs of OVCs (training, centers, linkages to services) • Increased number of facilities, services, and programs available to OVCs • Increased access to services • Increased number of OVCs served • Increased quality of service/care • Increased knowledge and understanding of HIV/AIDS prevention transmission and care *Leading to...* ➡	• Total number of persons trained to provide OVCs services • Number of resource centers operating • Number of OVCs programs • Number of visits to/from OVCs • Number of OVCs served by an OVCs program (number of services OVCs have accessed due to our efforts) • Action taken to improve quality of care • Number of OVCs and/or OVCs care providers who have increased knowledge regarding prevention and transmission of care (pre- and post-test)
OUTCOMES (RESULTS RELATING TO INTERMEDIATE CHANGE AND EFFECTS SOUGHT)	
• Improved health of OVCs • Improved educational levels of OVCs • Improved economic standing of OVCs and/or their care providers • Improved emotional well-being of OVCs • Improved protection of OVCs (reduced exploitation) • Improved HIV/AIDS prevention practices by OVCs *Leading to...* ➡	• Proportion of targeted OVCs who have improved their nutritional well-being • Proportion of targeted OVCs who have completed the school year • Proportion of targeted OVCs who have improved economic standing (have received a government grant, housing, scholarship or something else for the first time) • Proportion of targeted OVCs with improved emotional well-being (through accessing psycho-social care) • Proportion of targeted OVCs receiving a protection-oriented intervention • Level of HIV/AIDS prevalence in communities served by our organization (secondary data source and anecdotal evidence of improved prevention practices)
IMPACTS (RESULTS RELATING TO LONG-TERM CHANGE AND EFFECTS SOUGHT)	
• Increased quality of life for AIDS OVCs • In the long term: increased number of OVCs who are emotionally and psychologically stable, good parents and good citizens	• Proportion of OVCs with improved quality of life due in whole or part to our efforts (total number of OVCs who have increased their nutritional status, educational level, and economic status and who have assessed psycho-social care) • Stories of impact

A high-quality MER system tracks all levels of data but does not use input indicators as evidence of results or to evaluate effectiveness of the program.

Common Problems to Avoid

When selecting your indicators, avoid these common pitfalls:

- Selecting too many indicators, making the monitoring program too burdensome to implement
- Selecting indicators that narrowly focus on just the activities (inputs and outputs) rather than presenting an indicator of results (outcome and impacts)
- Selecting too many counting measures rather than opting for higher level indicators
- Selecting indicators that do not meet the criteria of good indicators, particularly selecting indicators that are not quantifiable or sensitive
- Selecting impractical indicators that require complicated measurement procedures or are too time-consuming to be followed over a long period of time
- Waiting until the last minute (prior to reporting) to either set up your data systems or enter or analyze data (resulting in data pileup)

ACTIVITY #5 WORKSHEET ▶ IDENTIFYING INDICATORS ACROSS THE FOUR LEVELS OF RESULTS

1. Review your results framework. Select one of your impacts, a related outcome, a related output, and input/process. Fill in chart.

2. Look at one of your results statements and think "what could I measure to see if this result had been achieved or not, or if conditions had at least changed?" There are usually many possible indicators for any desired outcome but some are more appropriate and useful than others. For each level of results, brainstorm at least three possible indicators. Use existing indicators or select new ones.

LEVEL OF RESULTS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Key results sought				
Potential Indicators	1.	1.	1.	1.
Potential Indicators	2.	2.	2.	2.
Potential Indicators	3.	3.	3.	3.

ACTIVITY #6 WORKSHEET ▶ ASSESSING INDICATORS

1. Select your indicators at the outcome level.
2. To assess and compare possible indicators, list the candidate indicators down the left side of the assessment worksheet.
3. Rate each indicator in terms of the criteria on a scale of 1–5, where 1 is LOW (indicator does not meet any of the criteria) and 5 is HIGH (indicator meets all of the criteria).
4. Add up the total score.
5. Select the best indicator.

Remember these ratings will help give an overall sense of the indicator's relative merit and help in the selection process. However, apply this approach flexibly and with judgment, because all seven criteria may not be equally important, or an indicator that scores a few points less than another indicator may still be more important to you as a manager.

Assessing Indicators

INDICATOR	RATE THE INDICATOR ON A SCALE OF 1 (LOW) TO 5 (HIGH) TO DETERMINE THE EXTENT TO WHICH THE INDICATOR IS:										
	MEASURABLE	PRACTICAL	RELIABLE	RELEVANT	USEFUL	DIRECT	SENSITIVE	RESPONSIVE	OBJECTIVE	DIS-AGGREGATED	TOTAL SCORE

The Emergency Plan Indicators

Introduction

Program evaluation is by nature complex. Determining whether changes observed in behavior and HIV prevalence reflect the natural course of events or result instead from an intervention or program is an important yet complex evaluation issue. Most donor programs are now responding to that complexity by lifting the burden of measuring outcome and impact-level results away from the program level grantee (or implementing organization) and focusing it instead on national measurement and evaluation activities supported through multi-donor and local host government initiatives, including population-based surveys, targeted facility surveys, sentinel surveillance systems or sero-surveys, and cohort studies. This frees implementing organizations to primarily focus on input and output level results.

If you are receiving USG funds, collection of certain input- and output-level data is required (as relevant to your program). These indicators are referred to as the Emergency Plan core-program-level indicators, and generally, within each program area (*e.g.,* prevention, palliative care, OVCs, etc.) the USG is tracking the ability to expand HIV/AIDS efforts to contribute to the "2–7–10" goals (*i.e.,* treating more than 2 million HIV infected individuals with effective combination ARV therapy; preventing 7 million new HIV infections; and caring for 10 million HIV infected individuals and OVCs). Program results for expansion are being tracked under indicator categories primarily representing the number of:

1. Service outlets/programs being supported through USG funding in each program area
2. Clients served in each program area
3. People trained in each program area

These three indicator categories are often further disaggregated (or broken down) by gender, date, service area, or other dimensions where appropriate.

The indicators on the following pages are the minimum program-level reporting requirements under the Emergency Plan. They are primarily input- and output-level indicators. The indicators presented on the following pages are required under your grant (but only those that are relevant to your program area). In addition, some USG country programs have identified additional indicators to give a better picture of USG-supported results in their countries; if these are available, Pact will provide them separately to you. Additional indicators are not required under your grant in most cases but in some cases you might be asked for these by your donor. USG encourages organizations to look at other indicators that they may need for their own planning and monitoring purposes. A good example of additional information that would be desirable is geographical coverage of service sites. Age of clients served is another useful variable that is not required in the aggregate counts (with the exception of ART), but it is recommended for program management planning purposes at the national level.

How to Count Emergency Plan Indicators

USG provides the following guidance:
(This guidance is current as of September 30, 2004. Please visit the OGAC website for any future updates http://www.usaid.gov/our_work/global_health/aids/pepfar.html.)

Counting the Number of Service Outlets/Programs

A service outlet/program is defined as a service site or program that receives at least some of its funding or support from the USG's Emergency Plan. Both terms—service outlet and program—are used to account for the different formats through which activities are delivered. The outlets/programs are counted at the lowest level for which data exists. For example, with regard to clinical activities, the lowest level for which data exists on service delivery would be service outlets, such as a hospital, clinic, or mobile unit. For programs such as prevention efforts implemented through mass media or community outreach, the level at which the program is counted is the level at which funds are obligated. For example, a national mass media program is counted only once. However, if the USG is independently funding mass media programs at the provincial level, each province's program should be counted as one program. OVCs services should be seen as a holistic package, which includes care, therefore, OVCs sub-services do not get counted separately.

Counting the Number of Clients Served

Clients served are defined as individuals receiving USG-supported services or programs (disaggregated by sex). For example, if the USG is contributing funds to support a clinic that focuses on preventing mother-to-child transmission (PMTCT) in a large hospital, all clients in that PMTCT clinic should be counted as USG clients, regardless of other funding received by the clinic. However, if the hospital is providing ARVs in another clinic that does not receive USG funds, clients in that clinic should not be counted as part of an USG-supported program. If, for example, a program receives USG funding for PMTCT and Global Fund (non-Emergency Plan) funding for Counseling and Testing, only the PMTCT clients will be reported and the service outlet counted under the Emergency Plan. However, if the program receives both USG and Global Fund funding for PMTCT, it is acceptable to report all clients served in PMTCT, as it would be very difficult to divide the clients served in some way. Palliative care is broadly defined in the Emergency Plan to include basic care through end-of-life care. All medical and psychosocial care after HIV diagnosis may be counted. Treatment and preventive care for TB/HIV is tracked separately under palliative care. It is assumed that nearly 100 percent of all clients on ART treatment are also receiving palliative care services. This assumption implies that some clients receiving palliative care will be the same individuals as those receiving ART.

Preventing double counting

Avoid double-counting the same individual within one service/program area during each reporting period. Thus, if one orphan or vulnerable child is receiving several services such as school-related expenses from a program and also periodic nutritional support and counseling, this child is only counted once within the reporting period.

This requires client-level tracking systems rather than simply counting visits/encounters. Tracking delivery of care services (such as providing care for OVCs or home-based palliative care) at the client level is essential for quality of care because monitoring the number of visits and types of services per client is vital for quality program management.

It is, however, acceptable to count the same person in multiple different program areas (*e.g.,* an OVCs may also be counted separately in ART programs and palliative care programs). It is not acceptable to count one person coming for the same service multiple times as multiple clients served. Therefore, if one person comes into a clinic once a week, he or she will only be counted once within the reporting period. However, persons receiving services in multiple reporting cycles will be counted again in the next cycle if they are still receiving services (*e.g.,* a person on ART served in one six-month period will also be counted if he/she is still on ART in the next reporting period). Your report should show the total number of persons currently being served within each reporting period.

Information on Direct Versus Indirect Beneficiaries

USG allows counting of both directly supported and indirectly supported beneficiaries as appropriate:

Direct support: Individuals receiving care and treatment through service delivery sites/providers that are directly supported (in whole or part) by USGs Emergency Plan funding/programs (commodities and/or drugs and/or supplies and/or supervision and/or training and/or quality assurance) at the point of service delivery. An intervention or activity is considered to be a type of direct support if it can be associated with counts of uniquely identified individuals receiving care and/or support at a service delivery point benefiting from the intervention/activity.

Indirect support: Individuals receiving care or treatment as a result of the USG's contribution to national, regional, or local activities such as policy development, logistics, protocols or guideline development, advocacy, laboratory support, training, or capacity building. Procedures for estimating these targets must be clearly documented.

If you provide training and then consistent follow-up mentoring, supervision, or support to a group of service providers and you have access to their patient files, you may count the number of clients they serve as direct beneficiaries (even if you do not pay for the service providers, visits or their programs). However, if you just fund a training (or series of trainings) for the service providers and then send them back to their sites (and do not provide any follow up mentoring/supervision), then their clients are seen as indirect beneficiaries.

Counting the Number of People Trained

People trained are defined as the number of persons provided instruction/training in a particular programmatic area. Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. A person trained more than once within a given period is only counted as one person trained; however, if this person is trained in different program areas (*e.g.,* OVCs, prevention, antiretroviral therapy, palliative care…), then he/she can also be counted for that area. The intention is for this number to represent unduplicated numbers within each broader programmatic area: prevention, PMTCT, counseling and testing, treatment, palliative care, OVCs, etc.

Other Key Definitions

USG-supported is defined as any HIV service outlet/program that receives at least some of its funding or support from the USG's Emergency Plan. It is likely that country service outlets/programs will be supported by a mixture of funds from varied sources, including the USG's Emergency Plan. Because we cannot separate USG clients from other clients in USG-funded service or program, all clients of a USG-supported service or program should be counted toward USG prevention, care, and treatment goals. In multi-service/program institutions, please count clients for the service or program component that is being funded. For example, if the USG is contributing funds to support a PMTCT clinic in a large hospital, all clients in that PMTCT clinic should be counted as USG clients, regardless of other funding received by the clinic. However, if the hospital is providing ARVs in another clinic that does not receive USG funds, clients in that clinic should not be counted as part of USG-supported program. If, for example, a program receives USG funding for PMTCT and Global Fund resources for counseling and testing, only the PMTCT clients will be reported and the service outlet is counted under PMTCT. However, if the program receives both USG and Global Fund funding for PMTCT, it is acceptable to report all clients served in PMTCT, as it would be very difficult to divide the clients served in some way.

Program Area Definitions: Definitions clarifying how the USG has defined the key elements of various program elements (such as palliative care, prevention/abstinence and be faithful…) are captured on the indicator matrices on page 52.

Collection of Emergency Plan Outcome and Impact Indicators

National outcome and impact indicators are measured with data sources including population-based surveys, targeted facility surveys, sentinel surveillance systems or sero-surveys, and cohort studies that are being implemented with multi-donor support in conjunction with the host country government agencies, (*i.e.,* National Department of Health and other national organizations.)

Each country has a strategy for data collection. If you are unaware of the strategy in your country, Pact and/or the USG can provide you with this information. For example, in South Africa, baseline data for outcome and impact USG indicators were collected in June 2004 using five studies:

1. Study of HIV/AIDS – South Africa HIV Prevalence, Behavioral Risks and Mass Media, Nelson Mandela/Human Sciences Research Council 2002
2. National Baseline Assessment of STI and HIV Services in South Africa Public Sector Health Facilities, National Department of Health/Wits University, 2002/2003
3. South Africa National Youth Risk Behavior Survey, National Department of Health, 2002
4. National HIV and Syphilis Antenatal Sero-prevalence Survey, National Department of Health, 2002
5. Key Health Statistics, National Department of Health, 2003

These numbers will be updated when South Africa's 2004 National Department of Health data are available. The department will collect surveillance information annually, using the antenatal survey; a national health facility survey is planned for 2005. Special studies may be desired in order to supplement existing data to address programmatic needs and to document successful models.

