This guide is addressed at Médecins du Monde project players whoever they may be – coordinators, desk officers, volunteer board delegates (RMs), volunteers, etc. Someone with little experience will find in this guide the basics needed to understand the logic of the project cycle. Those with more experience and with a good command of the project cycle already will be able to familiarise themselves with the concepts and approaches used within Médecins du Monde. It is a fact that a growing proportion of our managers in the field received their project-cycle training elsewhere than at MdM. The objective of the guide is therefore to provide entire project teams with a common lexicon, frame of reference and tools. Its objective is to encourage critical thinking and prompt a questioning attitude throughout a project's lifecycle. It is a matter of learning to ask oneself the right questions. The four chapters which make up the guide refer to the four phases of project planning, comprising diagnosis (or context analysis and needs identification), project programming (or designing), implementing and tracking, and finally evaluation. A selection of practical tools is offered in an annex to each chapter in the form of a CD-Rom.

www.medecinsdumonde.org
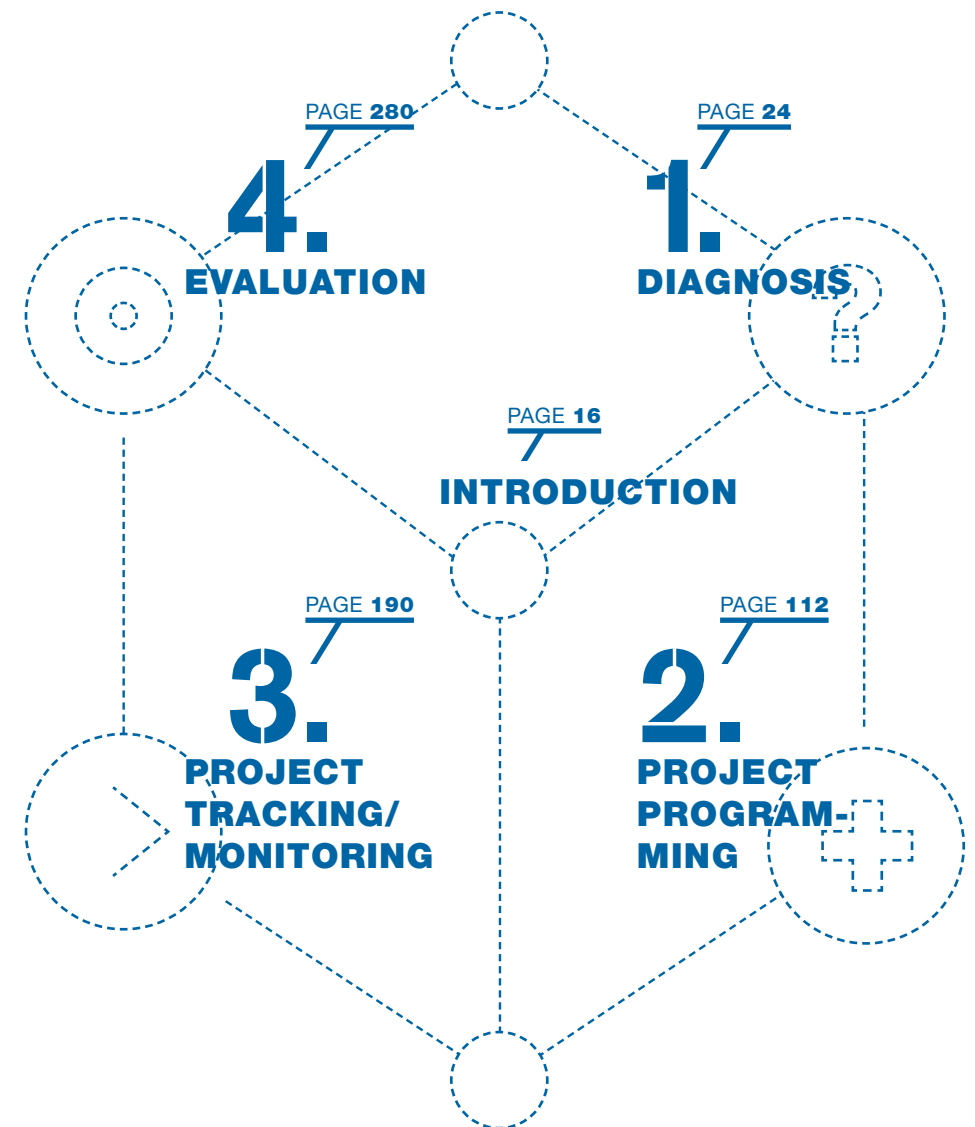
15 €

9 782918 362777

DVD INCLUS /
DVD INCLUDED /
INCLUYE DVD

HEALTH PROJECT PLANNING
>> HEALTH PROMOTION AND HUMANITARIAN ACTION

HEALTH PROJECT PLANNING

>>HEALTH PROMOTION
AND HUMANITARIAN ACTION

MÉDECINS DU MONDE

MÉDECINS DU MONDE

HEALTH
PROJECT
PLANNING

This guide has been printed on paper certified by FSC, a trademark guaranteeing products
of ecologically sustainable and socially beneficial forest management, with 100% of its inside pages
recycled, by printers «Imprim'Vert».

EVALUATION

DIAGNOSIS

EXIT

SITUATION ANALYSIS

REORIENTATION

COLLECTIVE HEALTH PROBLEMS

EVALUATION OF THE INTERVENTION

PUBLIC HEALTH PROBLEMS AND POSSIBLE INTERVENTIONS

ACCOUNTABILITY

ADJUSTMENTS

DEFINING OBJECTIVES/ RESULTS/ INDICATORS

TRACKING/ MONITORING

ACTIVITIES AND RESOURCES

SETTING UP

IMPLEMENTATION/ TRACKING/ MONITORING

PROGRAMMING

PROJECT CYCLE

- Evaluation ToR
- Evaluation matrix
- Recommendations follow-up.

- Fact-finding mission ToR
- Fact-finding mission report
- Stakeholder analysis
- Risk analysis

EVALUATION

DIAGNOSIS

TRACKING MONITORING

PROGRAMMING

- Security plan
- Monthly report
- Schedule / Gantt chart
- Budget follow-up
- Tracking donor relations
- Monitool: Indicators Summary & Monitoring Plan
- Accountability framework

- Country strategy
- Reference document & Budget
- Schedule / Gantt chart
- Monitool: Indicators Summary

INTRODUCTION

> Médecins du Monde has just rewritten its mission statement. This practical guide offers MdM project players a method of planning that is in line with the values reaffirmed and specified in that statement – to provide care and cure, to bear witness and advocate, and to support communities seeking social change. To fulfil the mission statement, a strategic plan, which is currently being prepared, will be added to these policy and operational instruments.

Project-planning issues

Planning means clarifying our intentions and detailing the expected outcomes, namely the changes it is hoped to bring about by a project and the mechanisms that can pave the way for these changes. In other words, it is about defining a vision of the future, an ideal objective, as well as the intermediate steps and concrete activities involved. It is also a method of establishing whether or not we are on the right track during the course of a project. These are all elements that combine to explain and compose a project. In practical terms, this reflective process is formalised in documents and tools shared within the

project team or with partners, such as the logframe which represents a simplified summary and which provides a way of checking that the various activities, resources and outcomes fit together and thus that the proposed strategy is coherent. This formalising allows the successive partners and teams to share the initial vision and thereby ensures better cohesiveness around a project.

Current debates on aid examine the best form for it to take to improve its effectiveness, particularly as regards the question of project users and States taking ownership of the proposed policies and strategies. International aid takes various forms, the principal ones being: budgetary aid paid directly to governments; sector-based aid

co-managed by governments, international institutions and donors; and project-based aid managed by NGOs, civil society and States. Project-based aid remains the most common method of operating.[1]

The discussions on the effectiveness of aid and the hegemony of the project approach, whose limited duration conflicts with the development timescale, are fascinating, but in this guide we adopt a pragmatic approach. This means that, while pursuing our efforts in the international arena to advocate a paradigm shift and to move away from an exclusively project-based approach, we also have a responsibility to train our teams in the project life cycle, a necessary, albeit not sufficient, precondition for implementing good quality projects.

Planning is a structuring exercise that entails clarifying, prioritising and **explaining** objectives, assumptions and intervention methods, which cannot be left implicit when working in a multicultural or partnership context. This process of collective construction leads to in-depth reflection and to the development of strategic thinking, and not just to a reasoning based on activities. Planning fulfils an ethical and professional obligation to continually improve project quality, relevance and effectiveness.

Planning must not impose a rigid structure on our work. The correct balance must therefore be found between planning and maintaining a certain capacity to adapt to changes in the context. Planning quality depends largely on understanding the intervention context, the methods of community organisation and the nature of relationships between players. A global

or even systemic approach to a situation takes account not only of all the factors characterising it but also – and especially – of the links and interactions between them. Furthermore, the stated expectations reflect only a part of what takes place around a project, for, as we know, the dynamic created by projects goes far beyond the objectives pursued. Paying attention to unexpected outcomes is an integral part of planning and of a quality assurance process.

The MdM planning model: reflecting the organisation's values and principles of action[2]

As a medical organisation, Médecins du Monde works to ensure that the **right to health** is exercised. It upholds the values conveyed by community-based approaches and health promotion, namely **social justice** as a vehicle for health equality, respect for fundamental rights and collective solidarity; and **empowerment** of populations, who find themselves vulnerable in terms of health and social circumstances, so they can be participants within society, exercise their rights and assume an active role in managing their own health.

As a humanitarian organisation, Médecins du Monde works to preserve human dignity and the means to survival. As well as responding to disasters, it operates in the field of pre-crisis disaster risk reduction and post-crisis recovery. Its humanitarian action is founded on the principles of humanity, impartiality, neutrality and independence.

1. A project is an intervention of limited duration, which is composed of a series of planned and connected activities, aimed at achieving defined outputs and outcomes. A project has a defined beginning and end and specific objectives, which, when they are attained, signify the completion of the project.

2. The object of this introduction is not to develop the values upheld by the organisation and the debates taking place within it. For these, the reader will find it helpful to refer to the 2015 redefined mission statement. We refer in this guide to the principal elements.

As a civic organisation, its legitimacy is based on **action in the field, both at home and abroad,** centring on three principles: dispensing care, providing testimony and engaging in advocacy, and supporting communities in their desire for **social change.** In addition to its caring role, MdM bears witness of human rights violations and restrictions on access to healthcare, and calls on national and international authorities to better protect the health of individuals and communities. This political vision goes with an outreach approach that takes into consideration the place of the project user and of partnership. MdM thus positions itself not only as a facilitator and supporter of social transformation but also as a mediator working with international institutions or donors. In this role, MdM translates their policies and procedures for the benefit of communities and civil society players.

Numerous project-management frameworks and models already exist. Whilst not seeking to develop a novel or different model for the traditional project cycle, it does seem important for MdM to adopt an approach that upholds its references and its values. The health promotion approach, as defined in the Ottawa Charter[3] , appears to best reflect MdM's values. Thus, the MdM health project planning model applies the principles of health promotion in designing the organisation's projects. These principles guide and influence the decisions taken throughout the planning process.

**FOCUS ON
HEALTH PROMOTION**

Health promotion represents both a concept and a set of strategies.

3. The Charter, signed in 1986 by more than 180 States, can be viewed at www.euro.who.int.

Firstly, it is a concept based on a *philosophical* and *political* approach. According to the Ottawa Charter, health promotion is a process by which individuals and populations acquire the means to increase their control over the determinants affecting their health, to exercise their health-related rights and to have an effect on their environment or to change with it, in order to maintain or improve their state of health. Health is seen as a resource for everyday life and not as an end in itself. Health promotion takes account of all the determinants – social, economic, cultural, political, etc. – affecting health. Individuals are viewed as autonomous and user participation in health projects is encouraged.