The Emergency Plan Program Monitoring Matrices and Indicators

	DIRECT	INDIRECT
PREVENTION PROGRAMS (TOTALS)		
Definition: Programs, services, and activities aimed at preventing the transmission of HIV, *i.e.,* abstinence and/or be faithful and other behavior change programs (mass media and community outreach), medical transmission (blood safety and injection safety).		
1. Total number of service outlets/programs providing prevention services, *i.e.*, the total of the number of abstinence and/or be faithful and other behavior change programs (mass media and community outreach) or medical transmission (blood safety). Note: PMTCT and counseling and testing counted separately.		N/A
2. Total number of individuals trained to provide prevention services, *i.e.*, the total of the number of persons trained in abstinence and/or be faithful and other behavior change programs (mass media and community outreach) or medical transmission (blood safety and injection safety).		N/A

PREVENTION: ABSTINENCE OR ABSTINENCE AND BE FAITHFUL

Definition: Mass media and community outreach programs that have as their primary behavioral objective the dissemination of A and/or B messages. Mass media programs could include national and/or sub-national programs that involve radio and/or television addresses and/or any other mass-scale dissemination of information and BCC messages to promote abstinence/abstinence and/or be faithful. Community outreach programs could include could include community mobilization, peer education, classroom, small group and/or one-on-one information, education, and communication (IEC) and BCC messages/programs to promote A and/or B. If program content primarily addresses be faithful messages (*i.e.,* a program for married men) it would count here.

Abstinence = Activities or programs that promote the:

- Importance of abstinence in reducing the prevention of HIV transmission among unmarried individuals
- Decision of unmarried individuals to delay sexual activity until marriage
- Development of skills in unmarried individuals for practicing abstinence
- Adoption of social and community norms that support delaying sex until marriage and that denounce forced sexual activity among unmarried individuals

Abstinence and be faithful = Activities or programs that promote abstinence combined with the:

- Importance of be faithful in reducing the transmission of HIV among individuals in long-term sexual partnerships
- Elimination of casual sex and multiple sexual partnerships
- Development of skills for sustaining marital fidelity
- Adoption of social and community norms supportive of marital fidelity and partner reduction using strategies that respect and respond to local customs and norms
- Adoption of social and community norms that denounce forced sexual activity in marriage or long-term partnerships

1. Number of community outreach abstinence and/or be faithful-focused programs		N/A
1a. Number of programs providing community outreach HIV behavior change services with the primary emphasis and content on promoting abstinence (a subset of total AB community outreach programs above).		N/A
2. Number of mass media abstinence and/or be faithful-focused programs		N/A
2a. Number of programs providing community outreach HIV behavior change services with the primary emphasis and content on promoting abstinence (a subset of total AB mass media programs above).		N/A
3. Number of individuals served by community outreach programs promoting abstinence and/or be faithful-focused programs		N/A
Male		N/A
Female		N/A
3a. Number of individuals served by community outreach programs promoting abstinence (a subset of persons served by AB community outreach programs above)		N/A
Male		N/A
Female		N/A
4. Estimated number of individuals reached by mass media programs promoting abstinence and/or be faithful		N/A
4a. Estimated number of individuals reached by mass media programs promoting abstinence (a subset of persons reached by AB mass media above)		N/A
5. Number of persons trained to promote abstinence and/or be faithful		N/A
5a. Number of persons trained to promote abstinence (a subset of persons trained to promote AB above)		N/A

PREVENTION: OTHER BEHAVIOR CHANGE		
Definition: Includes other behavior change activities outside of those primarily promoting abstinence and be faithful that are aimed at preventing HIV transmission. Could include mass media and targeted community outreach programs to promote avoidance or reduction of HIV-risk behaviors, community mobilization for HIV testing, and the social marketing and/or promotion of condoms. This includes work with high-risk groups such as injecting drug users (IDUs), men who have sex with men (MSM), commercial sex workers (CSWs) and their clients, and people living with HIV and/or AIDS (PLWHA).		
1. Number of programs providing community outreach for behavior change that are not focused on promoting abstinence and be faithful		N/A
2. Number of programs providing mass media for behavior change that are not focused on promoting abstinence and be faithful		N/A
3. Number of condom service outlets targeted to high-risk populations (or within high risk areas) that provide condom social marketing or distribution of condoms		N/A
4. Number of individuals served by programs providing community outreach for behavior change that are not focused on promoting abstinence and be faithful		N/A
Male		N/A
Female		N/A
5. Estimated number of individuals served by programs providing mass media for behavior change that are not focused on promoting abstinence and be faithful		N/A
Male		N/A
Female		N/A
6. Number of persons trained to provide behavior change not focused on promoting abstinence and be faithful		N/A
These indicators are not reported in country but are tracked by central databases:		
7. Total number of condoms purchased/shipped for social marketing campaigns		N/A
8. Total number of condoms sold/distributed through social marketing campaigns		N/A
9. Subset of total number of condoms (above) sold/distributed through targeted outlets		N/A
PREVENTION: MEDICAL TRANSMISSION/BLOOD SAFETY		
Definition: Activities supporting a national coordinated blood program, which includes policies; infrastructure, equipment and supplies; donor recruitment activities; blood collection, distribution/supply chain/logistics, testing, screening, and transfusion; waste management; training; and management to ensure a safe and adequate blood supply		
1. Number of service outlets/programs carrying out blood safety activities		N/A
2. Number of people trained in blood safety		N/A
PREVENTION: MEDICAL TRANSMISSION/INJECTION SAFETY		
Definition: Policies, training, waste management systems, advocacy, and other activities to promote (medical) injection safety, including distribution/supply chain/logistics, cost, and appropriate disposal of injection equipment, and other related equipment and supplies		
1. Number of persons trained in injection safety		N/A
PREVENTION: MOTHER-TO-CHILD TRANSMISSION SERVICES		
Definition: Activities aimed at providing the minimum package of services for PMTCT, including: a. Counseling and testing for pregnant women b. ARV prophylaxis to prevent MTCT c. Counseling and support for safe infant feeding practices d. Family planning counseling or referral		

1. Total number of service outlets providing at least the minimum package of PMTCT services according to national or international standards		N/A
2. Total number of pregnant women receiving counseling and testing and other PMTCT services.		N/A
2a. Total number of pregnant women receiving a complete course of antiretroviral prophylaxis in a PMTCT setting as a subset of the total number of pregnant women receiving counseling and testing and other PMTCT services		N/A
3. Total number of health workers newly trained or retrained in the provision of PMTCT services according to national or international standards		N/A

	DIRECT	INDIRECT
COUNSELING AND TESTING		
Definition: Activities in which both HIV counseling and testing are provided for those who want to know their HIV status (as in traditional VCT) or as indicated in other contexts (*e.g.,* STI clinics or TB centers, where HIV diagnosis is confirmed). Counseling and testing in the context of PMTCT is coded under PMTCT.		
1. Total number of service outlets providing counseling and testing according to national or international standards		N/A
2. Total number of individuals who received counseling and testing		N/A
Male		N/A
Female		N/A
3. Total number of individuals trained in counseling and testing according to national or international standards		N/A
TOTALS FOR TREATMENT SERVICES		
Definition: Activities including the provision of antiretroviral drugs and clinical monitoring for ART among those with advanced HIV infection in either an ART or a designated PMTCT+ setting. The total number of clients on ART has subsets of new clients and continuous clients. These are calculated based on the date at the end of the reporting period (*i.e.,* March 31 or Sept 30). If a woman is pregnant at any time during the reporting period she would count as pregnant (regardless of the outcome of the pregnancy). 1. It is assumed that nearly 100 percent of all clients on treatment, through an ART or a PMTCT+ program, are also receiving palliative care services (see palliative care below). This assumption implies that some number of the total number of clients receiving palliative care will be the same individuals as the total number of clients receiving treatment. 2. If an HIV+ OVC is receiving treatment as well as care in an OVCs program, the OVC should be counted both under treatment and under OVCs. 3. New = commenced/initiated ART since last reporting period. If a woman has received limited ARV prophylaxis during pregnancy and then begins full ART after the birth, she could be counted as new here. 4. Continuously on therapy does not necessarily require that an individual received therapy in only one site; as long as client records are tracked longitudinally from the onset of therapy, a person on therapy at one site may be counted as continuously on therapy for 12+ months at a new site where he/she is receiving treatment. Transfers in from another ART clinic are not "new." 5. Continuously in services does not account for treatment interruptions. Programs are recommended to monitor whether drug regimens are picked up and taken monthly. Further in-depth studies will be needed to measure adherence and continuity of ART. 6. Programs will need to track 6, 12, and 24 months continuously on therapy for the Required Outcome Indicator: (Care and Treatment 5). 7. In order to interpret survival on ART, programs should track deaths, discontinuation of therapy, and loss to follow-up separately.		
1. Total number of service outlets providing treatment (ART and PMTCT+)		N/A
2. Total number of individuals receiving treatment (ART and PMTCT+ sites combined)		

	Male		
	Female		
	Pregnant female		
	Adults (15 and over)		
	Children (0–14) (If an HIV+ OVC is receiving treatment as well as care in an OVCs program, the OVC should be counted both under treatment and under OVCs)		
	2a. Number of new individuals with advanced HIV infection receiving antiretroviral therapy (ART and PMTCT+ sites combined) disaggregated by sex, age (0–14 and 15 and older), and pregnancy status		
	Male		
	Female		
	Pregnant female		
	Adults (15 and over)		
	Children (0–14) (If an HIV+ OVC is receiving treatment as well as care in an OVCs program, the OVC should be counted both under treatment and under OVCs.)		
	2b. Number of current clients (ART and PMTCT+ sites combined) receiving continuous ART for more than 12 months, disaggregated by sex, age (0–14 and 15 and older) and pregnancy status.		
	Male		
	Female		
	Pregnant female		
	Adults (15 and over)		
	Children (0–14) (If an HIV+ OVC is receiving treatment as well as care in an OVCs program, the OVC should be counted both under treatment and under OVCs.)		
3.	Total number of health workers trained, according to national and/or international standards, in the provision of treatment (ART and PMTCT+)		N/A
4.	Total amount (in US dollars) spent on ARV drugs		N/A
5.	Number of ARV drugs (pills) purchased		N/A
6.	Number of ARV drugs (pills) distributed to clients		N/A

TREATMENT: ANTIRETROVIRAL THERAPY

Definition: Activities including the provision of antiretroviral drugs and clinical monitoring for ART among those with advanced HIV infection. ART activities within the context of PMTCT+ are counted separately (see below). The number of clients on ART has subsets of new clients and continuous clients. These are calculated based on the date at the end of the reporting period (*i.e.,* March 31 or Sept 30). If a woman is pregnant at any time during the reporting period, she would count as pregnant (regardless of the outcome of the pregnancy).

1. New = commenced/initiated ART since last reporting period. If a woman has received limited ARV prophylaxis during pregnancy and then begins full ART after the birth, she could be counted as new here.
2. Continuously on therapy does not necessarily require that an individual received therapy in only one site; as long as client records are tracked longitudinally from the onset of therapy, a person on therapy at one site may be counted as continuously on therapy for 12+ months at a new site where he/she is receiving treatment. Transfers in from another ART clinic are not "new".
3. Continuously in services does not account for treatment interruptions. Programs are recommended to monitor whether drug regimens are picked up and taken monthly. Further in-depth studies will be needed to measure adherence and continuity of ART.

4. Programs will need to track 6, 12, and 24 months continuously on therapy for the Required Outcome Indicator: (Care and Treatment 5).
5. In order to interpret survival on ART, programs should track deaths, discontinuation of therapy, and loss to follow-up separately.

1. Total number of service outlets providing ART services according to national or international standards			N/A
2. Total number of individuals with advanced HIV infection receiving antiretroviral therapy, disaggregated by sex, age and pregnancy status			
	Male		
	Female		
	Pregnant female		
	Adults (15 and over)		
	Children (0–14) (If an HIV+ OVC is receiving treatment as well as care in an OVCs program, the OVC should be counted both under treatment and under OVCs.)		
	2a. Number of new individuals with advanced HIV infection receiving antiretroviral therapy, disaggregated by sex, age (0–14 and 15 and older) and pregnancy status. This is a subset of the number of individuals with advanced HIV infection receiving antiretroviral therapy.		
	Male		
	Female		
	Pregnant female		
	Adults (15 and over)		
	Children (0–14) (If an HIV+ OVC is receiving treatment as well as care in an OVCs program, the OVC should be counted both under treatment and under OVCs.)		
	2b. Number of current clients receiving continuous ART for more than 12 months, disaggregated by sex, age (0–14 and 15 and older), and pregnancy status. This is a subset of the number of individuals with advanced HIV infection receiving antiretroviral therapy.		
	Male		
	Female		
	Pregnant female		
	Adults (15 and over)		
	Children (0–14) (If an HIV+ OVC is receiving treatment as well as care in an OVCs program, the OVC should be counted both under treatment and under OVCs.)		
3. Number of health workers trained to deliver ART services according to national or international standards			N/A

TREATMENT: PREVENTION OF MOTHER-TO CHILD TRANSMISSION PLUS (PMTCT+) SERVICES

Definition: Activities aimed at providing antiretroviral drugs within the minimum package of services for PMTCT+ including: a) counseling and testing for pregnant women; b) ARV prophylaxis to prevent MTCT; c) counseling and support for safe infant feeding practices; d) family planning counseling or referral; e) ARV therapy for HIV+ women, their children, and their families. The number of clients who received ART at a designated PMTCT+ site has subsets of new clients and continuous clients. These are calculated based on the date at the end of the reporting period (*i.e.,* March 31 or Sept 30). If a woman is pregnant at any time during the reporting period, she would count as pregnant (regardless of the outcome of the pregnancy).

1. New = commenced/initiated ART since last reporting period. If a woman has received limited ARV prophylaxis during pregnancy and then begins full ART after the birth, she could be counted as new here.

2. Continuously on therapy does not necessarily require that an individual received therapy in only one site; as long as client records are tracked longitudinally from the onset of therapy, a person on therapy at one site may be counted as continuously on therapy for 12+ months at a new site where he/she is receiving treatment. Transfers in from another ART clinic are not "new."
3. Continuously in services does not account for treatment interruptions. Programs are recommended to monitor whether drug regimens are picked up and taken monthly. Further in-depth studies will be needed to measure adherence and continuity of ART.
4. Programs will need to track 6, 12, and 24 months continuously on therapy for the Required Outcome Indicator: (Care and Treatment 5).
5. In order to interpret survival on ART, programs should track deaths, discontinuation of therapy, and loss to follow-up separately.

1. Number of service outlets providing the minimum package of PMTCT+ services, according to national or international standards			N/A
2. Total number of individuals with advanced HIV infection receiving ART at a designated PMTCT+ site, disaggregated by sex, age (0–14 and 15 and older), and pregnancy status			
	Male		
	Female		
	Pregnant female		
	Adults (15 and over)		
	Children (0–14) (If an HIV+ OVC is receiving treatment as well as care in an OVCs program, the OVC should be counted both under treatment and under OVCs.)		
	2a. Number of new individuals with advanced HIV infection receiving ART at a designated PMTCT+ site, disaggregated by sex, age (0–14 and 15 and older) and pregnancy status. This is a subset of the number of individuals with advanced HIV infection receiving ART at a designated PMTCT+ site.		
	Male		
	Female		
	Pregnant female		
	Adults (15 and over)		
	Children (0–14) (If an HIV+ OVC is receiving treatment as well as care in an OVCs program, the OVC should be counted both under treatment and under OVCs.)		
	2b. Number of current clients receiving continuous ART at a designated PMTCT+ site for more than 12 months at a designated PMTCT+ site, disaggregated by sex, age (0–14 and 15 and older) and pregnancy status. This is a subset of the total number of individuals with advanced HIV infection receiving ART at a designated PMTCT+ site.		
	Male		
	Female		
	Pregnant female		
	Adults (15 and over)		
	Children (0–14) (If an HIV+ OVC is receiving treatment as well as care in an OVCs program, the OVC should be counted both under treatment and under OVCs.)		
3. Number of health workers trained to deliver ART services as part of PMTCT+ according to national or international standards			N/A

	DIRECT	INDIRECT
PALLIATIVE CARE (NON-ART CARE) SERVICE/PROGRAMS (TOTALS)		
Definition: All clinic-based and home/community-based activities aimed at optimizing quality of life of HIV-infected (diagnosed or presumed) clients and their families throughout the continuum of illness by means of symptom diagnosis and relief; psychological and spiritual support; clinical monitoring and management of opportunistic infections, including TB and malaria and other HIV/AIDS-related complications; culturally appropriate end-of-life care; social and material support, such as nutrition support, legal aid, and housing; and training and support for caregivers. Given the need to independently track TB prevention, care, and treatment, totals for palliative care are made up of the two service categories below: basic health care and support and TB/HIV. 1. An HIV+ OVC receiving palliative care services among other services within an OVCs program should only be counted under OVCs to avoid double counting under the total care count.		
1. Total number of service outlets/programs providing general HIV-related palliative care including TB/HIV (basic health care and support plus TB/HIV)		N/A
2. Total number of individuals provided with general HIV-palliative care including TB/HIV (basic health care and support plus TB/HIV)		
Male		
Female		
3. Total number of persons trained in providing palliative care for HIV-infected individuals including TB/HIV (basic health care and support plus TB/HIV)		N/A
PALLIATIVE CARE (NON-ART CARE): BASIC HEALTH CARE AND SUPPORT (EXCLUDING TB/HIV)		
Definition: All clinic-based and home/community-based activities aimed at optimizing quality of life of HIV-infected (diagnosed or presumed) clients and their families throughout the continuum of illness by means of symptom diagnosis and relief; psychological and spiritual support; clinical monitoring and management (and/or referral for these) of opportunistic infections (excluding TB/HIV), including malaria and other HIV/AIDS-related complications; culturally appropriate end-of-life care; social and material support, such as nutrition support, legal aid, and housing; and training and support for caregivers. If palliative care programs are expanded to provide clients with ART, these clients would also be counted under Treatment. Activities that provide only clinical management of TB are to be counted in the TB category (see below).		
1. Number of service outlets/programs providing general HIV-related palliative care		N/A
1a. Number of service outlets/programs providing malaria care and/or referral for HIV-infected clients (diagnosed or presumed) as part of general HIV-related palliative care. This number is a subset of the number of service outlets/programs providing general HIV-related palliative care.		
2. Number of individuals receiving general HIV-related palliative care		
Male		
Female		
3. Number of persons trained in providing general HIV-related palliative care for HIV-infected individuals (diagnosed or presumed)		N/A
PALLIATIVE CARE: TB/HIV		
Definition: Activities including exams, clinical monitoring, treatment, and prevention of tuberculosis in HIV palliative care settings as well as screening and referral for HIV testing, and clinical care related to TB clinical setting. If TB programs go beyond HIV testing to provide other palliative care services such as clinical or psychosocial services (see definition above), these would be counted in both this table and the Basic Health Care and Support (excluding TB/HIV) table above. If TB programs are expanded to provide clients with ART, these would also be counted under treatment.		
1. Number of service outlets providing clinical prophylaxis and/or treatment for TB according to national or international standards		N/A
2. Number of individuals receiving clinical care for TB		

	Male		
	Female		
3. Number of persons trained in providing TB/HIV clinical care for HIV-infected individuals according to national or international standards			N/A

	DIRECT	INDIRECT
ORPHANS AND VULNERABLE CHILDREN		
Definition: Activities aimed at improving the lives of children and families directly affected by AIDS-related morbidity and/or mortality. The emphasis is on strengthening communities to meet the needs of OVCs affected by HIV/AIDS, supporting community-based responses, helping children and adolescents meet their own needs, creating a supportive social environment. Activities could include training caregivers; increasing access to education; economic support; targeted food and nutrition support; legal aid; medical, psychological, or emotional care; and/or other social and material support. Institutional responses would also be included. Orphans are defined as children under 18 who have lost either a mother or father. Vulnerable children are those affected by HIV through the illness of a parent or principle caretaker. If an HIV+ OVC is receiving ART treatment as well as care in an OVCs program, the OVC should be counted both under treatment and under OVCs. However, an HIV+ OVC receiving palliative care services among other services within an OVCs program should only be counted under OVCs to avoid double counting under the total care count.		
1. Number of OVCs programs		N/A
2. Number of OVCs served by an OVCs program		
Male		
Female		
3. Number of providers/caretakers trained in caring for OVCs		N/A

	DIRECT	INDIRECT
LABORATORY INFRASTRUCTURE		
Definition: Development and strengthening of laboratory facilities to support HIV/AIDS-related activities, including the purchase of equipment and/or commodities, the provision of quality assurance, staff training, and other technical assistance.		
1. Number of laboratories with capacity to perform HIV tests and CD4 tests and/or lymphocyte tests.		N/A
2. Number of individuals trained in the provision of lab-related activities.		N/A

	DIRECT	INDIRECT
STRATEGIC INFORMATION		
Definition: Activities related to HIV/AIDS surveillance, HMIS and M&E, including development of improved tools and models for collecting, analyzing, and disseminating HIV/AIDS behavioral and biological surveillance and monitoring information; facility surveys; other monitoring and health management information systems; assisting countries to establish and/or strengthen such systems; targeted program evaluations (including operations research); developing and disseminating best practices to improve program efficiency and effectiveness; planning/evaluating national prevention, care, and treatment efforts; analysis and quality assurance or demographic and health data related to HIV/AIDS; and testing implementation models (*e.g.,* to support the development or implementation of Global Fund proposals).		
1. Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS).		N/A

	DIRECT	INDIRECT
OTHER: POLICY ANALYSIS AND SYSTEM STRENGTHENING (CAPACITY BUILDING)		
Definition: Other HIV/AIDS-related activities including strengthening policies and systems to address stigma and discrimination, and to support national prevention, care, and treatment efforts; other activities to strengthen systems or build capacity to combat HIV/AIDS, including activities to support the implementation of national and/or multilateral programs. This could include the provision of technical assistance through small grants or assistance with proposal development, organizational management, network or coalition building, advocacy, and/or public/private partnership building.		
1. Number of HIV service outlets/programs provided with technical assistance or implementing programs related to policy and/or capacity building, including stigma and discrimination reduction programs		N/A
2. Number of individuals trained in implementing programs related to policy and/or capacity building, including stigma and discrimination reduction programs		N/A

Developing Indicator Protocols

Once you have selected indicators, you need to develop the protocols or details on the methods you will be using to collect the data. Protocols are instruction sheets and capture the reason for selecting indicators; describe the indicator in precise terms; and identify the plans for data collection, analysis reporting, and review. This information is documented not only to clarify and articulate what the indicators mean but also to provide the organization with the means to collect data over the life of the project and beyond, as required. Protocols also help ensure the reliability of indicators as they provide critical information to help different people repeatedly measure the indicator with the same precision. Indicator protocols are the heart of your MER plan. For each indicator, fill out a separate protocol table.

Indicator Protocol (Reference Sheet) #1
NAME OF INDICATOR:
DESCRIPTION
Precise definition(s): The indicator definition states what should be measured. It defines the variables that help measure change within a given situation as well as information that describes progress and impacts. The definition must be detailed enough to ensure that different people at different times, given the task of collecting data for a given indicator, would collect identical types of data. All terms used must be defined.
Unit of measure: The precise parameter used to describe the magnitude or size of the indicator (for example, cumulative, average, annual tally, number of individuals, hectares, local currency etc.)
Disaggregated by: Identify how data will be separated to improve the breadth of understating of results reported. Typical ways to disaggregate data include geographic location and gender.
PLAN FOR DATA ACQUISITION
Data collection method and timing: Describe exactly, and in detail, how and when you will collect the data. Identify what methods and instruments you will use. Note any equipment required to collect the data. Attach data forms when necessary. Some examples of data collection methodologies/approaches are: **1. Secondary data sources** 1a. Obtain data from data source outside your organization, often government or international agencies.

2. Expert judgmental or narrative sources

2a. Use an expert panel and/or peer judgments
Peer panel assesses the quality of programming or the quality of reporting. Experts rank separately and then may come together to discuss/reach consensus.

2b. Content analysis of press coverage or other documents/programs
Systematic coding by staff/filling out rating form for each document

3. Surveys

3a. Probability sample/random sample. USG suggests at least 1,200 to pick up changes in national sentiment (+ or – 3%).

4. Rapid appraisal/qualitative appraisals.
Often anecdotal in nature, quality of data often depends on skilled observer or trained interviewer. This is particularly valuable for looking at reactions of participants to the activities supported.

4a. Direct observations of field activities
Data collector visits sites or meetings, with a prepared list of topics to be observed and recorded and data are recorded. Useful for looking at planned to actual.

4b. Focus groups
Bring together a homogeneous group of 6–12 people for a facilitated discussion; careful probing and reporting of what was said.

4c. Key informant interviews
Key leaders or officials sought for opinions on their areas of expertise.

4d. Case studies
Examination of a particular site or phenomenon; used to understand how and why the case changes over time.

Data source: The source is the entity from which the data are obtained. Usually the group of individuals or organization that conducts the data collection effort. Data sources may include program officers, government departments, international organizations, other donors, NGOs, private firms, USAID offices, contractors, etc.

Estimated cost of data acquisition: Provide a rough estimate of what it will cost to collect and analyze this data.

Individual responsible and location of data storage: Identify who will take the lead/be the primary person responsible for collecting data on this indicator. Describe how data will be stored over time and in what formats.

PLAN FOR DATA ANALYSIS, REVIEW AND REPORTING

Data Analysis and reporting: Present a concise description of how data for individual indicators or groups of related indicators will be analyzed to determine progress on results. Note data analysis techniques to be used. Concisely describe how and when data results will be chronicled. Identify audiences that have particular interest in this indicator and note how information will be presented to them.

DATA QUALITY ISSUES

Known data limitations and significance: Identify where data may be weak or limited.

Actions taken or planned to address data limitations: Describe actions taken to address data limitations.

OTHER NOTES

Notes on baselines/targets: Any comments relevant to understanding baseline findings or targets set (*i.e.,* critical assumptions, potential issues, etc.)

Baseline is a record of what exists in an area prior to an action. The baseline values establish the starting point from which change can be measured.

Targets are the magnitude or level of outputs expected to be achieved. Targets are values against which the actual program/project achievements are measured. They should be realistic and quantitative statements of expected outcomes. If the targets are qualitative, there is need for a detailed statement of expected state of affairs at the end of a planning period.

Other notes: Provide any other information relevant to data collection and reporting of this indicator.

PERFORMANCE INDICATOR VALUES			
Time period	**Target**	**Actual**	**Notes**
Quarter1	—	(Baseline)	
Quarter 2			
Quarter 3			

THIS SHEET LAST UPDATED ON:

ACTIVITY #7 WORKSHEET ▶ DEVELOPING INDICATOR PROTOCOLS

For each indicator, fill out an indicator protocol table.