Health promotion is also a set of strategies: it is a global, multi-sector approach, which is applied simultaneously to the five intervention areas listed in the Ottawa Charter:

1. **Build healthy public policy** in all sectors that influence health and at every level – local, national and international. For MdM, this means advocacy action aimed at either the adoption of new policies to improve the health situation of populations (for example, the adoption of new national protocols for treating Hepatitis C), or the questioning of policies considered as contrary to the interests of the populations concerned (for example, promoting an end to criminalising people who inject drugs), or lastly respect for already existing policies or legal

norms not currently applied (for example, enforcing the legal right to treatment for incomplete abortions). Advocacy therefore assumes its full significance in all health-related action.

2. **Create supportive environments,** namely physical, social and legal ones, which support individuals and communities in their efforts to promote health and bring about change. For MdM this means making condoms or needles available in locations accessible to users; working to remove the financial barriers to access to care; taking action to facilitate the physical and geographical access to health services (for example, reinforcing access bridges and gangways), etc.

3. **Strengthen community actions,** namely ensure effective and real community participation in defining priorities, decision-making and drawing up planning strategies. For MdM this means supporting community mobilisation by training community players, involving users in managing actions and in decision-making processes, reinforcing management committees, supporting health mediators or promoters, assisting with setting up self-help groups, etc.

4. **Develop personal skills** of individuals by offering them information, ensuring provision of health education and improving essential life skills, so that they may exercise greater control over their health and its determinants.

For MdM this means awareness-raising and health education activities, informing people of their health-related rights, developing skills for the effective exercising of these rights (self-esteem, speaking in public, negotiating skills, etc.) and taking action to empower people.

5. **Reorient health services** (health service institutions and health professionals) in the curative and preventative fields, by broadening the scope of healthcare sector provision to include promoting multi-sector health policies and supporting individuals and groups in voicing their health needs. For MdM this means taking action to support national or local health systems by developing the skills of healthcare staff and updating or implementing protocols (for example, integrating mental health into primary healthcare and decentralising care in rural areas).

At MdM, these five points represent the areas for consideration when designing projects.

Planning in a complex world

We are conscious of the current issues and debates surrounding complexity. However, complexity, that is to say non-linearity and uncertainty, is not something which can be used to exempt us from planning or from the requirements of accountability. We have to commit to these as part of our obligations towards our interlocutors in the field as well as towards our donors,

and as an essential method of working for our practice in the field.

The logic underpinned by the logframe and by other elements of project planning is undeniably linear, with a simplified progression of predictable cause and effect. This is in complete contrast to the multiple forms taken by the world we live in, full of uncertainties and complexity. However, we do believe that, because we act within the short timeframes we have available, such an approach may help us frame our intervention choices better and act upon the levers that enable gradual change, without losing sight of the objectives of structural social change. While the problem tree allows us to grasp situations in all their complexity, planning makes it possible to take account of this complexity by tackling problems in a sequential way and by making realistic choices. It enables the construction of long-term strategies and the integration of multi-player approaches in a context of constrained resources.

Planning a project must therefore be dynamic, and be revised and corrected as the context evolves. The logframe must be seen as an instrument serving to structure and orient project planning and budgeting, and not as a rigid and restrictive template. It is, above all, a steering tool and not a bureaucratic constraint.

Our planning model is based on a method of iterative questioning. While the use of certain tools, such as the logframe, is recommended, we also believe that we should not confuse method and tools, and should not allow ourselves to be straitjacketed by the latter. On the contrary, it is essential to maintain the flexibility required to adapt to an ever-evolving context and to use the tools as aids to shared reflection and management.

Even if a project is of limited duration, it is almost inevitable that strategic adjustments and changes will be sought by users. This may be either because their environment has changed between indentifying the project and implementing it, or it may simply be that they did not have a clear idea of the issues and opportunities when the project was devised, and it is only when beginning to implement it that they more readily perceive the issues as well as the opportunities that it affords.

Target readership and objectives of the guide

This guide is addressed at Médecins du Monde project players whoever they may be – coordinators, desk officers, volunteer board delegates (RMs), volunteers, etc. Someone with little experience will find in this guide the basics needed to understand the logic of the project cycle. Those with more experience and with a good command of the project cycle already will be able to familiarise themselves with the concepts and approaches used within Médecins du Monde. It is a fact that a growing proportion of our managers in the field received their project-cycle training elsewhere than at MdM. The objective of the guide is therefore to provide entire project teams with a common lexicon, frame of reference and tools.

The content of this guide has been carefully considered over several years, tested during training and individual support sessions, and written taking advantage of appeasement in international events. Its objective is to encourage critical thinking and prompt a questioning attitude throughout a project's lifecycle. It is a matter of learning to ask oneself the right questions. Directed at players with significantly different roles and experience, the guide is educational in intent and sometimes simplifies what are complex notions. Indeed, the realities and constraints of a given context do not always make it possible to proceed as indicated. Similarly, this primarily methodological guide chooses

not to deal with the debates which are taking place in the international solidarity sector.

The four chapters which make up the guide refer to the four phases of project planning, comprising diagnosis (or context analysis and needs identification), project programming (or designing), implementing and tracking, and finally evaluation. The guide may be read as one continuous work in order to understand the logical progression of the different phases of the project cycle. To some degree and provided there is prior knowledge of the project cycle, the different chapters may also be read independently. In response to requests from project players, a selection of practical tools is suggested in an annex to each chapter in the form of a CD-Rom.

GENERIC EXAMPLE

The red insets entitled "Generic Example" provide an "educational device" in the form of a hypothetical case study of a fictional African country. The example serves to illustrate certain, specific points throughout the chapter.

OTTAWA CHARTER: HEALTH AS A RESOURCE FOR EVERYDAY LIFE...

1. DIAGNOSIS

DIAGNOSIS

Definition

Situation analysis is the first of four phases of the **project cycle.** It is an essential stage in setting up the action and aims to:
→ Provide an overall grasp of the context,
→ Improve understanding of a particular health phenomenon and its determinants,
→ Examine each individual's behaviour and perceptions,
→ List the elements which could hinder a future intervention (risk analysis).

It thus provides a way of defining the health problem selected and of setting goals and selecting interventions.

> **NOTE/**
> During the diagnosis, attention must also be paid to the risks run by MdM staff, service users[4] and partners within the framework of the intervention, whatever the overall context.

When to carry out a diagnosis

At Médecins du Monde, analysing the situation is a prerequisite for organising and setting up **any intervention,** whether it is taking place in **France or abroad,** in an **emergency** or **long-term context.**

The diagnosis can be carried out at the start of the project (initial diagnosis or fact-finding mission) or during the project (intermediate diagnosis). Although, in the latter case, the field is already familiar, an evaluation may have concluded that some adjustments were required. Also, the context may have changed since the project was set up. The appearance, disappearance or evolution of a certain number of factors may therefore make it necessary to carry out a fresh diagnosis before redefining/re-orienting the project underway.

**FOCUS ON
INITIAL DIAGNOSIS**

> In certain locations in France where we have had a presence for many years, an initial diagnosis needs to be carried out **before new projects are implemented, and the relevance of projects** underway needs to be

4. In this guide, we will refer to MdM project's service users rather than beneficiaries or patients.

examined in relation to contextual developments. What we know of our own particular situation is not a substitute for a structured diagnosis. The methodology remains the same in emergency situations. What differentiates emergency from long-term contexts is the fact that the project may be implemented before the end of the initial diagnosis (the project cycle is identical but unfolds much more rapidly). It is however extremely important not to ignore this phase of the project cycle in emergency interventions as, even when there is strong theoretical evidence for the existence of health problems, only a rigorously conducted diagnosis can confirm this and ensure that important elements have not been overlooked.

While the initial (or intermediate) diagnosis is a key time for data-collecting and for understanding the intervention context, it is important to continue refining this analysis throughout the term of the project.

In complex emergencies or open conflict situations, there are likely to be many rapidly changing factors with a negative impact on the project's successful outcome. The risk analysis must be regularly updated.

Understanding diagnosis in practice

The fact-finding phase (initial diagnosis) or intermediate diagnosis must provide important and relevant information. This presupposes **sufficient time** in the field to carry out satisfactory data collection using a **methodology devised in advance.** This is a key point at which to **establish the dynamics of participation.**

FOCUS ON
PARTICIPATION ISSUES⁵

The issues for aid workers cannot be summed up as "saving lives" and for victims as "being saved". For aid workers, it is also a matter of creating a programme of action within allotted deadlines with all the attendant issues surrounding the professional attitudes and positioning within an organisation.
As for the "victims", they too wish to play an active part alongside those who are helping them to acquire or strengthen their place in society or to fight against injustice. They are often trapped in an asymmetric aid relationship which, in the view of sociologist Marcel Mauss, is characterised by **the absence of a system of "gift exchange".** One of the key terms associated with reducing this imbalance and viewing individuals themselves as part of the response to their problems is **participation.** Participation must enable those benefiting from an action not to be solely "receivers" but also to be recognised for what they can contribute to their community. Participation may be understood as **the greater or lesser involvement of populations in one or more aspects of a project:** diagnosis, programming, implementation, monitoring and evaluation. It implies that project players are disposed to listen to what individuals have to say in order then to adjust and even change their objectives.
A population's participation and degree of involvement naturally differ depending on the situation and

5. MdM, "Working with communities", 2012.

context (urban or rural, emergency situation, time of conflict or peace, chronic emergency, etc.), but it must always be sought.

The fact-finding phase (initial diagnosis) and the intermediary diagnosis imply:
1. Gathering **quantitative** and **qualitative** data according to precise methodologies;
2. Analysing the data collected.

Both these operations must be carried out simultaneously. It is especially important not to wait for the end of the fact-finding mission before starting to analyse the data, as this is the point at which gaps in the information are identified, which must then be filled to complete the fact-finding phase.

Any analysis of the context involves combining **secondary data** (data from existing reports and documents) and **primary data** (new data) collected by the fact-finding team on field visits to the communities concerned (villages, displaced persons' camps and urban neighbourhoods).

Secondary data is that which is second-hand, which has been collected by other organisations and refers to:
→ National statistics, census and national health information systems (NHIS);
→ National and international statistics published by the United Nations (for example, Unicef Multiple Indicator Cluster Survey (MICS), demographic and health surveys (DHS), surveys published by NGOs, etc.;
→ Research by universities and institutes, etc.;
→ Routine health service data, health centre records, etc.;

→ Information given out by the media (local and national press for example), etc.

Some of this secondary data is only available **once in the field** (for example, routine health centre data). However, most data is collected and analysed **prior to the actual field phase** (document review and online research). The main advantage of this data is that it demands little in terms of time and money. The main disadvantage lies in the fact that the information has been gathered by other organisations for specific purposes which are often different from those of the fact-finding mission or from those of a new diagnosis. It is therefore rare to be able to find exactly the information sought; the research has to be supplemented by primary data collecting.

Primary data is collected directly by the teams in the field. It comprises:
→ Direct measurements (blood pressure, temperature, etc.);
→ Data from direct observation;
→ Data gathered during population-based surveys using tools such as questionnaires, focus groups, in-depth individual interviews, etc.

Collecting primary data should focus on providing missing information, verifying the validity of secondary data collected if necessary and understanding the current perspectives and priorities of the people themselves.

NOTE/
It is always very important to provide accurate details of sources of information.

Once all the data has been gathered, the information from the various sources should

be **compared (triangulated)** to obtain as complete and balanced a picture as possible, including an understanding of the different perspectives and interests.

The data collected should also be compared to other data:

→ Over time (deterioration or improvement in the situation in relation to a previous period or a significant fact/earthquake, cyclone, epidemic, etc.);

→ In space (with a neighbouring country and local versus national level);

→ In the literature (WHO norms, international standards, etc).

NOTE/

The approach is similar in an emergency: the data is gathered before the outset, and preferably well before this, as part of the work in preparation for an emergency response. It is essential to adopt this approach which must be routinely followed in high-risk zones where MdM has a long-term presence. If, as in extreme emergencies, some of the data quickly becomes obsolete due to sudden changes in the situation (as for example in Haiti), data must be gathered and updated on a daily basis on specialist websites (OCHA). However, some data retains all its relevance (sociocultural data for example) and it must be compiled in advance.

The diagnosis comprises **three stages:**

→ Situation analysis;

→ Identifying, prioritising and analysing collective health problems;

→ Identifying public health problems and possible interventions.

In practice, these three stages often take place simultaneously but it is important to clearly distinguish between them in terms of methodology and to master the various concepts. It is also necessary to cross-check these different stages throughout the diagnosis process so that the latter may be refined/validated/adjusted.

Once the quantitative and qualitative data has been compiled and analysed by using various methods on the one hand and the collective health problems of the population considered have been identified and prioritised on the other, the diagnosis phase reaches its conclusion. The decision is then taken as to which public health problem to tackle. An analysis of risks and opportunities for each potential intervention enables the most appropriate intervention strategy to be drawn up.

NOTE/

The set of data gathered, analysis tools and methods together used to identify and prioritise problems and possible interventions must be recorded and described in a fact-finding mission report. *(see annexes).*

1.1

SITUATION
ANALYSIS

?

IDENTIFY APPROPRIATE STAKEHOLDERS

And what's your analysis of the current geopolitical situation?

MDM
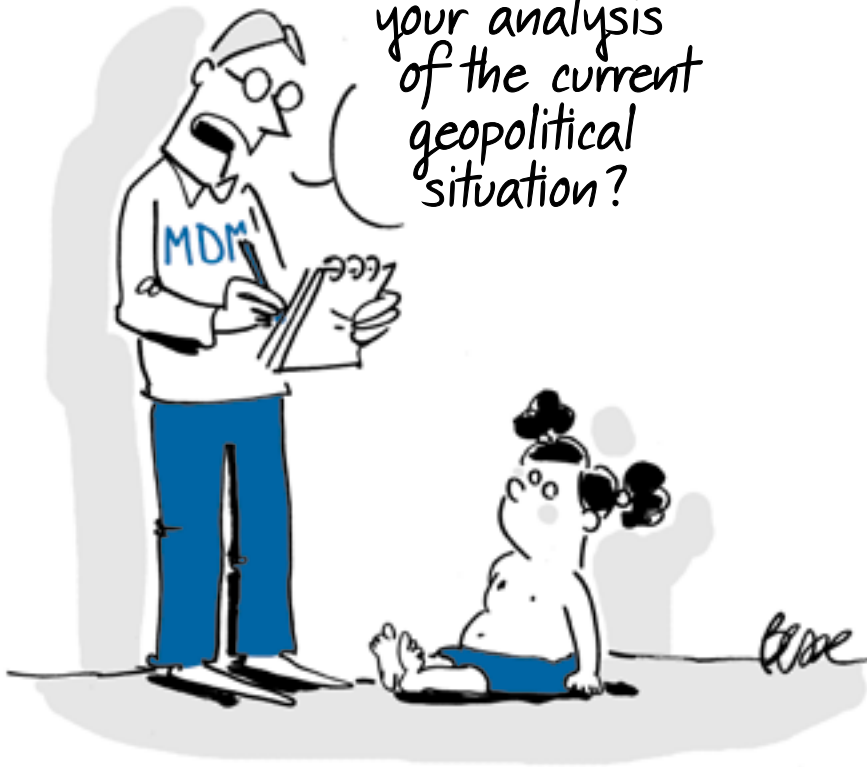
SITUATION ANALYSIS

> Situation analysis may be defined as **the analysis of factors and stakeholders** with a positive or negative influence on a given situation and on the health of populations in particular.

The **quality of a project** depends in large part on in-depth knowledge and **understanding of a context.** A project is not an isolated system, independent of the context in which it takes shape. On the contrary, it is part of an existing, dynamic environment, characterised by different factors and where different stakeholders, organised on the basis of rules and structures and conveying values and beliefs, coexist.

In order to achieve the desired changes, a project must try to compromise with existing synergies. It is therefore essential, when a project is being drawn up and implemented, to take account of what is already there, whether health sector initiatives, community sociocultural values or any other factor likely to positively or negatively influence the success of the project. A good understanding of the context in which the intervention is taking place is also fundamental for ensuring the safety and security of people and assets, for constructing an advocacy policy and for envisaging exit strategies.

FOCUS ON
SUSTAINABILITY OF CHANGES EFFECTED AND EXIT STRATEGIES[6]

A project's sustainability may be approached on the basis of three key concepts:
1. Maintaining the health benefits with or without the support of projects or organisations which have initiated and produced these benefits;
2. Pursuing the project activities within an institutional or organi-sational structure capable of generating the financial resources to cover its operating costs once funding from donors has ceased;

6. To find out more, refer to the "Manuel de planification des programmes de santé" [Handbook for Health Programme Planning], **MdM,** 2006 and the "Guide des bonnes pratiques pour conduire la pérennisation d'une innovation en santé" [Good Practice Guide for the Sustainability of Health Innovation], **groupe Pérennité,** 2005, which can be accessed at http://www.handicap-international.fr/fileadmin/documents/publications/PerenniteGuide.pdf.

3. Adoption and ownership by
the community of the components
of the project and its activities.

Examining the long-term future of a
project and envisaging exit strategies
for MdM represents a dynamic
process which lasts for the duration
of the intervention. It requires a good
understanding of the context and
sound knowledge of the existing
stakeholders.

This situation analysis stage must not be
viewed as a waste of time but, on the
contrary, as an **investment,** which allows
the factors for potential change to be
identified and sheds light on/explains certain
situations. It helps avoid mistakes being
made during subsequent phases.

1.1A

FACTORS INFLUENCING A SITUATION

> The factors influencing a situation, particularly
the health of populations, represent the first
element of the context to be analysed.
Initially, **a macro analysis** is undertaken then,
as the public health problems are identified
and an intervention strategy emerges, the factors
are re-examined to arrive at a more in-depth analysis
of those which are most relevant.

MdM classifies the factors into six distinct
groups[7] which can be set out in a context
table. Arranging the information gathered
into lists reinforces the systematic aspect
of the approach.

The six groups are:
→ Demographic and health factors;
→ Geographical and environmental factors;
→ Historical, political, regulatory
  and security factors;
→ Socioeconomic factors;
→ Sociocultural factors;

→ Factors relating to health policy
  and the organisation of the health system.

Several tables may be drawn up depending
on the level studied – general situation in
the country or local situation(s) in the area(s)
examined.

The lists of factor groups set out below
are not exhaustive and must be
supplemented and/or adapted depending
on the terrain and population being studied.

7. These groups of factors are all closely linked:
a context may be compared to a system
with interdependent and reciprocal constituent parts.

EXAMPLE OF SITUATION TABLE

Demographic and health factors

→ Population's state of health
  (macro data);
→ Population movement, migration;
→ Number of inhabitants, density;
→ Division by age and gender;
→ Birth rate, fertility;
→ Mortality;
→ Family structure;
→ Etc.

**Historical, political, regulatory
and security factors**

→ International, national and regional
  politics; social and family policies;
→ Choice and orientation
  of politicians' and elected
  representatives' priorities;
→ Legal texts, current regulations,
  degree of centralisation;
→ Human rights situation;
→ Significant historical events;
→ History of security situation
  in areas of intervention
  (e.g. ceasefire since xxx,
  sporadic violence between people
  in a particular group, etc.);
→ History of humanitarian
  interventions in the area(s)
  concerned;
→ Etc.

**Geographical
and environmental factors**

→ Topography;
→ Climate;
→ Natural wealth;
→ Rural/urban character;
→ Travel networks:
  road and other infrastructure;
→ Rainy season;
→ State of communications;
→ Earthquake or flood zone;
→ Etc.

Socioeconomic factors

→ Economic policy, international aid;
→ Economic life in the area studied;
→ Employment (types of jobs)
  and unemployment situation;
→ Income and cost of living;
  cost of transport;
→ Local activities and resources;
→ Population's means of obtaining
  information
→ Electricity and water;
→ Etc.

Sociocultural factors

→ Levels of schooling, education,
  literacy rate (men/women),
  approach to and type of knowledge
  transfer;
→ Organisation of social and family
  networks (male/female
  relationships), relationships to older
  generation, ethnic minorities/
  majorities, existence of civil society,
  etc.);
→ Types of accommodation,
  communal/individual living;

→ Working conditions and lifestyles;
→ Representations of health:
  normal and pathological, perception
  of seriousness and local terms
  for principal illnesses;
→ Presence/importance of traditional
  medicines in relation to modern
  medicine;
→ Religions and animism;
→ Local languages;
→ Etc.

**Factors relating to health policy
and the organisation
of the health system**

→ International, national, regional, etc.
  health policies;
→ National/traditional, public/private
  health systems; balance between
  curative/preventative care (including
  health promotion); procurement
  systems (drugs, equipment, etc.);
→ Services: accessibility, usage and
  coverage (cost of consultation,
  price of essential drugs, etc.);
→ Healthcare staff: number, type,
  effective availability, geographical
  spread, level of training, reputation,
  type of relationship with population
  (care for poor and ethnic
  minorities?); code of practice;
  professional confidentiality;
  corruption, level of pay
  for healthcare staff;
→ Drugs: Unofficial markets
  for sale of drugs;
→ Etc.

It is important for the collection of data to be directly linked to the nature of MdM's field of intervention. For example, a detailed exposé of the geopolitical situation which does not provide direct information on the state of the population's health should be avoided.

In contrast, those factors closely associated with the state of the population's health must be described both at national and local level as accurately as possible. An understanding of the health policy and the health system in a country or an area of intervention as well as consideration of sociocultural factors are **essential prerequisites** for defining and implementing any project.

FOCUS ON
ANALYSING THE HEALTH SYSTEM

The WHO defines a health system as consisting of "all the organisations, institutions, resources and people whose primary purpose is to improve health".

The function of a health system is not solely to offer services. According to the WHO, "a well-functioning health system responds in a balanced way to a population's needs and expectations by:
→ Improving the health status of individuals, families and communities;
→ Defending the population against what threatens its health;
→ Protecting people against the financial consequences of ill-health;
→ Providing equitable access to people-centred care;
→ Making it possible for people to participate in decisions affecting their health and health system."

Several elements now need to be considered when analysing a health system[8]:
→ **Range of services provided**
Nature, quality and organisation of medical and social care (health pyramid, referral mechanisms, package of curative, preventative and rehabilitation, protocols, etc.) and the environmental impact of the range of services offered (e.g. waste management). Both public and private health provision is of interest, as is any complementary range of services (e.g. traditional medicine).
→ **Human resources in health**
Availability (number, type, effective availability and distribution), qualifications (level of training and skills), pay, code of practice (professional confidentiality and corruption) of healthcare staff. It is also important to consider relationships between health staff and other players (community health workers, traditional birth attendants, peer educators, etc.) and service users (minority population, etc.).
→ **Drugs, medical consumables and medical equipment[9]**
Availability and quality as understood in the cycle of managing pharmaceutical products:

1 / selection; 2 / purchase and supply; 3 / transport, storage and distribution; 4 / proper use; 5 / waste destruction and elimination. Prices and unofficial markets are also of interest.
→ **Funding the health system**
Funding mechanisms (taxes, insurance/health cover, mutual fund, etc.) and management of health-related expenditure. The service users' share of funding (e.g. free at point of delivery) and thus the financial risk borne by families is of interest.
→ **Governance of health system**
Strategies, national and regional health plans, legislation and regulation (e.g. minimum standards and accreditation of health facilities, registering of service providers, etc.), setting up mechanisms for downwards accountability (e.g. service-user committees, mortality audits, etc.).