Indicator Protocol (Reference Sheet) #1			
NAME OF INDICATOR:			
DESCRIPTION			
Precise definition(s):			
Unit of measure:			
Disaggregated by:			
PLAN FOR DATA ACQUISITION			
Data collection method and timing:			
Original data source:			
Estimated cost of data acquisition:			
Individual responsible and location of data storage:			
PLAN FOR DATA ANALYSIS, REVIEW AND REPORTING			
Data Analysis and reporting:			
DATA QUALITY ISSUES			
Known data limitations and significance:			
Actions taken or planned to address data limitations:			
OTHER NOTES			
Notes on baselines/targets:			
Other notes:			
PERFORMANCE INDICATOR VALUES			
Time period	**Target**	**Actual**	**Notes**
Quarter1	—	(Baseline)	
Quarter 2			
Quarter 3			
THIS SHEET LAST UPDATED ON:			

Below are some examples of Indicator Protocol Sheets:

Example 1:

Example Indicator Protocol: Reference Sheet #1

NAME OF INDICATOR: TOTAL NUMBER OF SERVICE OUTLETS/PROGRAMS PROVIDING GENERAL HIV-RELATED PALLIATIVE CARE INCLUDING TB/HIV

DESCRIPTION

Definition: Total number of service outlets aimed at providing general HIV-related palliative care including TB/HIV care. Includes all clinic-based and home/community-based activities aimed at optimizing quality of life of HIV-infected (diagnosed or presumed) clients and their families throughout the continuum of illness by means of symptom diagnosis and relief; psychological and spiritual support; clinical monitoring and management of opportunistic infections, including malaria and other HIV/AIDS-related complications; culturally-appropriate end-of-life care; social and material support, such as nutrition support, legal aid, and housing; mentoring; and training and support for caregivers.

The term service outlet is used to account for the different formats through which activities are delivered on site and refers to the lowest level of service provision. For example, with regard to clinical activities, the lowest level for which data exists should be a service delivery point such as a hospital, clinic, or mobile unit. Count each catchment area separately, but not each home site. Or for clinic-level care, count each clinic site.

Palliative care is defined as services focused on improved well-being, care, and support for the chronically ill and families affected by HIV/AIDS. Ideally, services include accurate symptom diagnosis; appropriate treatment of pain and suffering; access to essential palliative care drugs, including morphine; and provision of spiritual and emotional support and grief counseling and bereavement planning. Services outlets may be counted if they include some but not yet all of these elements. Programs must be receiving direct funding or support (in whole or part) by USG's Emergency Plan to be counted.

Unit of measure: Service outlets - cumulative number active in the given reporting period

Disaggregated by: Type of palliative care service outlet program (community/home visits, clinic, hospital); location; type of services provided; number of people being served

PLAN FOR DATA ACQUISITION

Data collection method and timing: Data collection officers will participate in a baseline mapping exercise in each country and will identify the name of each facility/location/coverage/catchment area for each facility receiving direct funding (either whole or in part) by USG. Officers will fill out and submit attached data forms quarterly and send to the executive director who will collate and compile statistics once each quarter.

Data source: Original baseline mapping exercise in focus countries, data forms, quarterly program reports

Estimated cost of data acquisition: Initial costs included in field visit costs (may need some money for in-country data collection officers)

Individual responsible and location of data storage: Executive director will be responsible for data management. Data will be stored in the HQ office in both hard and soft copies.

DATA QUALITY ISSUES

Known data limitations and significance:

- TB/HIV services need to be tracked independently and may be difficult to count separately.
- Baseline mapping exercise may have some data which is potentially inaccurate, incomplete, or may be delayed data from secondary sources and member organizations.

Actions taken or planned to address this limitation:

- In-country data collection officers will be identified and will be trained in how to collect data on TB/HIV services.
- Sample site visits will be conducted to validate baseline mapping data.
- Clear guidelines will be developed and provided as to what constitutes palliative care.

PLAN FOR DATA ANALYSIS, REVIEW AND REPORTING

Data Analysis and reporting:
Data will be compiled, disaggregated, and quantified by staff quarterly. Reports are due quarterly to the board and donors on:

- Jan. 15 (for period covering Oct. 1 through Dec. 31)
- April 15 (for period covering Jan. 1– March 31)
- July 15 (for period covering Apr. 1 – June 30)
- Oct. 15 (for period covering July 1 through Sept. 30)

This may change if donor requirements change.

OTHER NOTES

Baseline: Baseline survey to be conducted next month

Targets: Targets very difficult to predict without available baseline information

Other:

PERFORMANCE INDICATOR VALUES

Time Period/Quarter	Target (Planned)	Actual	Notes
	Baseline		
Oct. – Dec. 04	10		
Jan. – Mar. 05	15		
April – June 05	20		
July – Sept. 05	25		
Oct. – Dec. 05	30		
Jan. – Mar. 06	30		

THIS SHEET LAST UPDATED ON: SEPTEMBER 2004

Example 2:

Indicator Protocol Reference Sheet #2

NAME OF INDICATOR: TOTAL NUMBER OF PERSONS TRAINED TO PROVIDE OVCs SERVICES

RESULT TO WHICH INDICATOR RESPONDS: CARE

LEVEL OF INDICATOR: INPUT OUTPUT OUTCOME IMPACT

IS THIS A PEPFAR CORE INDICATOR: YES

DESCRIPTION

Definition: Number of people who completed training in the given reporting period to provide OVCs services. Training refers to new training or retraining of individuals and assumes that training is conducted according to national (SETA accredited) or international standards when these exist.

Completed training means attended and successfully completed the course and thus received a certificate.

People refers to community leaders, community volunteers, and/or staff all of whom are providing some services.

A leader is considered trained to provide OVCs service once they complete: The capacity building program for Committee members (7 days training)

A volunteer is considered trained once they complete: The Volunteer training course (4 modules, 9 days)

A barefoot social worker is considered trained when they are trained as a volunteer and then complete: HIV/AIDS Counseling Skills Course (10 days)

A staff member is considered to be trained: The Capacity building program for Resource Centre Staff 10 days)

Unit of measure: Number of people who completed training to provide OVCs services.

Disaggregated by: Gender, type of training, type of individual trained, and location of where participants are from.

Justification and Management Utility: Training is an important aspect to any program to assure staff/volunteers have the proper knowledge base and can improve the quality of service provision. The number of people trained can demonstrate the first step to ensuring this.

If people are trained in multiple programmatic areas, they can be counted under each area, however if the training is in one area, even if they attend multiple courses/sessions, they are still counted as one.

PLAN FOR DATA ACQUISITION

Data collection method and timing: The training coordinators will ensure that at the end of each training session, there is a completed attendance register of all the people who attended and completed the training. Updated information will be entered by the training coordinators on a monthly basis using these attendance registers. The data is transmitted to the regional office where it is aggregated.

Data Source: Official organizational OVCs database

Frequency and Timing of Data Acquisition: Regular updates as to when the training sessions are scheduled.

Estimated Cost of Data Acquisition: Cost for printing, plus staff time and volunteer time.

Individuals Responsible: Training coordinators and MER Program Coordinator

Location of Data Storage: Original copies of attendance registers will be stored on file at the regional offices. The data will then be collated into the database.

DATA QUALITY ISSUES

Known data limitations and significance:

The number of people trained does not reflect how effective the training was or whether the person applied the skill obtained to their work. Quality of course content.

Actions Taken or Planned to Address this Limitation:

Additional indicators/tools should be used for management to determine quality and effectiveness of training, such as pre-test and post-test scores and/or follow-up visits.

Date of Initial Internal and External Data Quality Assessments: August 2004

Date of Future Data Quality Assessments: November 2004 when internal mid-term evaluation is to be conducted

PLAN FOR DATA ANALYSIS, REVIEW AND REPORTING

Data Analysis and reporting:

The attendance registers will be conducted at ark level. This information will then be assimilated at regional level, through the ark builders and training coordinators. It will then be analyzed by the MER program coordinator and used in line with striving towards achieving organization's mission.

Presentation of Data: The data will be presented on a quarterly basis using bar charts for each area/ community within the regions and what they have been trained in.

Review of Data: An internal assessment (mid-term evaluation) end-November 2004.

Reporting of Data: The data will be reported on to Pact and USAID in quarterly reports, as well as in Board reports, annual reports and seminars.

PERFORMANCE INDICATOR VALUES					
Year	**Community**	**Baseline**	**Target** (by March 2005)	**Actual**	**Notes**
08/2004	Town A	0	A total of 120 community leaders and 240 community volunteers trained, plus 42 resource centre staff		
	Town B	0			
	Town C	0			
	Town D	NA			
	Village A	NA			
	Village B	0			
	Village C	NA			
	Village D	NA			
		0			
		0			
		0			
THIS SHEET LAST UPDATED ON: JULY **2004**					

Data Collection Form #1

Instructions: Fill out form for the first time after the baseline mapping exercise is completed. Update annually on Jan. 1 for period covering Oct. 1 through Dec. 31; April 1 for period covering Jan. 1– Mar. 31; July 1 for period covering Apr. 1 – June 30; and Oct. 1 for period covering July 1 through Sept. 30. E-mail findings to HQ office.

YOUR NAME:			DATE::	
Name of Palliative Care Service Outlet	**Type of service program:** 1. Community/home visits, 2. Clinic 3. Hospital 4. Mobile unit Select one only. If there are two or more types of service programs, use a new line for each program.	**Location:** (City, Province, Country)	**Type of palliative care services being provided in this recording period** (List all that apply): 1. Symptom diagnosis 2. Treatment of pain and suffering 3. Provision of essential palliative care drugs 4. Provision of spiritual and emotional support and grief counseling 5. Succession/bereavement planning 6. Other (please note what)	**Number of individuals being served in this recording period** 1. Number male: 2. Number female: 3. Number/percent under 24:
Example: Kazuri Home Based Care	Community/home visits program	Kazuri Village, Tita Province, Rwanda	4. Provision of spiritual and emotional support and grief counseling 5. Succession/bereavement planning 6. Other—provision of traditional herbs/medicine	50 males 63 females 15/13% under 24

CHAPTER 4

MONITORING

In this chapter, readers will learn:

- To identify other monitoring tools that may be useful to management

Introduction

In addition to indicator protocols, there are several other monitoring tools an organization may wish to use to track progress of their programs. Here are four examples:

1. **A benchmark calendar** (planned) is a listing of the key (or critical) activities an organization is undertaking laid out by date (a weekly calendar) over the period of a program (usually 1–2 years). This is updated quarterly re-scheduling activities as required based on changes in implementation. See example on page 70.
2. **An activity-based budget of the benchmark calendar** (planned) is an estimate of the inputs required to undertake each benchmark activity. This is usually completed once a year or one time per project. See example on page 71.
3. **A comparison chart** compares by line item what was actually planned and budgeted versus what actually occurred and was spent.
4. **A deliverables schedule** captures what is required of the organization to deliver (under contract or agreement) to a specific donor or partner, and the date it is due. It is updated quarterly, noting when items were actually delivered, who actually delivered it, and by what means (e-mail, by hand, post, etc.).

These items are usually updated quarterly so managers can track progress of projects and programs.

BENCHMARK CALENDAR

ORGANIZATION

UPDATED

		D/M/YY		NO. OF DAYS	MAY				JUNE				JULY				AUG				SEPT				OCT				NOV				DEC			
NO.	PLANNED ACTIVITY	START	END	NO. DAYS	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1.	Develop workshop materials																																			
2.	Conduct 3 workshops																																			
3.	Disseminate proceedings																																			
4.																																				
5.																																				
6.																																				
7.																																				
8.																																				
9.																																				
10.																																				

ACTIVITY-BASED BUDGET: PLANNED										
ORGANIZATION:					DATE BUDGET COMPLETED:					
NAME OF PROGRAM:										
BENCHMARK ACTIVITIES (INPUT ITEM)	LABOR	SUPPLIES	EQUIPMENT	TRAVEL	PER DIEM	OTHER DIRECT COSTS		INDIRECT COSTS		TOTALS
1. Conduct planning workshop	$1,000.00	$100.00	$50.00	$250.00	$50.00	Food/teas	$150.00	N/A	—	$1600.00
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.										
*Totals:										
*Must equal cumulative monthly financial reports										

ACTIVITY BASED-BUDGET: QUARTERLY COMPARISON OF PLANNED VS ACTUAL

ORGANIZATION: **DATE BUDGET COMPLETED:**

NAME OF PROGRAM:

PLANNED

BENCHMARK ACTIVITIES (INPUT ITEM)	LABOR	SUPPLIES	EQUIPMENT	TRAVEL	PER DIEM	OTHER DIRECT COSTS		INDIRECT COSTS		TOTALS
1. Conduct planning workshop	$1,000.00	$100.00	$50.00	$250.00	$50.00	Food/teas	$150.00	N/A	—	$1600.00
2.										
3.										
4.										
5.										
*Totals:	$1,000.00	$100.00	$50.00	$250.00	$50.00	Food/teas	$150.00	N/A	—	$1600.00

**Must equal cumulative monthly financial reports*

ACTUAL

BENCHMARK ACTIVITIES (INPUT ITEM)	LABOR	SUPPLIES	EQUIPMENT	TRAVEL	PER DIEM	OTHER DIRECT COSTS		INDIRECT COSTS		TOTALS
1. Conduct planning workshop	$1,500.00	$200.00	$100.00	$150.00	$350.00	Food/teas	$50.00	N/A	—	$2350.00
2.										
3.										
4.										
5.										
*Totals:	$1,500.00	$200.00	$100.00	$150.00	$350.00	Food/teas	$50.00	N/A	—	$2350.00

**Must equal cumulative monthly financial reports*

DELIVERABLES SCHEDULE

NAME OF PROJECT AND DONOR/PARTNER WHO WILL RECEIVE DELIVERABLE	DELIVERABLE	DATE DELIVERABLE IS DUE (Planned)	ACTUAL DATE IT WAS DELIVERED (This is filled in after delivery has been made.)	MEANS OF DELIVERY (PERSON/METHOD) (This is filled in after delivery has been made.)
Example: Moramanga Regional Policy Program/CARE	Legislative roadmap handbook	January 15, 2003	January 12, 2003	Edith sent a copy by e-mail and a hard copy by car to George

CHAPTER 5

EVALUATION

In this chapter, readers will learn:

- About evaluation and why it is important
- Different types of evaluations
- Who should be involved in evaluations
- How to develop a learning agenda

In this chapter, readers will complete the following tasks in building their MER systems:

- Develop an evaluation program and schedule
- Identify some of the learning agenda questions

What is Evaluation and Why is it Important?