MdM intervenes to support and strengthen public health systems as guarantors of access to the right to health. In order to tailor interventions as effectively as possible, the health system must be analysed in detail. The range of care offered by MdM must integrate into the overall provision and must intervene within existing services to ensure continuity of care.

FOCUS ON
THE IMPORTANCE OF CONSIDERING SOCIOCULTURAL FACTORS[10]

There is inevitably a cultural interface involved at the point where a health project supported by MdM and the population concerned coincide. MdM has its own identity and culture distinct from those of other NGOs. MdM's culture and structures are therefore inevitably elements within the context. MdM has to acknowledge itself within its project (culture) and cannot avoid putting forward a project (structure) which de facto imposes explicit or implicit cultural and structural constraints (ways of thinking, ways of operating, goals pursued and underlying values, etc.). In France, as abroad, the environments in which health projects are established also possess specific cultures. The population in a country is not culturally homogenous and the various cultures meet in a communal space referred to as "intercultural". The question of interculturality is posed even more clearly when teams of expatriates work abroad. The sociocultural aspects are not always given adequate consideration despite the significance of the issues involved. Exporting projects based on the principles of western medicine can sometimes give rise to difficult situations. It is fundamentally important not to ignore existing local knowledge and practice in areas of intervention.

8. WHO, "Key components of a well-functioning health system", 2010.
9. Also included here are vaccines, diagnostic tools and other health and laboratory technologies. For more information on the cycle of managing pharmaceutical products, see the technical fact sheets on the "Management Cycle for Quality Pharmaceutical Products", **MdM,** 2015, available in English, French and Spanish on the MdM intranet.

10. For more information, see the handbook entitled "Working with Communities", **MdM,** 2012 and "Access to Healthcare, Sociocultural Determinants, **MdM,** 2012, available on MdM's website in English, French and Spanish.

In France, as abroad, a lack of sensitivity or know-how may result in projects being developed which do not take account of ways of thinking about health, childbearing, illness and treatment. Adapting our working approach to the sociocultural realities in the countries or areas of intervention and to the perceptions of the population concerned is essential to avoid certain mistakes which may lead to the failure of a project.
To understand the community with which one wants to work, it is crucial to listen to what the community has to say, to allow those potentially involved in the future of the project the chance to speak and to make it easier for them to express their needs by using tools from the social sciences and, more particularly, qualitative methods.

Consideration must also be given to elements which could threaten the progress of the project. A project which is not well-regarded by the population and which upsets personal interests (e.g. local doctors and pharmacists who might view the free care provided by MdM as unfair competition) or political interests (e.g. one party in a conflict may also see the presence of MdM as an advantage and exploit it) and disruptive seasonal weather are factors which may influence MdM's capacity to intervene. A full analysis of the intervention context provides information concerning a project's feasibility and sustainability.

FOCUS ON
RISK ANALYSIS

Anyone carrying out a health diagnosis seeks in essence to devise a project

which best responds to a population's needs. Motivated by this goal and with the help of this handbook, the fact-finding mission team is responsible for drawing up and implementing an action which responds to the needs identified and depends on Médecins du Monde's capacities and mission statement. However, the team needs to bear in mind that the action must be established for the long-term and, to achieve this, it must determine the elements (risks) which could limit, delay and even disrupt the project and, consequently, the delivery of care to the population.
In addition to the operational obligation to assess the risks, MdM has a moral (and legal) duty to minimise these to avoid physical or psychological harm to its staff and partners.
Above all, it is essential to understand what constitutes a risk. The benchmark guide (GPR8)[11] to managing security in humanitarian contexts provides a convoluted but full definition:
"Risk is a measure of vulnerability to threats in the environment.
In other words, risk is about the potential for harm: the likelihood of something harmful happening and the extent of that harm if it does. […] a threat is anything that can cause harm or loss, while vulnerability refers to the likelihood or probability of being confronted with a threat and the consequences or impact if and when that happens.
The combination of threat and vulnerability to that threat constitutes risk."

11. Humanitarian Practice Network, "Operational security management in violent environments", 2010, p.30.

In familiar environments, measures to reduce the risks faced by each individual are an integral part of daily behaviour. For example, to minimise the risk of being knocked down by a car, people look both ways before crossing the street. In a new environment, it is essential to learn how to identify threats and to find the measures needed to reduce vulnerability to these. A good knowledge and understanding of one's environment and culture as well as the dynamics of a conflict and the history of humanitarian interventions in the region may help identify the risks and their potential impact on the viability of a project. A clear understanding of the way MdM is viewed, the issues relating to the project and its stakeholders also helps evaluate the strengths and weaknesses of the intervention programme.

GENERIC EXAMPLE
ANALYSIS
OF CONTEXTUAL FACTORS

Médecins du Monde is planning to start a project in Libertalia, a fictitious country in sub-Saharan Africa.
After collecting and analysing primary and secondary data, the fact-finding team, comprising a general practitioner and a person specialising in coordination, logistics and security, has just returned from the field.
Its conclusions are presented on the basis of six groups of factors.

Historical, political, regulatory and security factors

After 15 years of civil war, today Libertalia receives significant support from the international community to restore and maintain peace and to launch the country's democratic process and economic recovery. However, the political, economic and security situation there remains unstable.
Since the presidential elections of 2011, which were marked by acts of violence, the political situation seems to be improving. The priorities for the government in power fall into several categories: fighting corruption, supporting the reconciliation process and stimulating the economy.
Current stability in the country is, however, ensured by the presence of a UN peacekeeping force of around 9,000, and the risk of conflict remains given the instability in the sub-region.
As a result of their presence in the country over many years, international NGOs are viewed positively by the population.

Socioeconomic factors

Although production capacity was severely reduced during the war, the economy seems now to be reviving due to the increase in foreign investment in particular.
The unemployment rate remains high among the population at 85% and working conditions are extremely precarious. Three quarters of the population live below the poverty line of 1.25 US dollars per day.

Sociocultural factors

Access to education is difficult (literacy rate is 59.1%) and the education system is fee-paying. French is one of the country's official languages but is spoken by only 30% of the population. There are more than twenty local dialects. Knowledge transfer is mainly an oral process. Community networks are tradition-ally strong but have been undermined by years of civil war with the appearance of divisions, involvement of certain leaders in rebel groups, etc., which makes it more difficult to involve these networks in projects, despite the need to strengthen the links with health facilities. Lastly, religion occupies an extremely important place.

Demographic and health factors

The country has 4.1 million inhabitants with a male to female ratio of 0.99. The crude birth rate is 39.1 per 1,000 inhabitants, the fertility rate 5.2 per woman[12] and the population growth rate 2.5%[13].
The principal health indicators remain at worrying levels: the maternal mortality rate is estimated to be 990/100,000 (compared to a sub-Saharan average of 720), the infant mortality rate 74/1,000 (compared to a sub-Saharan average of 76) and the mortality rate for children under five 103/1,000 (compared to a sub-Saharan average of 121).[14]

12. **WHO,** World Health Statistics 2012.
13. **Unicef,** "The State of the World's Children 2012: Children in an Urban World", outlook for 2010-2030.
14. **Unicef,** "The State of the World's Children 2012: Children in an Urban World", data for 2008 (maternal mortality rate) and 2010 (infant mortality rate and mortality rate for children under five).

Life expectancy is currently 54 years for men and 57 years for women, which is close to the regional average of 52 years and 56 years respectively. Malaria, acute respiratory infections, diarrhoea, tuberculosis, HIV/AIDS and sexually transmitted infections (STI), skin diseases, malnutrition and anaemia are the most common causes of ill-health.

Factors relating to health policy and the organisation of the health system

The years of conflict have destabilised all sectors of the national economy and public services. The health system has been particularly weakened; it depends largely on international aid to function and international NGOs have a major role to play in directly supporting health facilities: of 521 health facilities, only 389 of which are functional, 300 are supported. At a national level, work is underway on a strategic plan to eradicate poverty, but the health plan for 2010-2015 places the emphasis on maternal and infant health, human resources in the health sector, developing health infrastructure and decentralising public health policy. Following a decree in September 2012, a licence is now required to practise as a midwife, a role which includes prescribing life-saving drugs. Although all maternal deaths must be registered, to date there is no audit and systematic review of these.

There are four levels of health facility:
1. **Clinic:** Primary healthcare (PHC) facility covering rural areas within a 15 km radius;

2. **Health centre:** Same activities as the clinics + 24-hour emergency and maternity service;
3. **Regional referral hospital:** Secondary healthcare facility in every region;
4. **National referral hospital:** Tertiary healthcare provided at one such facility in the capital.

In these healthcare facilities, treatment is free and staff members are considered civil servants. However, they often have excessive workloads leading to relatively long waiting times and shortened consultation times. While healthcare workers appear to take patient confidentiality seriously, the means to ensure it do not always exist, such as designated consultation areas. On the other hand, they make themselves readily available to and have a significant presence in the community, particularly for providing emergency cover outside health facility opening hours. As a result, they are viewed extremely positively by the population. Numerous private health facilities have developed alongside the public health system, notably in the capital. These offer services of variable quality, but some health services are only available privately – ophthalmology, dental care and psychological services. Lastly, traditional practitioners often remain the first port of call for people in times of ill-health.
The supply of drugs to public health facilities is irregular, inadequate and problematic. In theory, it is supposed to be carried out by the Central Pharmacy but, given shortfalls in the system, it is more often NGOs who serve as intermediaries between

the Central Pharmacy and health facilities, ensuring payment for and transport of drugs. Numerous "grassroots pharmacies" also constitute an important source of drugs supply for the people. According to the most recent census carried out by the Ministry of Health, Libertalia currently has 4,970 health service staff, including 122 doctors, 270 medical assistants, 402 nurses and 297 midwives.
There are also community health workers trained by the Ministry of Health. Although the ratio of health staff to population appears appro-priate, the figures mask a lack of qualified staff and, in addition, the geographical distribution of staff is uneven. The salary for medical staff varies from 75 US dollars for a nursing assistant to 800 US dollars for a doctor and it is often met by international NGOs. In addition, there are sporadic reports of instances of corruption, such as demanding payment for treatment which should be free.

Geographical and environmental factors

The geographical accessibility of health facilities varies hugely depending on the region and is much reduced during the rainy season between May and September due to poor road conditions and high rainfall.

1.1B

STAKEHOLDERS

> Stakeholders represent the second contextual element to analyse after the factors influencing a situation.

1 / DEFINITION

Stakeholders represent any individual, group of individuals or organisation **likely to be associated with,** influence or be affected by a project, whether directly or indirectly, negatively or positively.

2 / MAPPING STAKEHOLDERS

Mapping stakeholders involves gathering data at national, regional and, particularly, local level in order to:
→ Draw up as comprehensive a list as possible of the stakeholders likely to be associated with, to influence or to be affected by the project, whether directly or indirectly, negatively or positively;
→ Describe their fields and areas of intervention, the geographical area in which they operate and, where possible, their strategy.

Even if the project has not yet been defined, **all stakeholders** – individuals, groups and organisations – who **might** have a direct or indirect effect on MdM's intervention should be identified, including those who could block or sabotage the carrying out of the project, such as political and military stakeholders and those with vested interests.

FOCUS ON
THE IMPORTANCE OF CONSIDERING COMMUNITY STAKEHOLDERS[15]

A number of Médecins du Monde projects now develop **a community approach** and work with different types of community representatives – peers, community health workers, traditional practitioners, religious leaders, etc. This is based on the notion that peoples' **participation** not only helps improve the quality of projects by enabling a more accurate analysis of the situation and the context but also gives people "the means to exercise greater control over their own health".

15. MdM, "Working with communities", 2012.

The effective involvement of community stakeholders also makes the changes brought about by the project more sustainable. Stakeholders in southern countries frequently highlight the fact that if local stakeholders do not have the time to take ownership of a project, then nothing of it remains once it is completed.
But the work of community stakeholders is also subject to its own limitations and problems (isolation, limited technical skills, lack of credibility with the community or professionals, community, political and religious rivalries and pressures, conflicts of interest and even threats to safety). These problems/constraints must be identified at the same time as the stakeholders.
To avoid projects "constructing" and "manufacturing" community workers who are not really rooted in the community at the start of the project, it is essential to identify pre-existing stakeholders at the initial diagnosis stage. Identifying existing community stakeholders can also reveal the mechanisms of local solidarity which the project could tap into. It does not matter whether it is an emergency or non-emergency situation, it would be counter-productive to go against local strategies and capacities for tackling a problem.

The task of mapping stakeholders is completed at subsequent stages of the diagnosis by a closer examination of the dynamics existing between the stakeholders and their respective influence.

Any existing or future MdM project fits into the networks of stakeholders with whom it must reach a modus operandi. Understanding these networks provides a way in to existing dynamic relationships. This makes the changes brought about by a project more sustainable, while avoiding the creation of artificial means of organisation. Short-termism is known to influence how people view projects: they are "just foreigners passing through". A project involving three or four years of activities, however, represents a long-term presence. But the end of a project does not mean that the conditions for sustainability on a local basis have been established: on the contrary, the completion of a project almost automatically leads to the activities coming to an end. Sustainability is therefore a dynamic process which must be borne in mind throughout the project. Mapping stakeholders with whom the project will take shape is thus a prerequisite.

Mapping is equally essential for establishing any advocacy strategy as an integral part of the project. It is a way to familiarise oneself in advance with the issues of power and influence associated with the subjects being tackled. When it comes to the project programming stage, those stakeholders who will have a specific role to play with regard to the chosen advocacy subject must be particularly pinpointed[16].

Cross-checking carries on between the different stages for as long as the diagnostic phase remains to be completed. Mapping, prioritising and analysing collective health problems – the second stage of the diagnosis – refines analysis of the stakeholders by taking account of each stakeholder's strategic influence over every health issue selected. Once the presence or absence of stakeholders is known and their strategies

16. For more information on drawing up an advocacy strategy, see the "Advocacy Guide. Access to Medical Certificates for Victims of Violence" and "Advocacy Toolkit", MdM, 2011, available on the MdM intranet in English, French and Spanish.

have been assessed, interventions can then be selected during the third stage of the diagnosis, depending on which activities are covered and which are not. If, during subsequent stages, it becomes apparent that the initial risks and assumptions were not the most relevant, a fresh analysis of stakeholders will then be required.

While, when analysing the stakeholders, it is useful to identify which of them might be potential partners, it is important not to simply stop the research there. While existing players represent stakeholders since they might be linked to a project, they may not, in contrast, constitute – at this point or indeed ever –, partners. It is therefore important to make the distinction between the two.

In MdM, mapping stakeholders provides an opportunity to establish the array of existing players in detail. Presenting the data collected in a table provides a basic systematic framework.

GENERIC EXAMPLE
EXAMPLE OF A TABLE LISTING THE DIFFERENT STAKEHOLDERS

	Public sector	Private sector	Civil society	International cooperation (UN, NGO, etc.), donors
Central level	Ministry of Health, Central Pharmacy,[1] Ministry of Finance, Ministry of Justice	Media	Action Pour la Santé (APS)[2] (local NGO)	Merlin, SC-UK[3] MSF-B, CICR, Marie Stopes, Unicef, UNFPA[5], WHO, Clinton Foundation, EU, USAID
Regional level (district)	Head of local civil service (Préfet), police, regional health authorities, public health facilities	Hospitals/ private clinics, private pharmacies	AMPF[4] (local NGO)	SC-UK[3], Africare, Marie Stopes, Clinton Foundation
Local (community) level	Deputy head of local civil service (Sous-préfet), health centre head of nursing, police	Traditional practitioners, private clinics, private pharmacies /"grassroots" pharmacies, community radio	Churches and religious leaders, mayors, traditional women's groups, Traditional Birth Attendants (TBAs), Community Health Workers (CHWs)	SC-UK[3], Africare

1. Not-for-profit public service body
2. Well-known medical NGO in Libertalia
3. Save the Children UK
4. Action Médicale Pour les Femmes, local NGO in the district of Saapland
5. United Nations Population Fund

On the basis of the above table, the fact-finding team comes to the following conclusions:

→ **Numerous international NGOs present:** Although rivalry exists between certain INGOs the majority collaborate to pool resources and to create a synergic relation between actions taken. Despite every effort, problems persist over coordinating and harmonising strategies.

→ **Health authorities involved with limited HR and financial resources:** Focus on maternal health, HIV/AIDS and malaria at national level; determined to decentralise more and more responsibility to regional health authorities.

→ **UN agencies have a major presence at national level but a minimal visible presence regionally:** UNFPA promotes sexual and reproductive health on a national scale by sharing lessons learned and experience gained with the organisation Marie Stopes International (MSI) on the issue of abortion and with SC-UK and Africare on effective provision of free childbirth care.

→ **An important private sector presence.** The private sector is well used but is of debatable quality and beyond the reach financially of a proportion of the population. Some medical services are only available from this sector – ophthalmology, dental care and psychological services.

→ **A significant culture of voluntary bodies and non-governmental organisations** is focused on social objectives but **civil society remains fragmented as a result of social and community divisions** which emerged during the civil war (some leaders were involved in rebel groups); these divisions are particularly evident among the networks of traditional birth attendants (TBA), community health workers (CHW) and traditional women's groups.

→ **Desire expressed by one local NGO (AMPF) to work with Médecins du Monde on issues of sexual and reproductive health:** Qualified staff but lack of resources and coordination; strong presence in community networks.

1:1C

THE PARTNERSHIP ISSUE

1/ PARTNERSHIPS, ALLIANCES AND OTHER TYPES OF RELATIONSHIP

In spite of the diverse range of approaches to partnerships and related practices among French NGOs, they have, under the umbrella of Coordination Sud (a member of Concord, the European NGO confederation), reached a broadly agreed definition of a partnership. Following discussions, a partnership was defined as "the relationship between two or more organisations established for the purpose of project implementation. The pillars of the partnership should be cooperation and equal power relations, and it should be based on exchange, confidence, commitment to the agreements made, transparency and reciprocity. It is a dynamic, long-term process evolving around the recognition of the competencies and responsibilities of each partner and a shared vision of development…"

In addition, the formal document produced to enshrine thirty years of MdM's work resulted in a **partnership** being defined as: "[…] a relationship established between partners, that is to say associates,

two individuals, groups or organisations who come together around a common idea or fact (organising action, carrying out a project, etc.). The relationship may take different forms – partners, allies, associates, collaborators – depending on the different stakeholders' shared objectives."**17**

For many organisations, a partnership is a means to involve civil society stakeholders in a humanitarian response and in delivering aid. This approach ensures the population can play a bigger role. However there are other dimensions to a partnership: it may be established with other stakeholders than those from civil society (for example, with the ministry of health, private sector stakeholders, etc.); in addition, the relationships MdM forms in the field of intervention are not necessarily all the result of partnerships.

MdM affirms the importance of establishing partnerships and does so for several reasons. Partnerships:
→ Promote empowerment and participation of local stakeholders;**18**

17. Forum 30 ans de partenariat, "Humanitaires et partenaires: nouvelles donnes?" [Forum on 30 Years of Partnership: "Aid workers and partners: New parameters?"], Revue Humanitaire, 26, MdM, 2010.
18. For more information, see the handbook entitled "Working with Communities", MdM, 2012 available on MdM's website in English, French and Spanish.

→ Add credibility to an initiative or project (influential relationships);
→ Encourage project sustainability;
→ Ensure the continuum of care, i.e. global, person-centred provision within the family, community, peripheral health facilities and referral hospitals; this often requires complementary and coordinated interventions by several providers;
→ Secure technical and material support (relationships with experts);
→ Share information (networking relationships);
→ Develop advocacy strategies, etc.

AN EXAMPLE FROM THE FIELD¹⁹ [19]

> **Project in response to the cholera outbreak in Haiti (2010-2011)**
>
> **The response to the epidemic was based on several partnerships without which the volume and quality of the activities would have been inadequate. The search for partnerships is time-consuming and leads to concessions but, at the same time, it makes a larger-scale response possible.**
>
> **RECOMMENDATION**
> ›› **Partnerships and a multidisciplinary approach are preferable when responding to cholera epidemics in order to provide an integrated response.**

Partnerships are created by bringing together complementary knowledge and skills, although sometimes the capacities

19. Recommendations extracted from capitalisation and evaluation reports. These reports are available on the MdM intranet.

of partner organisations need to be increased to make a partnership operate effectively and smoothly. Such relationships are referred to as **mentoring or supportive** and involve supporting partner organisations seeking to develop their institutions. The aim is to help them structure and organise their activities in order to fulfil their role as a stakeholder.

> **NOTE /**
> Sometimes there is no existing or recognised structure. In such instances, a "partnership" can be used to support the creation of new organisations or committees. However, care must be taken to avoid imposing committees which would be alien to the prevailing work or solidarity culture. Moreover, these new types of organisation should not be superimposed on or overload other forms of aid or solidarity, at the risk of weakening that which already exists.**20**

Alliances represent another form of collaboration but are less formal than partnerships. An agreement or joint initiative involving several individuals, groups and organisations for their shared interests is not necessarily set out in a formal document. Creating alliances involves mediating between different parties to define objectives, a basic code of ethics and joint areas of action.

An alliance may be a one-off arrangement aimed at a specific short-term goal (for example in the case of a joint advocacy action). Thus, an alliance may be formed between organisations which do not necessarily share the same fundamental values or the same methods of operating but which find themselves in agreement

20. MdM, "Working with communities", 2012.

on a specific issue (for example, signing a joint letter to the authorities). An alliance differs from a network in the sense that its modus operandi is not formalised and it may be a temporary arrangement.

Depending on the stakeholders present and the specific needs of the project, MdM may establish other types of relationships in areas where it intervenes:[21]

→ **Network relationships:** a network comprises a collection of natural or legal persons who maintain formal or informal links relating to shared issues or concerns.

→ **Delegating or subcontracting relationships:** These involve a contract in which an individual (the Principal), engages another (the Agent) to carry out a task on his/her behalf which involves wholly or partly delegating some decision-making power.

→ **Funding relationships:** With institutional donors, companies, etc.

These relationships do not come under the heading of a partnership as defined above but are just as important for implementing MdM's projects.

> **NOTE /**
> The question of partnerships is therefore a particularly important one for MdM, which requires systematic examination in every field of intervention.

2 / PARTNERSHIP QUALITY CRITERIA

Some guidance is important when considering which partners to choose: several criteria may weigh for or against a particular choice. These guideline criteria vary in importance depending on existing balances of power and the project's objective. While it is difficult to compile an exhaustive list of the partner selection criteria (the choice being dependent on the context of the proposed intervention), a list of "exclusion criteria" can, in contrast, be drawn up.