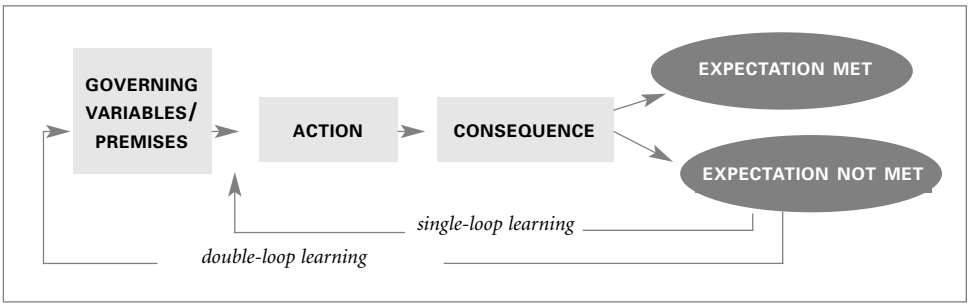
The previous chapters identified the measures and methods that will be used to track data for your organization. Unfortunately, however, that data cannot tell managers why results are being achieved or not. To get this information, which is often crucial for decision-making, organizations may have to conduct evaluations to analyze the cause-and-effect linkages in their program. Evaluation is most valuable when an organization wants to look not only at results on a cursory level but seeks to understand the underlying reasons why change is occurring or not occurring in the field and then uses that information to learn and adapt both its actions and its conceptual (results) framework.

Evaluation is an analytic effort undertaken selectively to answer specific management questions regarding the program. In contrast to monitoring, which provides ongoing structured information, evaluation is more periodic. Evaluation focuses on why results are or are not being achieved, on unintended consequences, or on issues of interpretation, relevance, effectiveness, efficiency, impact, or sustainability. An effective MER system includes a program and schedule for evaluation that is based on the development of a learning agenda in combination with an adaptive management approach to ensure the re-examination of management decisions/activities based on new information or learning.

Using an Adaptive Management Approach

Adaptive management is an approach to evaluation and decision-making involving a cycle of planning, implementation, monitoring, research, and subsequent re-examination of management decisions based on new information that may alter existing plans and priorities. In its simplest form, adaptive management is action in response to learning.

Adaptive management is ideal for learning about and understanding complex systems and structures as it recognizes that systems are inherently changing and unpredictable. Adaptive management copes with these uncertainties by monitoring decision-making results and re-examining choices in light of these results and on new information that becomes available. Adaptive management is based on double loop learning and solving problems by reexamining premises and goals of organized cooperation. When successful, "real" learning occurs and understanding of the realities of the system is improved.



Single loop and double loop learning (Argyris, 1992)

If we use an adaptive management approach, we not only periodically evaluate activities, we occasionally ensure that we go back and evaluate our results frameworks, hypotheses, and cause-and-effect linkages (the premises on which an organization selects activities to undertake) to ensure they are still valid based on what we have learned through our implementation and evaluation efforts. We do this through gathering feedback from the public, managers, scientists, and decision-makers.

Types and Purposes of Evaluation

Several evaluation methods support adaptive management efforts:

1. ***Formative Evaluation:*** Formative evaluation normally takes place at the beginning of (or prior to) a program in the concept and design phase. Formative evaluations are geared toward helping organizations understand the operational setting of a potential program and focus on determining if an intervention or program is required (and where), what exactly is required, who should be involved in the intervention, and how the intervention will be carried out. Formative evaluation provides the information needed to define realistic goals, objectives, and strategies for a program. Methods to undertake formative evaluation may include:
    - Reviews of existing information and knowledge (literature reviews and discussion with potential beneficiaries and partners)
    - Focus group or small group discussions
    - Individual in-depth interviews or short surveys
    - Participant observation

2. ***Process Evaluation:*** Process evaluations take place once activities are underway and focus on tracking the efficiency of a given program or organization. Process evaluations focus on providing information relating to what extent planned services are being realized, how well services are being provided, in what timeframe, at what cost, and with what result. Process evaluations analyze how efficiently inputs (money, time, equipment, personnel, etc.) are being used in creation of outputs (products, results, etc.). Process evaluations help organizations analyze what they planned to do versus what they actually are achieving and are used to make adjustments or refinements in tactics or implementation strategies. Process evaluations are often conducted informally (staff meetings, etc.) at regular intervals during the program year to assess progress toward achieving the results. They need to be based on performance data (results from indicator data collection) as well as staff observation of projects and programs.

Mid-Term Evaluations

Most organizations are also familiar with mid-term evaluations, which are process evaluations conducted halfway through a strategic cycle. Mid-term evaluations may be required or planned for some projects but should also be considered as a way to review your program or strategic plan. Mid-term evaluations normally:

- Assess the organization's progress in implementing activities
- Assess progress toward achievement of objectives or benchmarks
- Assess whether interventions and budgets are sufficient to reach desired results
- Identify barriers to achievement of results, objectives, and activities
- Identify opportunities, unanticipated accomplishments, or innovation
- Specify course correction or changes required

Mid-term evaluations provide recommended actions to prompt mid-course adjustments in the last half of the program. To the degree possible, mid-term evaluations should be participatory in nature and include stakeholder (target population) analysis of programs.

Methods for process evaluation include:

- Reviews of service records and regular reporting systems
- Key informant interviews
- Direct observations
- Population-based surveys, etc.

3. ***Effectiveness Evaluation:*** Effectiveness or impact evaluations normally take place toward the end of a program intervention and focus on assessing the overall outcomes and impacts attained. Effectiveness evaluations focus on questions pertaining to what results have been achieved, what short-term and intermediate effects were observed as a result of program effort, and what the outcomes mean. Does the program make a difference towards the larger development impact sought?

External or Donor Evaluations

A donor may require (and may be required by its own rules) an external evaluation. This means the donor will hire a person or team to look at the activities, processes, outputs, outcomes, and/or impacts of your project or program. External evaluations can be very beneficial to an organization as they call for third-party analysis (often thought to be less biased) and bring in fresh perspectives.

Organizations still have a key role to play in external evaluations as staff needs to ensure that evaluators understand the objectives of the program, the approach (results framework), what is working well or not, and how the organization is fixing what isn't working. If your organization is evaluated by a third party, make sure to request a copy of the results so you can use this information internally.

Final Evaluations

Most organizations are familiar with final evaluations, which are normally effectiveness evaluations. Final evaluations may be required or planned for some projects but should also be considered as a way to review and update your strategic plan. Final evaluations normally:

- Assess why progress toward planned results has been unexpectedly positive or negative
- Test the validity of hypotheses and assumptions underlying a results framework
- Assess how well needs of different customers were met (*e.g.,* by gender, age, ethnic group)
- Identify and analyze unintended consequences and effects of assistance activities
- Examine sustainability of activities and their results
- Distill lessons learned that may be useful elsewhere and/or by others

To the degree possible, final evaluations should be participatory in nature and include stakeholder (target population) analysis of programs.

Methods for effectiveness evaluation include:

- Reviews of service records and regular reporting systems
- Key informant interviews
- Direct observations
- Population-based surveys, longitudinal studies, review of secondary data, etc.

Developing a Learning Agenda and Evaluation Schedule

Regardless of which type of evaluation format it has planned to use, an organization initially needs to identify the questions it wants to pose and when it wants to collect the data—in other words, develop a learning agenda.

Developing a learning agenda includes:

1. Determining what components of your program you want to learn about (identifying what needs to be evaluated). To do this, review your implementation plan, deliverables and results framework and identify key components, sub-components, or aspects of your program that you will analyze in terms of your organization's efficiency to implement them and/or their effectiveness in obtaining results.
2. Clarifying what exactly you want to learn about each component you identified (what questions you will answer or evaluate). To help determine what question to ask review your planned deliverables, results frameworks and indicators. Some questions you might include ask:
    - What do you want to know about this subject?
    - What was changed as a result of our program?
    - How do targeted stakeholders perceive our programs?

- What sort of reach do we have?
- How many home visits are we supporting?
- How was the target population affected?
- How much money did we spend?

For example, if you determine that the training component should be evaluated, you might ask what evidence suggests that the training implemented has resulted in new ways of doing things or increased knowledge and skills of the participants.

3. Identifying how you will obtain the data. What data do you already have to help analyze this issue and what data do you need to be able to answer your questions? For example, will you need a focus group discussion, hire a research consultant, hold a staff meeting, or use data from specific indicators?

4. Identifying who should be involved in answering the questions and in participating in analysis of the answers.

5. Determining deadline dates for obtaining the data and conducting the analysis. Do you need the information every month, each quarter, at the end of the project?

6. Identifying how you plan to document the things you have learned, disseminate findings, and adapt your program activities and/or update underlying premises or results frameworks, thus altering the program design.

See Activity #8 on page 80 for an example.

Ensuring Evaluation and Learning Processes are Participatory

To ensure that a breadth of opinion is captured relating to the performance, and because evaluations include important capacity development and learning dimensions, they should be as participatory as possible. Stakeholder involvement in learning efforts usually promotes a sense of partnership among all the key people and/or groups interested in the organization. A participatory process is essential to provide more insight into programs and allows analysis of how well the needs of different stakeholders are being met. A variety of different perspectives is particularly helpful in analyzing unintended consequences and sustainability of activities.

Attributing Impact to Program Effort

Perhaps the most important thing to remember when focusing on attribution is to worry less about capturing scientifically valid attribution at the outcome and impact level and more about really learning and evaluating the impact of program activities in terms of improvement in the knowledge, capacity, reach, access, and service quality of HIV/AIDS programs. (Consider using secondary data sources or anecdotal data at this level.) This requires an organization to analyze the underlying premises it used to select the activities to undertake and measure whether they are still valid based on the implementation and evaluation efforts. Capturing and forwarding best practices at this level remains a cutting edge issue for improving HIV/AIDS response internationally.

ACTIVITY #8 WORKSHEET ▶ IDENTIFYING YOUR LEARNING AGENDA AND EVALUATION SCHEDULE

WHAT COMPONENTS OF THE PROGRAM DO WE WANT TO LEARN MORE ABOUT OR EVALUATE?	WHAT QUESTIONS DO WE WANT TO ANSWER OR WANT EVALUATED/ EXPLORED?	WHAT DATA DO WE HAVE TO HELP US ANALYZE THIS QUESTION/TOPIC?	WHAT FURTHER DATA WILL WE NEED TO ACQUIRE?	WHO SHOULD BE INVOLVED IN EITHER GIVING INPUT OR ANALYZING INFORMATION?	WHEN WILL WE OBTAIN THE INFO (DATES) OR CONDUCT ANALYSIS?	WHEN AND HOW WILL WE DISSEMINATE THE DATA AND ADAPT OUR PROGRAM?
Example: Our program to support targeted media staff to increase skills and knowledge so they may better formulate, cover, and program stories relating to A and AB messages in mass media settings	How many journalists participated in our programs and how many reported that they increased their knowledge of HIV/AIDS and the role of A and AB messages? How many mass media prevention programs ran during the reporting period that promoted abstinence and/or being faithful? Did journalists who participated in our programs increase their coverage of A and AB messages? Was the coverage accurate? What media sources covered A and AB messages during the reporting period? Did one type of media seem more appropriate than others?	Sign-in sheets from training Training evaluation forms Indicator data on # of A and AB mass media programs conducted and estimated number of people reached Financial records (budget spent on this activity)	Audience perception of mass media programming/ audience focus group Additional journalist input/perception of our support	Program staff Journalists/ media experts Audiences Local BCC orgs and experts	Training evaluation form completed after each training Indicator data updated quarterly Mid-term assessment meetings and discussion conducted with key stakeholders (January 2006) Final evaluation workshop (January 2008)	Training results discussed at monthly staff meetings, activity refined after Mid-term assessment will be completed by January 2006, disseminated among key stakeholders via an executive summary, course corrections to programs made at the time Results framework reviewed in January 2008

ACTIVITY #8 WORKSHEET ▶

WHAT COMPONENTS OF THE PROGRAM DO WE WANT TO LEARN MORE ABOUT OR EVALUATE?	WHAT QUESTIONS DO WE WANT TO ANSWER OR WANT EVALUATED/ EXPLORED?	WHAT DATA DO WE HAVE TO HELP US ANALYZE THIS QUESTION/TOPIC?	WHAT FURTHER DATA WILL WE NEED TO ACQUIRE?	WHO SHOULD BE INVOLVED IN EITHER GIVING INPUT OR ANALYZING INFORMATION?	WHEN WILL WE OBTAIN THE INFO (DATES) OR CONDUCT ANALYSIS?	WHEN AND HOW WILL WE DISSEMINATE THE DATA AND ADAPT OUR PROGRAM?
	What was the single most important factor that journalists reported helped them better cover HIV messages? How much did we spend on this activity versus how many stories were produced during the program period? How many individuals were reached with mass media HIV/AIDS prevention programs that promoted abstinence and/or being faithful? What was the audience response to the mass media programs?					

ACTIVITY #8 WORKSHEET ▶

WHAT COMPONENTS OF THE PROGRAM DO WE WANT TO LEARN MORE ABOUT OR EVALUATE?	WHAT QUESTIONS DO WE WANT TO ANSWER OR WANT EVALUATED/ EXPLORED?	WHAT DATA DO WE HAVE TO HELP US ANALYZE THIS QUESTION/TOPIC?	WHAT FURTHER DATA WILL WE NEED TO ACQUIRE?	WHO SHOULD BE INVOLVED IN EITHER GIVING INPUT OR ANALYZING INFORMATION?	WHEN WILL WE OBTAIN THE INFO (DATES) OR CONDUCT ANALYSIS?	WHEN AND HOW WILL WE DISSEMINATE THE DATA AND ADAPT OUR PROGRAM?

CHAPTER 6

REPORTING

In this chapter, readers will learn:

- About reporting and why it is important
- The different types of reports and communication tools that are usually produced by organizations
- Formats for quarterly and final project reports

In this chapter, readers will complete the following tasks in building their MER systems:

- Develop a reporting program and schedule.