So, any organisation belonging to civil society and fulfilling one or more of the following criteria may be considered an inappropriate choice of partner for MdM:

→ Values which run counter to MdM's core values;
→ Breaches of human rights;
→ Religious proselytizing;
→ Political proselytizing;
→ Participation in armed conflict;
→ Partiality in dispensing care, etc.

Partnerships with local established organisations or informal groups are difficult, particularly as a result of their multiplicity and geographical spread. In addition, most villages have experienced at least several successive and sometimes simultaneous uncoordinated projects.
The local history of these past projects cannot be ignored. It has a profound impact on how populations perceive external stakeholders who have already intervened and may have a real impact on the acceptance of new projects.

> **The partnership between MdM, New Vector and Hepa+ in the Harm Reduction project in Georgia**
>
> "MdM has proven that they take this programme seriously. Whenever we ask MdM for support, they actually do it and they do it fast. We know other international organizations from the past but the relationship was always difficult. They didn't listen to us and were really slow."
>
> **» New Vector staff member**

From an organisational point of view, a partnership is based, on the one hand, on the joint definition of goals and the means required to attain these; on the other hand, it is based on a sharing of responsibilities and on a mutual learning process. Partnerships are difficult but essential: partners are often sociocultural interpreters who have the advantage of a sound knowledge of the terrain and of how communities are organised[23]. Being rooted in the local area, they assume the role of "legacy-bearers", ensuring that activities can be repeated and sustained. Considerable attention must always be paid to how a partner is perceived by the community or by a section of the community, particularly where major divisions exist.

Concord, the European platform of Coordination Sud, has identified a set of essential quality criteria for forming robust and balanced partnerships[24]:
1. Identical project goals;
2. Joint development of an implementation strategy;
3. The degree and type of involvement of each partner in the project;
4. Agreement on the distribution of the roles, activities and resource provision;
5. Complementary competencies and means;
6. Reciprocity;
7. Long-term relationship;
8. The quality of the human relationships;
9. Transparency.

There are now **4 dimensions** to a partnership:

→ **Joint conception:** A common goal with shared, jointly devised objectives;

→ **Joint responsibility:** Commitments are reciprocal and complementary (in terms of skills and resources);

→ **Joint management:** Information is shared and the role of each party in managing the activities and resources is clearly defined;

→ **Joint decision-making:** The decision-making process involves negotiation, consultation and cooperation, and is subject to consensus.

> **NOTE /**
> For MdM, the question of managing decision-making is a crucial aspect which must be negotiated when partnership agreements and contracts are being signed.

21. For more information, see Annexes IV and V of the "Manuel de planification des programmes de santé" [Handbook for Health Programme Planning], **MdM,** 2006.

22. Recommendations extracted from capitalisation and evaluation reports. These reports are available on the MdM intranet.

23. This is, of course, in cases where partnerships are established with local and not international organisations.

24. Coordination Sud, Partnership Guide, A Practical Guide to be Used by Partners from the North and the South, 2005 available at http://www.coordinationsud.org/wp-content/uploads/GuidePartenariatCSUDcompletGB.pdf

3 / STAGES IN BUILDING A PARTNERSHIP

A partnership can be forged at different stages of a project, although it is often preferable to establish it from the outset to improve understanding of the roles and objectives of each party.

AN EXAMPLE FROM THE FIELD[25]

Harm Reduction project in Vietnam (2005-2011)

To ensure the programme's sustainability, several Vietnamese partners were identified but not until ten months before the end of the programme. As expected, this was then too late to set up a partnership and ensure the transfer of the activities.

RECOMMENDATION
>> Establish a partnership from the outset of the project to develop the partner's skills over time and thus avoid the project activities coming to an abrupt end.

The Groupe URD sets out the following stages for building a partnership:
1. Identify the partner;
2. Establish the principles of the partnership;
3. Clarify the roles and responsibilities of each party;
4. Plan the resources;
5. Set up a mechanism for conflict resolution;
6. Draw up the partnership agreement.

Initial identification of potential partners is based on analysing the context (although this must not be limited to the search for partners). Knowledge is needed of pre-existing dynamics and initiatives for possible requests for partnerships and/or potential complementary areas of work to be identified.

AN EXAMPLE FROM THE FIELD[26]

Disaster Risk Reduction project in Madagascar (2008-2010)

The local authorities were placed at the heart of awareness-raising activities for the population. This increased their legitimacy in the eyes of the population and their responsibility for managing risks. Their roles and activities provided an incentive and encouraged others to emulate them, with the result that committees undertook other initiatives to coordinate their responses to disasters.

RECOMMENDATION
>> Before creating any Disaster Risk Management (DRM) body, find out whether any similar, even inactive, bodies exist to avoid setting up parallel entities which might not be recognised or adopted.

A "good" partner can be identified by analysing the stakeholders. Any belief that the various stakeholders are solely motivated by collective interest is misplaced and can be damaging to the development of joint action. Vested interests, even if not explicitly stated, often govern the commitment

of potential partners. Knowledge of existing players enables these interests to be explicitly stated and used as motivating factors in building a common resource.[27]

Clarifying roles and responsibilities

This stage should come at the start of the project and is essential for avoiding misunderstandings, conflicts or frustration. The following questions should be asked: What resources need to be mobilised by each partner? Who takes part in the decision-making? Who does what? The roles must be allocated in a realistic way and this implies a good knowledge and understanding of each party's skills and capacities. A steering committee is a useful tool, but there has to be agreement as to who represents each partner, each party's authority to take decisions and the frequency of meetings.

Partnerships involve MdM as an institution and not the individuals who devise them. The relationships established between partners must be formally documented in view of the commitments they represent and the nature of these partnerships. **The partnership agreement**[28] is the contractual expression of the accord reached. Although the contract may sometimes not be legally enforceable in the modern sense of the term (due to an inadequate legal framework, failures in the rule of law, a system based on common law, etc.), this does not lessen the need for one. The partnership agreement remains essential for clarifying, explaining and communicating. It is also a means of recognising and legitimising the relationship.

The relationship between stakeholders is dynamic, as is the relationship between partners. These relationships are built during the cycle of the project and require sufficient time, considerable patience and numerous explanations of the reasons for the intervention and of the NGO's methods, system of operating and social mission in order to establish an atmosphere of trust. Unlike a subcontracting relationship, which involves getting others to do something, a partnership presupposes a collaborative relationship which places the parties on an equal footing.

AN EXAMPLE FROM THE FIELD[29]

The partnership between MdM, New Vector and Hepa+ on the Harm Reduction project in Georgia

"Approximately one year after being implemented, this is still a young partnership. However, it appears from the results that there is broad agreement that the partnership has developed in increasingly positive terms with a marked increase in trust and satisfaction around August 2011. However, it also became clear that, for the first months of the partnership, the partner relationship was somewhat strained.
Interview results indicate that – during this time – MdM aimed to construct a legitimate and effective self-help NGO through various forms of financial and non-financial support, particularly geared at implementing services in the DIC. But the partner organization, New Vector,

25. Recommendations extracted from capitalisation and evaluation reports. These reports are available on the MdM intranet.

26. Recommendations extracted from capitalisation and evaluation reports. These reports are available on the MdM intranet.

27. "Manuel de planification des programmes de santé" [Handbook for Health Programme Planning], **MdM**, 2006.
28. Cf. Partnership agreement templates in the annex in the CD-Rom.

29. Recommendations extracted from capitalisation and evaluation reports. These reports are available on the MdM intranet.

"was facing a set of challenges related to its rapid growth as well as the need for further development of its internal structures and human resources. [...] MdM identified these challenges in a timely manner, however, and responded with clear staffing decisions and additional emphasis on capacity development and programme planning. This is exemplified by a series of training events, the engaging of one additional full-time HR expert from France (who also conducted a series of participatory planning workshops), and the introduction of regular management meetings, among others. At this stage, ample time was allocated to partnership development, planning and training. By doing so, MdM slowly managed to build trust and a learning environment, to integrate multiple perspectives, negotiate balances of power and resources, discover common ground and create a shared vision, key factors for developing every successful partnership which does indeed require sufficient time to grow."

The next two stages of the diagnosis are particularly significant points at which to begin defining and building a partnership.

SUMMARY

KEY POINTS IN ANALYSING THE CONTEXT

→ Analysing the context involves **collecting data on the factors influencing a given situation and the stakeholders who might positively or negatively influence** health-related action, and analysing the information;

→ Proper analysis of the stakeholders **identifies potential project partners;**

→ Detailed analysis of the context **identifies potential problems in carrying out the action and the possible risks to staff,** partners and service users;

→ Data is compiled and analysed using **complementary quantitative and qualitative methods;**

→ **Data must be analysed as it is compiled** in order to identify and fill any gaps;

→ It is important **to sort the information** and to retain only what is relevant;

→ The data retained and analysis of it must be written up in **a fact-finding mission report;**

→ Contexts evolve and so **the process must be a dynamic one with data being reviewed and updated** at subsequent planning stages and phases.
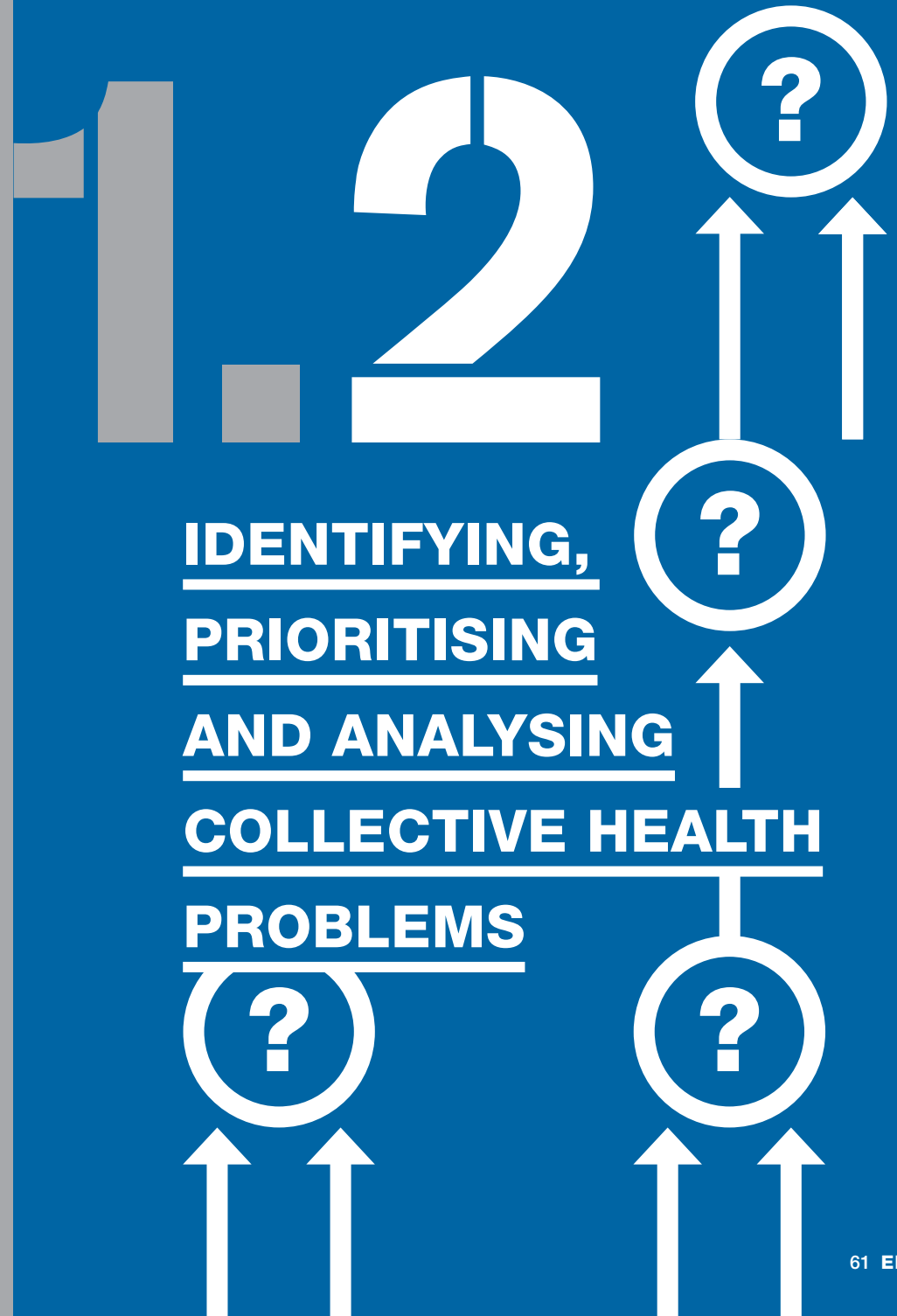
1.2

IDENTIFYING, PRIORITISING AND ANALYSING COLLECTIVE HEALTH PROBLEMS

IDENTIFYING, PRIORITISING AND ANALYSING COLLECTIVE HEALTH PROBLEMS

> MdM's planning model is based on a **problem-centred approach,** with a particular problem placed at the heart of the project's construction. In practice, as a result of MdM's priority subject areas, a **mixed approach** is most commonly preferred: a **population-centred approach** identifies vulnerable population groups in advance (for example, in the case of a harm reduction project for people who use drugs or who are sex workers); a **problem-centred approach** provides a more precise understanding of the issues which are a priority for these vulnerable groups.
This second stage identifies and confirms the most important collective health problems based on an analysis of the context. It leads to the third and final stage of the analysis: identifying the public health problem which will be targeted by the intervention. Even when the public health problem, which is the focus of the intervention, has been identified in advance, it is essential to examine the collective health problems to validate the choice made and to compare it with the realities in the field.

AN EXAMPLE FROM THE FIELD

The Harm Reduction project in Georgia

During the fact-finding mission to Georgia, the team set off with clear assumptions of what the intervention would involve: a needle exchange service to reduce the transmission of hepatitis C among intravenous drug users (IDU) and the population in general. During its investigations, the team confirmed the existence of a significant hepatitis C epidemic and the growing presence of HIV among the IDU population. But it also discovered another collective health problem with considerable consequences for public health and which had not been specifically tackled, namely neurodegenerative conditions linked to intravenous use of highly toxic psychotropic substances manufactured from legal pharmaceutical products. In the end, the team radically altered the intervention strategy and chose to direct the intervention towards reducing the harm associated with consumption of these products.

The choice of key resource persons for the fact-finding mission is extremely important: a personal specialism or interest naturally has a tendency to influence the way of looking at the information and the type of data gathered (for example, a gynaecologist will be more attuned to sexual and public health problems, an infectious diseases specialist to HIV, etc.). The use of a rigorous methodology and the involvement of a multidisciplinary team for the initial analysis can minimise this bias. The terms of reference must be precise and several stakeholders

– drawn from HQ and from the field – must be involved in formulating these. As regards the diagnosis, it must be carried out by a minimum of two people.

1.2A

DEFINITIONS

> A health problem, whether personal or collective, represents **a gap** between the physical, mental or social state of health which has been identified, observed and expressed and the desirable or expected state of health as defined by medical references written by experts, the legislative body, etc., or by social norms.

A collective health problem is characterised by **a combination of at least two** of the following three elements:
→ **Its magnitude:** High incidence, high prevalence or recurrence;
→ **Its severity:** Real or potential (may to lead to significant changes in quality of life, major disability or death);
→ **Its consequences:** Social and economic (potentially high cost for society, healthcare system and/or individuals concerned).

It should be noted that context has a significant positive or negative influence on a collective health problem. Likewise, the greater the financial and information resources at a society's disposal, the more readily self-help groups, such as patients' associations, form around what are sometimes extremely rare diseases, transforming them into a collective health problem.

EXAMPLES FROM THE FIELD
Different types of health problems

Individual health problems:
While their magnitude may be significant, their severity is low and they therefore have little social or economic impact (e.g. warts, haemorrhoids, etc.).

Health problems which are individual or collective depending on the context and seasonal occurrence:
These are:
→ **Serious health problems of varying magnitude** depending on the context and whose socioeconomic consequences depend on their magnitude (e.g. HIV in Syria with an extremely low prevalence rate is to date an *individual health problem* as against HIV in Botswana which is a *collective health*

problem; diabetes in Mali with an low prevalence rate is to date an *individual health problem* as against diabetes in Gaza, where the prevalence rate is parti-cularly high, which is a *collective health problem*).

→ **Health problems of a considerable magnitude and of varying degrees of severity** depending on the context and whose socioeconomic consequences depend on their severity, which itself is linked to access to a quality healthcare system (e.g. viral infantile diarrhoea in France which is an *individual health problem* as opposed to viral infantile diarrhoea in Liberia where it is a *collective health problem*).

→ **Health problems of limited severity whose magnitude is seasonal** and whose socioeconomic consequences become significant (e.g. influenza during a non-endemic period which is an *individual health problem* as opposed to influenza during an endemic period which is a *collective health problem*).

Collective health problems:
Problems whose severity, socioeconomic consequences and epidemic risk are such that they are collective health problems whatever their magnitude (e.g. Ebola outbreak).

1.2B

IDENTIFYING COLLECTIVE HEALTH PROBLEMS

> Overall, at any given moment and in any given context, a large number of individual and/or collective health problems exist. Not all collective health problems can be recorded but a large proportion can be identified using two complementary analyses: an **epidemiological diagnosis and perception analysis.**

1/ EPIDEMIO-LOGICAL DIAGNOSIS

On the one hand, epidemiology provides an inventory of health problems and their determinants based on quantitative data relating to magnitude and distribution within a population and, on the other hand, risk factors and consequences associated with them.

At the initial diagnosis stage, this information is gathered from secondary sources (NHIS/HIS, registry records kept by the community, study reports, etc.). It is only when the data required does not exist that,

in certain cases, specific surveys may be envisaged to collect primary quantitative data *(see the paragraph on primary and secondary data).*

Epidemiology provides essential information on the magnitude, severity and social and economic consequences of collective health problems. Epidemiological data has the advantage of significant legitimacy among health professionals and authorities.

Epidemiological data should, however, be used with a certain amount of caution:
→ **Collecting epidemiological data is complex and demands considerable resources.** Consequently, secondary sources are most often all-inclusive and rarely provide the desired detail for a satisfactory understanding of the situation on a local scale.

→ **Epidemiological data requires careful interpretation and in-depth consideration.** Epidemiological data is subject to many forms of bias associated both with how it is collected and how it is analysed. As a result of this bias, certain aspects tend to be over– or underestimated and comparing them with data collected and/or analysed using other methods is made more difficult.

2 / PERCEPTION ANALYSIS

Perception analysis provides an inventory of collective health problems "felt" (or perceived) and expressed by a population. Collected using qualitative (interview, observation and focus group) or quantitative (questionnaire) methods, this information provides an understanding of the importance, distribution and consequences of health problems through "the experience, knowledge of a situation and personal testimony of the general population and the professionals."[30] These diagnoses of collective health problems are drawn from the opinions of the general population and health professionals, which are forged by the knowledge, beliefs and values of a group at a given moment in its history.

Similarly, as for the epidemiological diagnosis, existing secondary data must be automatically sought before consideration is given to collecting primary data.

It is essential to carry out a perception analysis as:
→ Increasing the points of view provides

30. Translation of quote from **Baumann M, Cannet D, Châlons S,** "Santé communautaire et action humanitaire: le diagnostic de santé d'une population" [Community health and humanitarian action: Analysing the health of a population], Nancy, ENSP, 2001.

a rich source of material from which to gain the most comprehensive understanding possible of the problem. In this respect, social sciences experts provide a particularly pertinent appraisal of health problems.
→ Incorporating the opinions of people potentially involved in a project responds to concerns for an ethical approach.
→ Involving groups in improving their state of health is a motivational approach which begins to create the dynamics for increased participation. If choices are made in a consensual manner, both when identifying the collective health problems and when seeking solutions, the actions become increasingly relevant and effective and are more readily accepted[31].

Lastly, as with epidemiological data, collecting and using data relating to perceived health problems requires close examination of certain points:
→ **The time required and the methodological resources deployed must be appropriate for this approach to ensure that good quality data is collected.** Consulting individuals involves specific skills.
– The listener must remain as objective as possible to avoid projecting his/her own issues on to what is heard.
– A climate of trust must be established to encourage individuals to express themselves freely.
– Lastly, it is essential to avoid the few pitfalls likely to impede interpretation of the results.

→ **We need to widen the scope of the health problems we are familiar with to include how other interlocutors feel about and perceive them, so that areas of action, which are not part of MdM's remit, can be indicated.**

31. To find out more, see "Data collection: qualitative methods", **MdM,** 2nd edition, 2012.

Interventions relating to different sectors of society are therefore planned when conducting a global analysis of collective health problems. This inter-sector approach encourages us to enter into partnership with organisations engaged in actions which complement ours. But we should be careful not to raise false expectations.

FOCUS ON
CONDUCTING A KAP SURVEY DURING THE DIAGNOSTIC PHASE: AN EPIDEMIOLOGICAL DIAGNOSIS OR PERCEPTION ANALYSIS?

Everything depends on the information gathered during the survey. For certain diseases, the epidemiological data may not be available. In such cases, the survey may involve quantifying these diseases in terms of magnitude, severity and socioeconomic consequences. Strictly speaking, this does not come within the terms of a KAP survey but it provides the opportunity to "slip in" some questions and even epidemiological measurements. The information gathered is quantitative and the analysis epidemiological.

The survey may also seek to identify what individuals themselves feel to be health problems based on their knowledge, beliefs, attitudes, values, etc. The information gathered is qualitative and the analysis perceptual.

FOCUS ON
SEEKING THE VIEWS OF CIVIL SERVANTS AT THE MINISTRY OF HEALTH DURING THE ANALYSIS PHASE: AN EPIDEMIOLOGICAL OR PERCEPTION ANALYSIS?

Everything depends on the supporting data. If the civil servants at the ministry of health rely on a collection of accurate quantitative data accessible to MdM, then it is an epidemiological analysis. If no supporting quantitative data exists or it is not accessible to MdM, the view expressed is simply a personal opinion, even if the person in question is the minister of health. This is therefore a perception analysis.

3 / SYNTHESIS OF BOTH DIAGNOSTIC APPROACHES

It is important to note that the epidemiological diagnosis and perception analysis do not oppose but **complement** each other. Information gathered may or may not overlap.

There are therefore three potential situations:
→ **Ideal situation:** the collective health problems are situated at the interface and the opinions coincide. This is a common situation;
→ **Perception analysis** sets out what collective health problems are felt/ expressed but which are not included in the epidemiological diagnosis;
→ **Epidemiological diagnosis** takes account of collective health problems which are not expressed or felt.

Ideal situation

Epidemiology diagnosis

Perception analysis
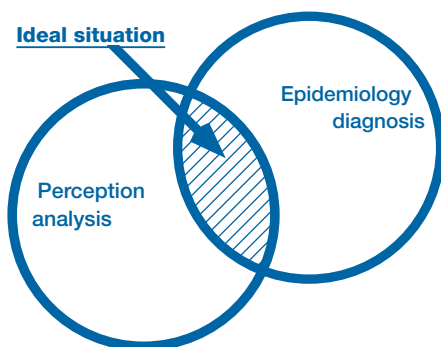
When **collective health problems which fall within the interface** are taken into account, it is easier to mobilise the population and the various stakeholders to solve them. This approach contributes to the effectiveness and efficiency of the intervention. However, working on health problems beyond the interface may be equally justified.