Reporting to Your Internal and External Audiences

There is not much point to collecting and monitoring evaluation data unless you know how and by whom that data will be used. Your challenge is to turn raw data and information into useful knowledge and then report your results to the different program audiences (*e.g.,* donors, board members) in a way that will be useful both to them and your organization.

What is Reporting?

A report is a compilation of descriptive information. A report is a communication tool to present monitoring and evaluation results by presenting raw data and information as knowledge. A report is an opportunity for project implementers to inform themselves and others (stakeholders, partners, donors, etc.) on the progress, problems, difficulties encountered, successes, and lessons learned during implementation of programs and activities.

Why is Reporting Essential?

Reporting enables the assessment of progress and achievements and helps focus audiences on the results of activities, enabling the improvement of subsequent work plans. Reporting helps form the basis for decision-making and learning at the program level. Reporting communicates how effectively and efficiently an NGO is meeting its objectives.

Elements of a Good Report

A good report:

- Focuses on results and accomplishments
- Assesses performance over the past reporting period, using established indicators, schedules, baselines and targets
- States explicitly whether and how much progress or results surpassed, met, or fell short of expectations, and why
- Specifies actions to overcome problems and accelerate performance, where necessary
- Explains the influence of comparative performance by objectives on the resource request
- Addresses issues related to PLHWAs, including the issues of specific gender and other vulnerable groups, in the analysis of program performance

- Identifies the need to adjust resource allocations, indicators, or targets, where necessary
- Discusses the way forward and the prospects for successful program closeout or graduation, and addresses aspects of sustainability of results

- One large program report supplied to every stakeholder is not usually a useful way to share knowledge. Consider smaller reports or presentations targeting different audiences and their differing interests or data needs.
- For each audience, ask yourself: "What is the key message that we want to communicate to this audience? What exactly do they want to know?" Then review your information and identify what data you have to tell that story.

Identifying the Audience and the Appropriate Communication Tool

The first step in reporting is identifying your audience and their information needs. (This was done in Activity #2 on page 8.) The second step is to determine how you will report to each audience by selecting a presentation format that best suits the information that you want to convey to the specific audience you are trying to reach. Think about what their primary interest in the data is. What exactly does that audience want to know? Next, review your information and identify what data you have to tell that story. For each audience, ask yourself what key message your organization wants to communicate and what the best tool for communicating that message and reaching the audience is. Specific types of communication tools include:

- Oral presentations
- Discussion sessions
- Informal contacts
- Written progress reports/updates
- Written performance/evaluation reports
- Press and media releases
- Brochures and pamphlets
- Formal academic papers and books
- Visual presentations
- Internet, e-mail, and websites
- Play, music, and dances

Types of Communication Tools Often Required by Donors

Three types of communication are often required by donors (in addition to regular financial information):

1. Written progress reports (quarterly)
2. Internal mid-term evaluations
3. Participatory final evaluations

Generic Outline for Quarterly Progress Reports

Quarterly progress reports are probably the most common and most important format an organization has for conveying information about a project to its donor. Progress reports should focus on presenting in a concise format the advances (or lack thereof) made on a project during a specific quarter. Quarterly reports are often laid out in the following manner:

I. INTRODUCTION: Brief one to two paragraph introduction (concise presentation of the objectives of the project, the need for this report and what the report includes).

II. COMPARISON OF PLANNED VERSUS ACTUAL EVENTS: Brief narrative comparing planned activities and budget to actual activities undertaken and budget spent during the quarter. The basis of this narrative is an updated benchmark calendar or work plan and information from the Comparison Worksheet on page 72. Included in this narrative is a description of the factors that disrupted what you had planned and how you are responding (tells the donor why something that was planned did not take place, and what you plan to do about it); and/or the facilitating factors that helped you achieve activities faster than expected (tells the donor if you are ahead of schedule and why).

III. ADMINISTRATIVE REVIEW: Discuss the status of your administration of the program. During the reporting period, were there any changes in staffing, organizational development issues (new systems, failing systems, etc.), managerial issues, or results on special awards conditions (if applicable)?

IV. FINANCIAL REVIEW/EXPENDITURE REPORT/COST SHARE REPORT: Provide a brief management review of the organization's financial status (compare what the organization planned to spend to what the organization actually spent). Do you need a budget re-alignment? Will rescheduling of activities affect the budget? How are the cost-share components functioning? Are these on track with expectations? Explain any very low or very high expenditure rates.

V. INDICATOR DATA AND MER DATABASES: Discuss your progress in collecting and storing project indicator data. When you have new data, report the baseline figures and provide a brief analysis of the new information. Provide updated protocols if changes occurred.

VI. NOTABLE LESSONS, INNOVATIONS, OR QUOTES: Briefly capture any lessons learned during the recording period, interesting anecdotes suggesting program impacts, or small success stories.

VII. ISSUES REQUIRING IMMEDIATE SUPPORT/ATTENTION BY THE DONOR: In bullet form note any issues requiring the immediate assistance or attention of donor personnel in support of your project. (This is a concise list of items that may be mentioned otherwise in the report.)

Example

- Project budget re-alignment is requested to account for change in workshops venue.

ANNEX 1. BENCHMARK CALENDAR: An updated Benchmark Calendar on page 70. This should be re-worked each quarter to reflect your progress or lack thereof during the recording period.

ANNEX 2. STATUS OF DELIVERABLES: An updated Deliverables Schedule on page 73. This should be re-worked each quarter to reflect your progress or lack thereof during the recording period.

Final Evaluation/Performance Report

Donors usually require that grantees submit a final evaluation/performance report at the end of the funding cycle. Final reports are often laid out in the following manner:

EXECUTIVE SUMMARY: This section captures the essence of the report and provides an overview of its contents. It is the last section to be written and does not exceed one page.

I. INTRODUCTION: Presents a very concise overview of the need for and history of this program. Describes the results, objectives, and activities anticipated under the program during the period of agreement.

II. METHODS USED: Briefly describes the methods and approach used to implement the program.

III. RESULTS/IMPACTS: Compares planned versus actual achievement. Summarizes program accomplishments or failings. Presents findings as to why progress toward planned results was unexpectedly positive or negative. Presents findings as to how well needs of different customers were met (*e.g.,* by gender, age, ethnic group). Presents indicator results/tables and anecdotal information to support findings. Assesses the value of the contribution made by the program (clarify exactly how the achievement of your objectives contributed to the development outcome and impact). Reviews the validity of hypotheses and assumptions underlying the results framework based on lessons learned in implementation. Describes mitigating factors that disrupted what was planned (and the organization's response to the disruption) and describes the facilitating factors that helped spur results. Identifies and analyzes unintended consequences and effects of assistance activities.

IV. A SUMMARY OF THE PROSPECTS FOR SUSTAINABILITY: Describes the progress made in meeting the sustainability objectives of the program including the approaches used to build financial sustainability (*e.g.,* local financing, cost recovery, resource diversification, and corporate sponsorships). Presents any cost leveraging achieved during the project. Identifies what the beneficiary communities say about sustaining project services through alternative funding sources at the close of the project.

V. REVIEW OF DELIVERABLES: Reviews the deliverables submitted. Provides comments and recommendations regarding how unfinished work should be forwarded.

VI. LESSONS LEARNED/BEST PRACTICES/RECOMMENDATIONS FOR FUTURE PROGRAMS: Distills lessons learned or best practices identified through program implementation that may be useful elsewhere and/or by others. Provides recommendations regarding program continuation and direction or new program development.

ANNEX 1. FISCAL REPORT: Describes in detail budget find out and closeout matters, captures cost share results, or how any matching funds were used.

DON'T FORGET TO:

- Check spelling and grammar on all reports.
- Have a second project person proofread/edit your document before submitting it.
- Include page numbers and a table of contents.
- Ensure all acronyms and abbreviations are noted in their full text when they are first used in the report and/or list them in a glossary of terms.

ACTIVITY #9 WORKSHEET ▶ IDENTIFICATION OF REPORTING TOOLS AND SCHEDULES

AUDIENCE	COMMUNICATION TOOL SELECTED FOR REPORTING PURPOSES	SCHEDULE FOR REPORTING
EXAMPLE: Donor: Pact	Quarterly report	Mar. 1, June 1, Sept. 1, and Dec. 1
	Quarterly e-mail update	Apr. 1, July 1, Oct. 1, and Jan. 1
	Financial reports	Monthly and quarterly
	Final report	30 days after end of grant
	Final financial report and closeout audit	30 days after end of grant

CHAPTER 7

MER Review

Components of the MER plan should include:

I. INTRODUCTION

Present a concise statement of the need and purpose of the MER plan. Present a summation of your audiences, and their information needs per Activity #2 Worksheet on page 8.

II. RESULTS FRAMEWORK

Present the impacts, outcomes, outputs and inputs you plan to accomplish as an organization. Presentation in table format (or log frame) is fine.

III. MONITORING PLAN

A. Present indicators selected. Include an Indicator Protocol for each indicator using the Activity #7 Worksheet on page 64 which states the source, method, frequency and schedule of data collection, the individuals responsible for data collection, how data will be analyzed, compared, reviewed and presented, and associated forms or tools to be used in data collection.

B. Present any other monitoring tools to be utilized by the organization such as a benchmark calendar, line item budgets, comparison charts, deliverables lists, etc.

IV. EVALUATION PLAN

Present the evaluation program and schedule in table format as per Activity #8 Worksheet on page 80.

V. REPORTING PLAN

Identify reporting tools and schedules in table format as per Activity #9 Worksheet on page 87.

MER Checklist

I. Understanding Our MER Needs

__We have identified why quality MER (on this grant and in general) is important to our organization.

__We have identified our audience—who needs specific monitoring and evaluation data information from us regarding this program; what information they need; and when they need it. This includes both our internal and external audiences.

II. Results Framework and Implementation Plans

__We have articulated a chain of results with inputs, outputs, outcomes, and impacts that illustrate the cause-and-effect linkage that is believed to exist by our organization.

__We have described our critical assumptions (conditions outside the control of the organization that are likely to affect results that we assume will or will not take place).

__We have laid out and finalized a course of action through an implementation plan or work plan.

III. Monitoring Tools

Indicators / Protocols

__We have identified key input and process level indicators to support our efforts in monitoring our efficiency in completing activities and meeting targets.

__We have identified key output level indicators to help us identify if short-term conditions have or have not changed (based on our work) and targets have been met.

__We have identified key outcome and impact-level indicators (and/or secondary data sources) to help us identify intermediate changes in conditions and the impact of our program.

__We have developed indicator protocols (instruction sheets) describing in detail the methodologies and instruments to be used in collecting information.

__We have measured baseline levels for each indicator identified and made changes to the protocols and targets if necessary.

__We have created an official filing system with a separate file for each indicator and the raw data and have established any databases we need to track and record data.

__We have established realistic targets for projected change based on our baseline information and other national and regional data.

__We have clearly described our strategies for monitoring program implementation and interventions.

__We have clearly described how we plan to use data and information from different types of monitoring activities to make adjustments in the way the project is managed and the manner in which interventions are implemented.

Benchmark Calendar

__We have clearly laid out in a weekly calendar format (covering the entire grant period) a listing of the key activities we are undertaking in our grant and are updating this quarterly.

Activity-Based Budget

__We have an activity-based budget estimating the financial resources and financial inputs required to undertake each benchmark activity. (This is usually just completed once at the beginning of the grant.)

Comparison Chart

__We have a comparison chart or method developed for comparing benchmark activities and budgeted financial data to what actually occurred during the quarter. We are filling out this chart quarterly so that we can analyze what was actually planned and budgeted versus what actually occurred and was spent to monitor our efficiency.

Deliverables Schedule

__We have developed a chart outlining what is required of the organization to deliver (under the grant) to the donor or partner and the date it is due. We are updating this chart quarterly, noting when things were actually delivered, who actually delivered it, to whom it was delivered and by what means to track our efficiency.

IV. Evaluation/Learning Agenda

__We have identified the key things we want to learn and how (and when) we will go about learning them.

__We have clearly described a plan for measuring the project results at the mid-term and end of the project.

__We have indicated the aspects of our project that we expect to remain in place when our grant funding terminates.

V. Reporting

__We have identified which communication tools will be best suited to report to our various audiences. We have identified a format for various reports and developed a schedule identifying when the reports are due.

Glossary of Terms

Adaptive management: An approach to monitoring, evaluation, and management decision-making that involves a cycle of planning, implementation, monitoring, research, and subsequent re-examination of management decisions based on underlying premises and in conjunction with new information. In its simplest form, adaptive management is action in response to learning.

Audience: Those individuals/groups/organizations who actually need information or data from an organization (*e.g.,* the project team, the board, membership, partner organizations, community members with whom the project is working, donors, and policy and decision-makers in government and other agencies, etc.).

Baseline: A record of what exists in an area prior to an action. The baseline values establish the starting point from which change can be measured.

Benchmark calendar: A listing of the key (or critical) activities an organization is undertaking laid out by date in a weekly calendar over the period of a program (usually one to two years). This list is updated quarterly, re-scheduling activities as required based on changes in implementation.

Comparison chart: Compares by line item (the benchmark activities and corresponding financial data) what was planned to what actually occurred during the quarter.

Critical assumptions: Conditions outside the control of an organization that are likely to affect results and that are assumed will or will not take place. Some examples might be the continued existence of a positive policy environment, a relatively free press, absence of severe drought, or a peaceful election process.

Data analysis: Concise description of how performance data for individual indicators or groups of related indicators will be analyzed to determine progress on results. Data analysis techniques and data presentation formats are identified.

Data collection method: The approach to data collection, both primary and secondary, taken by the organization for each indicator. Primary data are data collected specifically within the context of the program. Secondary data are data collected by another source for some other purpose.

Data limitations: Identifies where data may be weak or limited. Describes actions taken to address data limitations.

Data source: The source is the entity from which the data is originally obtained. Data sources may include field staff or clinics, partner organizations, government departments, international organizations, donors, NGOs, private firms, contractors, or activity-implementing agencies.

Deliverables schedule: Captures what is required of the organization to deliver under contract or agreement to a specific donor or partner and the date it is due. Updated quarterly noting when it was actually delivered, who actually delivered it, and by what means (e-mail, post, hand, etc.).

Development objective: The overall and long-term effect of an intervention. It is the highest level of impact anticipated.

Disaggregated: How data are to be separated to improve the breadth of understanding of results reported. Typical ways to disaggregate data include geographic location, gender, and age.

Effectiveness: Measures the degree to which results/objectives have been achieved. An effective organization is one that achieves its results and objectives.

Effectiveness or impact evaluation: Analysis focused on questions pertaining to what results have been achieved, what short-term and intermediate effects were observed as a result of program effort, and what the outcomes mean. Does the program make a difference towards the larger development impact sought? Normally, this takes place toward the end of a program intervention and focuses on assessing the overall outcomes and impacts attained.

Efficiency: Measures how productively inputs (money, time, equipment, personnel, etc.) were used in the creation of outputs (products, outcomes, results). An efficient organization is one that achieves its objectives with the most resourceful expenditures of resources.

Estimated cost of collection: Rough estimate of cost of data collection efforts to the organization. Personnel time to follow normal monitoring and evaluation activities is usually not incorporated.

Evaluation: A systematic process of collecting and analyzing information to assess the effectiveness of the organization in the achievement of goals. Evaluation provides regular feedback that helps an organization analyze the consequences, outcomes, and results of its actions. Evaluation also provides regular feedback that helps organizations assess their relevance, scope, and sustainability. In its simplest terms, evaluation is the collection and analysis of information to assess the impact of the organization's work.

Formative evaluation: Analysis focused on helping organizations identify and understand the operational setting of a potential program and determine if an intervention is required (and where), what exactly is required, who should be involved in the intervention, and how the intervention should be carried out. Normally, this takes place at the beginning of (or prior to) a program in the concept and design phase. Formative evaluation provides the information needed to define realistic goals, objectives, and strategies for a program.

Frequency of data collection: How often data is to be collected. The frequency of monitoring will depend on the variables being investigated. Depending on the performance indicator, it may make sense to collect data on a quarterly, annual, or less frequent basis. When planning the frequency and scheduling of data collection, it is important to consider management's needs for timely information for decision-making.

Impact-level results: The overall and long-term effects of an intervention. Impacts are the ultimate result attributable to a development intervention over an extended period, such as improvement in food security or higher standards of living. Impacts usually reflect a result achieved over a longer time period (5–10+ years).

Indexed measure: Derived by measuring a compilation of discreet variables across a scale (*e.g.,* key elements or a series of steps are identified, points assigned as to the level of completion of each, and then the total added to determine the level of measurement).

Indicator: What will be measured to know if conditions have or have not changed. Key measures, functions, elements, or objects which, by virtue of their physical, biological, economic or organizational attributes, are so closely associated with the system in which they are found as to be indicative of the state or trends (improvement or deterioration) of the system. A performance indicator is a quantitative or qualitative dimension or scale to measure program results against a strategic objective or a program outcome. A performance indicator should be a precise, direct measure of the relevant objective. It should be practical; that is, data is available or can be generated, and disaggregated where possible and appropriate.

Input- and process-level results: The resources and methods employed to conduct an activity, project, and/or program. Inputs can be physical (*e.g.,* equipment rental or purchase), material (*e.g.,* supplies and provisions), human (labor costs such as salaries for technical assistance, staff, etc.) or financial (such as travel costs, per diem costs, direct and indirect costs). Processes are the methods or course of action selected to conduct work (*e.g.,* training, capacity building, service provision, message promotion).

Learning agenda: The program and processes an organization identifies to ensure it answers key questions it wants to pose or evaluate. Normally, organizations determine what components of their programs they want to evaluate or learn about; clarify what exactly they want to learn (pose questions they want to answer or evaluate); identify how they will obtain the data; identify who will be involved in answering the questions and in participating in analysis of answers and when; and identify how they will document what was learned, disseminate findings, and adapt program activities and or update underlying premises or results frameworks.

MER: Monitoring, evaluation and reporting.

Monitoring: A systematic process of collecting and analyzing information to track the efficiency of the organization in achievement of goals. Monitoring provides regular feedback that helps an organization track costs, personnel, implementation time, organizational development, and economic and financial results to compare what was planned to actual events. In its simplest terms, monitoring is collection and analysis of information to track what is going on.

Monitoring, evaluation, and reporting plan: A comprehensive performance-monitoring plan is designed to track program/project efficiency and effectiveness/impacts in all the program/project phases. The variables to be tracked are carefully selected and they must be good measures of the anticipated changes. The monitoring plan describes all the indicators to be monitored, the units of measurement, data sources, methodology of data collection, monitoring frequency, responsibility, baseline values, and targets set within the planning horizon.

Outcome-level results: Broad changes in development conditions. Outcomes help answer the "so what?" question: we trained 100 people and increased their knowledge but did they or did they not change their behavior? Outcomes often reflect behavior or economic changes and help analyze how activities and projects scale up or contribute toward development outcomes. Outcomes usually reflect a result achieved in an intermediate time period (2–5 years).

Output-level results: Information, products, or results produced by undertaking activities or projects. Outputs relate to completion of activities and are the type of results over which managers have a high degree of influence. Outputs reflect what the organization hoped to produce from a particular input (or set of inputs). For example: if the process is to train people, "people trained" is the result at the input/process level while "knowledge level increased" is the result at an output level. The assumption being that if people are trained, they will increase their knowledge on a given subject. Outputs usually reflect a result achieved in a relatively short-time period (0–2 years).

Process evaluations: Analysis focused on providing information relating to what extent planned services are being realized, how well services are being provided, in what timeframe, at what cost, and with what result. Process evaluations analyze how efficiently inputs (money, time, equipment, personnel, etc.) are being used in creation of outputs (products, results, etc.). Process evaluations help organizations analyze what they planned to do versus what they are actually achieving and are used to make adjustments or refinements in tactics or implementation strategies.

Protocols: Instructions that capture the reason for selecting indicators, describe the indicator in precise terms, and identify the plans for data collection, analysis reporting, and review. This information is documented not only to clarify and articulate what the indicators mean but also to provide the organization with the means to collect data over the life of the project and beyond, as required. Protocols also help ensure the reliability of indicators as they provide critical information to help different people repeatedly measure the indicator with the same precision.

Proxy indicators or proxy measures: Alternate or indirect measures used to stand in for another indicator when obtaining direct information is too difficult, time-consuming, or sensitive. For example, the number of people trained could be seen as an indirect measure for level of knowledge, if we assume that when people are trained, their level of knowledge always increases. Another example is the household consumption of maize, which could be a proxy indicator for household income if it is known that maize consumption always rises with income gain.

Reporting: Systematic and timely provision of essential (useful) information at periodic intervals. Reporting provides regular feedback that helps organizations inform themselves and others (stakeholders, partners, donors, etc.) on the progress, problems, successes, and lessons of program implementation.

Result: A consequence of a particular activity, project, or program that an organization can effect and for which it is willing to be held accountable. A change in condition attributable in whole or part to an organization.

Results-based management: Management approach by which an organization ensures that its processes, products, and services contribute to the achievement of clearly stated results.

Results-based monitoring: Sometimes referred to as performance monitoring or outcome monitoring. In addition to tracking general project implementation information (such as how much money was spent on an activity), a MER system also measures how an organization's processes, products, and services contribute to broader development objectives.

Results framework or results chain: Tabular or log frame presentation of the short-, intermediate-, and long-term results anticipated (inputs, outputs, outcomes, and impact-level results). The results chain/framework describes the development hypothesis of an organization, illustrating the cause-and-effect linkage that it believes to exist. The framework is an "if… then" approach to planning and implementation. "If we improve the message promotion…then people will improve their knowledge about HIV…and then people will change their behaviors…and then HIV will be reduced." Results in the framework are based on critical assumptions.

Secondary data: Data not collected by an organization but used by that organization to monitor results.

Target: Magnitude or level of outputs expected to be achieved. Targets are values against which the actual program/project achievements are measured. They should be realistic and quantitative statements of expected outcomes. If the targets are qualitative, there is need for a detailed statement of the expected state of affairs at the end of a planning period.

Unit of measurement: The precise parameter used to describe the magnitude or size of the indicator.

Sources and Recommended Resources

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HIV/AIDS APDIME Program Management Toolkit: Version 2.0. 2004. http://www.synergyaids.com/apdime/index.htm#

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UNAIDS. National AIDS Councils Monitoring and Evaluation Operations Manual. 2002. http://www1.worldbank.org/hiv_aids/docs/M&EManual.pdf

UNAIDS/WHO Working Group. *Guidelines for Effective Use of Data Form HIV Surveillance Systems.* World Health Organization. 2004. http://www.unaids.org/html/pub/publications/irc-pub06/jc1010-usingdata_en_pdf.pdf

Working Document on Monitoring and Evaluating of National ART Programmes in the Rapid Scale-up to 3 by 5. World Health Organization. http://www.who.int/3by5/publications/documents/en/3by5_monitoring_evaluation.pdf

The World Bank. *Turning Bureaucrats into Warriors: Preparing and Implementing Multi-Sector HIV-AIDS Programs in Africa.* June 2004. http://www1.worldbank.org/hiv_aids/docs/WorldBankGOMFinalJune.pdf

APPENDIX

ACTIVITY #1 WORKSHEET ▶ DESCRIBING WHY MER IS USEFUL

Beyond the five reasons cited in this chapter, please list why having a functional MER system could be useful to your organization:

1. _____

2. _____

3. _____

4. _____

5. _____

ACTIVITY #2 WORKSHEET ▶ AUDIENCE AND INFORMATION NEEDS ANALYSIS

WITHIN MY ORGANIZATION, WHO NEEDS INFORMATION ABOUT THE PROGRESS AND RESULTS/PERFORMANCE OF PROGRAMS?	WHAT INFORMATION DO THEY NEED?	WHY DO THEY NEED THE INFORMATION? WHAT WILL THE DATA HELP THEM DO?
WHO ARE THE EXTERNAL AUDIENCES THAT NEED INFORMATION ABOUT THE PROGRESS AND RESULTS/PERFORMANCE OF OUR PROGRAMS?	**WHAT INFORMATION DO THEY NEED?**	**WHY DO THEY NEED THE INFORMATION? WHAT WILL THE DATA HELP THEM DO?**

ACTIVITY #3A WORKSHEET ▶ REFINING RESULTS STATEMENTS AND FRAMEWORKS

Put the following results statements in the correct results level categories:

Example: *Improved knowledge and understanding on HIV/AIDS on prevention practices; reduction of HIV incidence; communication messages developed; reduced number of partners. (See answer in chart.)*

1. Access increased to food/nutrition sources; resource centers built (including kitchens); increased quality of life for OVCs; improved nutrition of targeted OVCs.
2. Improved quality of life of persons living with HIV/AIDS; reduced stigma and discrimination; increased knowledge and understanding of how HIV/AIDS is (and is not) transmitted; course curriculum developed for secondary schools.

INPUTS	OUTPUTS	OUTCOMES	IMPACTS
Example: Communication messages developed	**Example:** Improved knowledge and understanding of HIV/AIDS prevention practices	**Example:** Reduced number of partners	**Example:** Reduction of HIV incidence
1.			
2.			

ACTIVITY #3B WORKSHEET ▶ REFINING RESULTS STATEMENTS AND FRAMEWORKS

A quality MER plan starts with quality results statements and reflects your strategic plan.

1. Impact-Level Results—Your Long-Term Development Objective

a. Review the precise wording and intention of your vision statement. (You may also want to review your mission statement and objectives.)

b. In the box below, re-write your vision as a results statement describing the overall and long-term effects of your organization's interventions. Make sure that:

- The result is an effect or consequence of a particular activity, project, or program of your organization for which you are willing to be held accountable (perhaps in partnership with others).
- The statement is one-dimensional (you may have more than one strategic outcome).
- The statement is written as an accomplishment.

Do not include how you will achieve results. Focus on describing the results you hope your intervention will accomplish. Do not include extemporaneous factors, just critical outcomes.

Example:

Vision as written in plan: *OVCs in South Africa are socially and physically healthy and live in economically stable conditions.*

Vision as written as an impact-level results statement: *Improved quality of life of OVCs (health, education, and economic stability).*

Results Framework

LEVEL OF RESULTS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Key results sought				• Improved quality of life of OVCs (health, education, and economic stability)

ACTIVITY #3B WORKSHEET ▶

Your vision statement: _____

Your vision statement written as an impact-level results statement(s): _____

Your Results Framework

LEVEL OF RESULTS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Key results sought				

2. Outcome-Level Results—Your Intermediate Results

a. Review the precise wording and intention of your mission statement. You may also want to review your objectives and strategies.

b. In the box below, re-write your mission as results statements. Make sure that:

- The result is an effect or consequence of a particular activity, project, or program of your organization for which you are willing to be held accountable (perhaps in partnership with others).
- The statement is one-dimensional. You may find that you have more than one development outcome.
- The statement is written as an accomplishment.

c. Look at the results statements you have drafted and then determine if they describe the intermediate outcomes of your organization's interventions. They should answer the "so what?" question of why you are undertaking a series of activities and are often related to behavior or economic change, or they describe the outputs or products of a series of activities. Capture each statement in the appropriate boxes. If more detail is needed to clarify the linkages, add it and refine your results statements.

ACTIVITY #3B WORKSHEET ▶

d. Do not include how you will achieve results. Focus on describing the results you hope your intervention will accomplish. Do not include extemporaneous factors, just critical outcomes.

Example:

Mission as written in plan:
Improve the quality of life of all OVCs through provision of services (or referrals) to improve the health, education, and economic capacity of OVCs and/or their care providers and to ensure the emotional well-being and protection of OVCs, including HIV/AIDS prevention/care.

Mission written as results statements:

- *All OVCs covered*
- *Improved health of OVCs*
- *Improved educational levels of OVCs*
- *Improved economic capacity of OVCs and/or their care providers*
- *Improved emotional well-being of OVCs*
- *Improved protection of OVCs (reduced exploitation)*
- *Improved HIV/AIDS prevention practices by OVCs.*

Results Statements Organized by Level

LEVEL OF RESULTS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Key results sought in program area			• A majority of OVCs receiving care and support services • Improved health of OVCs • Improved educational levels of OVCs • Improved economic capacity of OVCs and/or their care providers • Improved emotional well-being of OVCs • Improved protection of OVCs (reduced exploitation) • Improved HIV/AIDS prevention practices by OVCs	• Improved quality of life of OVCs (health, education, and economic stability)

ACTIVITY #3B WORKSHEET ▶

Your mission statement: _____

Your results statements: _____

Your Results Statements Organized by Level

LEVEL OF RESULTS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Key results sought in program area				

ACTIVITY #3B WORKSHEET ▶

3. Output-Level Results – Your Short-Term Results

a. Review the wording and intention of your objectives and strategies.

b. In the box below, draft results statements describing the short-term outputs of your organization's interventions from the objectives, strategies, and activities draft. Remember these are project-oriented results and often relate to knowledge change, access change, service change, or quality change.

c. Make sure that:

- The result is an effect or consequence of a particular activity, project, or program of your organization for which you are willing to be held accountable (perhaps in partnership with others).
- The statement is one-dimensional. You may find that you have more than one development outcome.
- The statement is written as an accomplishment.

d. Do not include how you will achieve results. Focus on describing the results you hope your intervention will accomplish. Do not include extemporaneous factors, just critical outcomes.

e. Repeat the process with other objectives.

Example:

Objectives and strategies as written in plan:

- *Increase/strengthen capacity of communities to address the needs of OVCs*
- *Increase number of facilities, services, and programs available to OVCs*
- *Increase access to services*
- *Increase number of OVCs served*
- *Increase quality of service/care*
- *Increase knowledge and understanding of HIV/AIDS transmission prevention and care.*

Objectives and strategies written as results statements:

- *Increased/strengthened capacity of communities to address the needs of OVCs*
- *Increased number of facilities, services, and programs available to OVCs*
- *Increased access to services*
- *Increased number of OVCs served*
- *Increased quality of service/care*
- *Increased knowledge and understanding of HIV/AIDS transmission prevention and care.*

ACTIVITY #3B WORKSHEET ▶

Results Statements Organized by Level

LEVEL OF RESULTS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Key results sought in program area		• Increased/strengthened capacity of communities to address the needs of OVCs • Increased number of facilities, services, and programs available to OVCs • Increased access to services • Increased number of OVCs served • Increased quality of service/care • Increased knowledge and understanding of HIV/AIDS prevention, transmission, and care	• A majority of OVCs receiving care and support services • Improved health of OVCs • Improved educational levels of OVCs • Improved economic capacity of OVCs and/or their care providers • Improved emotional well-being of OVCs • Improved protection of OVCs (reduced exploitation) • Improved HIV/AIDS prevention practices by OVCs	• Improved quality of life of OVCs (health, education, and economic stability)

Your objectives and strategies: _____

Your objectives and strategies written as results statements: _____

ACTIVITY #3B WORKSHEET ▶

Your Results Statements Organized by Level

LEVEL OF RESULTS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Key results sought in program area				

4. Input/Process-Level Results—Your Immediate Results

a. In the box below, develop results statements describing the immediate inputs of your organization's interventions from your activities. Remember, these are project-oriented results and relate to process and resources utilized to undertake an activity (for example: training, services, staff, materials, etc.).

b. Make sure that:

- The result is an effect or consequence of a particular activity, project, or program of your organization for which you are willing to be held accountable (perhaps in partnership with others).
- The statement is one-dimensional. You may find that you have more than one development outcome.
- The statement is written as an accomplishment.

c. Do not include how you will achieve results. Focus on describing the results you hope your intervention will accomplish. Do not include extemporaneous factors, just critical outcomes.

d. Repeat the process with other outcomes.

ACTIVITY #3B WORKSHEET ▶

Example:

Activities as written in plan:

- *Secure funding*
- *Train service providers in needs of OVCs*
- *Provide mentoring of OVCs' care givers*
- *Develop materials for service providers*
- *Identify best practices*
- *Disseminate best practices to service providers*

Activities written as results statements:

- *Funding for programs, facilities, and materials provided*
- *Training/mentoring programs for key stakeholders and service providers funded*
- *Materials and facilities provided*
- *Curriculum/best practices/lessons identified and disseminated*

Results Statements Organized by Level

LEVEL OF RESULTS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Key results sought in program area	• Funding for programs, facilities, and materials provided • Training/mentoring programs for key stakeholders and service providers funded • Materials and facilities provided • Curriculum/best practices/lessons—identified and disseminated	• Increased/strengthened capacity of communities to address the needs of OVCs • Increased number of facilities, services, and programs available to OVCs • Increased access to services • Increased number of OVCs served • Increased quality of service/care • Increased knowledge and understanding of HIV/AIDS prevention, transmission, and care	• 50% of OVCs receiving care and support services • Improved health of OVCs • Improved educational levels of OVCs • Improved economic capacity of OVCs and/or their care providers • Improved emotional well-being of OVCs • Improved protection of OVCs (reduced exploitation) • Improved HIV/AIDS prevention practices by OVCs	• Improved quality of life of OVCs (health, education, and economic stability)

ACTIVITY #3B WORKSHEET ▶

Your activities: _____

Your related activities written as results statements: _____

Your Results Statements Organized by Level

LEVEL OF RESULTS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Key results sought in program area				

ACTIVITY #4 WORKSHEET ▶ DEVELOPING AN IMPLEMENTATION PLAN

Implementation Plan							
PROGRAM NAME/ORGANIZATION NAME:							
GRANT GOAL # ____:							
OBJECTIVE # ____:							
KEY ACTIVITIES	TARGET BENEFICIARIES	TIME FRAME		PERSON/PARTNER RESPONSIBLE	RESULTS ANTICIPATED (TARGET INPUTS/OUTPUTS)	BUDGET	COMMENTS
		STARTING ON	ENDING ON				

ACTIVITY #5 WORKSHEET ▶ IDENTIFYING INDICATORS ACROSS THE FOUR LEVELS OF RESULTS

1. Review your results framework. Select one of your impacts, a related outcome, a related output, and input/process. Fill in chart.

2. Look at one of your results statements and think "what could I measure to see if this result had been achieved or not, or if conditions had at least changed?" There are usually many possible indicators for any desired outcome but some are more appropriate and useful than others. For each level of results, brainstorm at least three possible indicators. Use existing indicators or select new ones.

LEVEL OF RESULTS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES	IMPACTS
Key results sought				
Potential Indicators	1.	1.	1.	1.
Potential Indicators	2.	2.	2.	2.
Potential Indicators	3.	3.	3.	3.

ACTIVITY #6 WORKSHEET ▶ ASSESSING INDICATORS

1. Select your indicators at the outcome level.
2. To assess and compare possible indicators, list the candidate indicators down the left side of the assessment worksheet.
3. Rate each indicator in terms of the criteria on a scale of 1–5, where 1 is LOW (indicator does not meet any of the criteria) and 5 is HIGH (indicator meets all of the criteria).
4. Add up the total score.
5. Select the best indicator.

Remember these ratings will help give an overall sense of the indicator's relative merit and help in the selection process. However, apply this approach flexibly and with judgment, because all seven criteria may not be equally important, or an indicator that scores a few points less than another indicator may still be more important to you as a manager.

Assessing Indicators

INDICATOR	RATE THE INDICATOR ON A SCALE OF 1 (LOW) TO 5 (HIGH) TO DETERMINE THE EXTENT TO WHICH THE INDICATOR IS:										
	MEASURABLE	PRACTICAL	RELIABLE	RELEVANT	USEFUL	DIRECT	SENSITIVE	RESPONSIVE	OBJECTIVE	DIS-AGGREGATED	TOTAL SCORE

ACTIVITY #7 WORKSHEET ▶ DEVELOPING INDICATOR PROTOCOLS

For each indicator, fill out an indicator protocol table.

Indicator Protocol (Reference Sheet) #1

NAME OF INDICATOR:
DESCRIPTION
Precise definition(s):
Unit of measure:
Disaggregated by:
PLAN FOR DATA ACQUISITION
Data collection method and timing:
Original data source:
Estimated cost of data acquisition:
Individual responsible and location of data storage:
PLAN FOR DATA ANALYSIS, REVIEW AND REPORTING
Data Analysis and reporting:
DATA QUALITY ISSUES
Known data limitations and significance:
Actions taken or planned to address data limitations:
OTHER NOTES
Notes on baselines/targets:
Other notes:
PERFORMANCE INDICATOR VALUES

Time period	Target	Actual	Notes
Quarter1	—	(Baseline)	
Quarter 2			
Quarter 3			

THIS SHEET LAST UPDATED ON:

ACTIVITY #8 WORKSHEET ▶ IDENTIFYING YOUR LEARNING AGENDA AND EVALUATION SCHEDULE

WHAT COMPONENTS OF THE PROGRAM DO WE WANT TO LEARN MORE ABOUT OR EVALUATE?	WHAT QUESTIONS DO WE WANT TO ANSWER OR WANT EVALUATED/ EXPLORED?	WHAT DATA DO WE HAVE TO HELP US ANALYZE THIS QUESTION/TOPIC?	WHAT FURTHER DATA WILL WE NEED TO ACQUIRE?	WHO SHOULD BE INVOLVED IN EITHER GIVING INPUT OR ANALYZING INFORMATION?	WHEN WILL WE OBTAIN THE INFO (DATES) OR CONDUCT ANALYSIS?	WHEN AND HOW WILL WE DISSEMINATE THE DATA AND ADAPT OUR PROGRAM?
Example: Our program to support targeted media staff to increase skills and knowledge so they may better formulate, cover, and program stories relating to A and AB messages in mass media settings	How many journalists participated in our programs and how many reported that they increased their knowledge of HIV/AIDS and the role of A and AB messages? How many mass media prevention programs ran during the reporting period that promoted abstinence and/or being faithful? Did journalists who participated in our programs increase their coverage of A and AB messages? Was the coverage accurate? What media sources covered A and AB messages during the reporting period? Did one type of media seem more appropriate than others?	Sign-in sheets from training Training evaluation forms Indicator data on # of A and AB mass media programs conducted and estimated number of people reached Financial records (budget spent on this activity)	Audience perception of mass media programming/ audience focus group Additional journalist input/perception of our support	Program staff Journalists/ media experts Audiences Local BCC orgs and experts	Training evaluation form completed after each training Indicator data updated quarterly Mid-term assessment meetings and discussion conducted with key stakeholders (January 2006) Final evaluation workshop (January 2008)	Training results discussed at monthly staff meetings, activity refined after Mid-term assessment will be completed by January 2006, disseminated among key stakeholders via an executive summary, course corrections to programs made at the time Results framework reviewed in January 2008

ACTIVITY #8 WORKSHEET ▶

WHAT COMPONENTS OF THE PROGRAM DO WE WANT TO LEARN MORE ABOUT OR EVALUATE?	WHAT QUESTIONS DO WE WANT TO ANSWER OR WANT EVALUATED/ EXPLORED?	WHAT DATA DO WE HAVE TO HELP US ANALYZE THIS QUESTION/TOPIC?	WHAT FURTHER DATA WILL WE NEED TO ACQUIRE?	WHO SHOULD BE INVOLVED IN EITHER GIVING INPUT OR ANALYZING INFORMATION?	WHEN WILL WE OBTAIN THE INFO (DATES) OR CONDUCT ANALYSIS?	WHEN AND HOW WILL WE DISSEMINATE THE DATA AND ADAPT OUR PROGRAM?
	What was the single most important factor that journalists reported helped them better cover HIV messages? How much did we spend on this activity versus how many stories were produced during the program period? How many individuals were reached with mass media HIV/AIDS prevention programs that promoted abstinence and/or being faithful? What was the audience response to the mass media programs?					

ACTIVITY #8 WORKSHEET ▶

WHAT COMPONENTS OF THE PROGRAM DO WE WANT TO LEARN MORE ABOUT OR EVALUATE?	WHAT QUESTIONS DO WE WANT TO ANSWER OR WANT EVALUATED/ EXPLORED?	WHAT DATA DO WE HAVE TO HELP US ANALYZE THIS QUESTION/TOPIC?	WHAT FURTHER DATA WILL WE NEED TO ACQUIRE?	WHO SHOULD BE INVOLVED IN EITHER GIVING INPUT OR ANALYZING INFORMATION?	WHEN WILL WE OBTAIN THE INFO (DATES) OR CONDUCT ANALYSIS?	WHEN AND HOW WILL WE DISSEMINATE THE DATA AND ADAPT OUR PROGRAM?

ACTIVITY #9 WORKSHEET ▶ IDENTIFICATION OF REPORTING TOOLS AND SCHEDULES

AUDIENCE	COMMUNICATION TOOL SELECTED FOR REPORTING PURPOSES	SCHEDULE FOR REPORTING
EXAMPLE: Donor: Pact	Quarterly report	Mar. 1, June 1, Sept. 1, and Dec. 1
	Quarterly e-mail update	Apr. 1, July 1, Oct. 1, and Jan. 1
	Financial reports	Monthly and quarterly
	Final report	30 days after end of grant
	Final financial report and closeout audit	30 days after end of grant

Pact is a networked global organization that builds the capacity of local leaders and organizations to meet pressing social needs in dozens of countries around the world. Our work is firmly rooted in the belief that local communities must be the driving force in ending poverty and injustice. Through community-based approaches we enhance the capacity of individuals, organizations, networks and communities to deliver services and increase learning in six key sectors: democracy and governance, HIV/AIDS, livelihoods, peace building, community-based natural resource management and equity and empowerment of vulnerable groups.

Cover Photo: Susan Liebold

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ISBN 1-888753-44-7