In community health for example, the choice is made to work primarily on **collective health problems which are felt/expressed** wherever possible. Moreover, collective health problems are often not included in statistics, as is the case, for example, with sexual violence or mental health problems in conflict situations. Only a perception analysis approach can bring these collective health problems to light.

In North Kivu, for example, there is no statistical data regarding women who have suffered sexual violence, although testimony from numerous victims reveals this violence to be a significant collective health problem in the region.

Conversely, it may be just as relevant to respond to collective health problems which are not voiced by individuals. This is the case for taboo subjects (e.g. in Mali women suffering from a vesico-

vaginal fistula are afraid to talk about this condition because of the stigma attached to it) or where awareness-raising campaigns have not enabled the population to identify a health problem as part of their everyday reality (e.g. AIDS when the illness first appeared in certain regions). It is nevertheless important to know whether these people feel particularly worried about these problems; indeed this information may have a direct impact on project programming and implementation.

When prioritising, it is therefore important not to exclude collective health problems which fall outside the interface. During this phase, it is equally crucial not to focus on a specific intervention topic, even when the diagnosis was prompted by the belief that a collective health problem existed. It is advisable to keep an open mind as to the possibility of uncovering health problems which are ultimately more significant than those initially assumed. To ensure this open-mindedness, **a list of between at least five and ten collective health problems** should be identified at this point.

Once identified by one form of diagnosis or another, the characteristics of the collective health problems selected must be described in response to the following questions: **Who** (number and type of people affected by this health problem), **When** (seasonality) and **Where.**

GENERIC EXAMPLE
SYNTHESIS OF BOTH DIAGNOSTIC APPROACHES

In Libertalia in Africa, the statistics from the Ministry of Health highlight several collective health problems:

→ The **maternal mortality rate** is estimated to be 990/100,000 compared to the sub-Saharan average of 720; 37.1% of births take place in a healthcare facility and 10.2% of women use a modern contraceptive method.

→ **Diarrhoea** is the second major cause of morbidity and mortality nationally in children under 5 years and occurs particularly in the rainy season.

→ Estimates of the **HIV** prevalence rate vary widely: the Poverty Reduction Strategy Paper suggests a figure of 5.2%, the Demographic and Health Survey figure is 1.5%, while local sentinel surveys carried out across the country give a prevalence rate of about 3%.

→ **Malaria** accounts for more than 40% of outpatient consultations and as many as 18% of deaths in children under 5 years.

→ **Malnutrition** causes 20% of deaths in infants and the rate of acute malnutrition is 6.2%. It is particularly high in urban zones.

→ **Pneumonia** is responsible for 14% of deaths in children under 5 years and 69.6% of children under 5 years with an acute respiratory tract infection are treated at a healthcare facility.

→ As in many other post-conflict countries, there is an extremely high incidence of **mental health problems**, including Post Traumatic Stress Disorder (PTSD).

Focus groups and individual interviews organised with community leaders, health committees, religious leaders and community health workers on the one hand and with traditional birth attendants and women's groups on the other have identified the collective health problems perceived by the population.

While there is an overlap between most of the collective health problems raised by both groups, **little reference was made by either to mental health problems.** The problems cited mostly relate to births, the high occurrence of maternal deaths and HIV/AIDS. The large number of children per household is also felt to be a problem issue. Reference is made to the numerous cases of malnutrition, diarrhoea and pneumonia among children under 5 years. Lastly, the focus group involving the women revealed the **existence of extensive gender-based violence** in the district.

FOCUS ON
THE HEALTH PROMOTION APPROACH: COMBINING EPIDEMIOLOGICAL DIAGNOSIS AND PERCEPTION ANALYSIS

The health promotion approach is at the heart of MdM's action. It is therefore fundamentally important to have a good grasp of this concept which should guide and influence decision-making throughout the planning process. Health promotion represents both a particular concept and certain strategies.

→ **The concept is based on a
philosophical and political approach**
According to the Ottawa Charter,
health promotion is the process
of enabling people to increase control
over their health and to improve it;
to change their environment or
to adapt with it in order to maintain
or improve their health. Good health
is thus perceived as one of daily life's
resources and not an end in itself.
Health promotion takes account
of all determinants affecting health
– social, political, economic change,
etc. – and is aimed at promoting
effective public participation.
Individuals are seen as autonomous
and service users are acknowledged
participants in programmes.

→ **Strategies**
Health promotion is a global,
multi-sector approach. At each
of the four phases of the project cycle,
it combines not only the curative
and preventative aspects of care
but also the health determinants
linked to organisations and policies.

In health promotion, the aim is
to act simultaneously on the 5 areas
of intervention listed in the Ottawa
Charter. For MdM, these five areas
represent the basis for considering
and defining project intervention
strategies. These areas comprise
such essential elements as access
to health care (health services,
supportive environments and personal
skills), the community dimension
(community approaches) and
advocacy (healthy public policy),
all of which are priorities for MdM
projects.

1.2CI

PRIORITISING COLLECTIVE HEALTH PROBLEMS

> Collective health problems are therefore identified using epidemiological and perception analysis. Between five and ten such problems are selected at which point they are put in order of priority and **two or three collective health problems are selected** for in-depth analysis.

Collective health problems **are prioritised** on the basis of a **predefined** methodology as well as by **negotiation** between the various stakeholders to find **a common language.**

Two distinct methodologies exist for prioritising the collective health problems identified:
→ **Criteria-based prioritisation** means categorising collective health problems according to pre-established data;
→ **Pair-wise ranking** means assessing problems by comparing them in pairs.

These two methods are complementary and neither should be overlooked.

1/ CRITERIA-BASED PRIORITISING

Criteria-based prioritising involves ranking the importance of 5 to 10 selected collective health problems for a given population (general/vulnerable population, etc.). The **criteria** used for characterising a collective health problem are:
→ **Magnitude:** Raw rates and data for prevalence and incidence, morbidity and recurrence;
→ Real or potential **severity:** Mortality, disability/dependency;
→ Psychosocial, social, economic, etc. **consequences**.

The level of importance can be defined on the basis of the quantitative and qualitative data collected during the diagnosis. Collective health problems are therefore ranked according to the degree of severity, magnitude and consequences experienced.

The prioritising exercise must result in a shortlist of a maximum of three collective health problems.

Using the list of health problems identified as a starting point, each collective health problem is assigned a value of one cross (not very important), two crosses (important) or three crosses (very important) for each of the criteria specified below (severity, magnitude and consequences).
Once the table is complete, each line is totalled and the three collective health problems with the highest number of points are selected.

**GENERIC EXAMPLE
CRITERIA-BASED PRIORITISING TABLE**

Collective health problem	Magnitude (Incidence, prevalence, etc.) National/local level	Severity (Death, incapacity, etc.) National/ local level	Consequences (Absence from school or work, drop in household income, social exclusion, etc.)	Total
A: Malaria	+++	++	+++	8
B: Diarrhoea	++	+	+	4
C: HIV/AIDS	+	+++	++	6
D: Pneumonia	++	++	++	6
E: Psychological problems	++	+	++	5
F: Maternal mortality	++	+++	+++	8
G: Malnutrition	+	++	++	5
H: Gender-based violence	++	++	++	6

Quantitative data collected during the epidemiological diagnosis enabled the fact-finding team to establish the degree of severity and magnitude and the consequences (indicated by one, two or three crosses) of collective health problems A to H.
The crosses against "Gender-based violence" were supplemented by qualitative data on the severity,

magnitude and consequences experienced by people, which was gathered during the women's focus group and interviews.
The collective health problems prioritised are therefore malaria (total = 8) and maternal mortality (total = 8). These are followed by HIV/AIDS (total = 6), pneumonia (total = 6) and gender-based violence (total = 6).

Using pre-defined criteria relating to severity, magnitude and social and economic consequences as a basis, the problems are then ranked in order of priority. The criteria are relatively complex notions which are sometimes difficult to explain to those questioned, who may have a different understanding of them. It is thus simpler, and just as effective, to ask the various groups of people questioned (communities, health professionals, etc.) to rank the collective health problems in order of importance as they see them, whatever the implicit criteria used.

2 / PAIR-WISE RANKING

Pair-wise ranking involves classifying the collective health problems identified in relation to each other by comparing them in pairs.

It is particularly important to ensure that the voices of minority groups are heard. To do so, this exercise should ideally be carried out in focus groups which bring together the different stakeholders either from among the population or the professionals. Where it is not possible to set up focus groups, those groups assembled should at least be homogenous to avoid any **minorities** being overwhelmed and, instead, **encourage their views to be expressed.**

The method consists of presenting participants with pairs of collective health problems and asking them to decide which of the two they consider is more important.

Beginning with the first box at the top left-hand corner of the table, the collective health problem of each line is compared with that of each column: for example, line 1 (HIV/AIDS) in relation to column B (malaria),

then column C (diarrhoea) etc. The same process is then followed for line 2 (malaria) and so on in the same way.

Based on their feelings and experiences and without having been given any particular criteria, the participants choose which of the two collective health problems seems to them to be more important. Working from left to right and from top to bottom of the table, all the pairs of collective health problems are compared in turn. Once this has been accomplished, the number of times each collective health problem is chosen is tallied and the three collective health problems with the highest number of points are then selected.

This exercise is carried out with different groups and, by the end of the process, there are as many tables as there are groups participating. What is then required is not to summarise the different tables but rather to examine the points where they converge and diverge in order to arrive at between 1 and 3 priority collective health problems.

**GENERIC EXAMPLE
PAIR-WISE RANKING TABLE**

Those collective health problems considered a priority by the focus group involving community leaders, health committees, religious leaders and community health workers *(see table next page)* **are malaria (total = 6), HIV/AIDS (total = 5) and maternal mortality (total = 4).**

The exercise was carried out again with the focus group involving traditional birth attendants and women's groups and gave different results. In the pair-wise ranking, gender-based violence was seen

	A: HIV/AIDS	B: Malaria	C: Diarrhoea	D: Pneumonia	E: Maternal mortality	F: Psychological problems	G: Gender-based violence
A: HIV/AIDS		B	A	A	A	A	A
B: Malaria			B	B	B	B	B
C: Diarrhoea				C	E	C	C
D: Pneumonia					E	D	D
E: Maternal mortality						E	E
F: Psychological problems							G
G: Gender-based violence							

Total A = 5; Total B = 6; Total C = 3; Total D = 2; Total E = 4; Total F = 0; Total G = 1

as more important than HIV/AIDS, malaria, diarrhoea, pneumonia and psychological problems.

Total A = 4; Total B = 5; Total C = 2; Total D = 1; Total E = 4; Total F = 0; Total G = 5

The collective health problems seen as a priority vary slightly and are **malaria** (total = 5) and **gender-based violence** (total = 5), followed by **HIV/AIDS** (total = 4) and **maternal mortality** (total=4).

FOCUS ON
PRIORITISING COLLECTIVE HEALTH PROBLEMS

The mere presence of an organisation during the diagnostic phase raises a population's expectations. Prioritising collective health problems is the first step towards taking action and is part of the formal conclusion of the diagnostic phase. Making it part of a participative exercise can improve understanding of the project and of the choices subsequently made by the population. This does not necessarily mean that consensus can be reached over what the top priority is, but rather that there is a clearer understanding of what the priorities are and for whom.

People's needs vary and the process of prioritising may be a long and even controversial one.

3 / CROSS-CHECKING BOTH METHODS

The collective health problems ranked as a priority during the prioritising process may be the same or may differ in accordance with the method applied.

When collective health problems have been designated a priority by both methods and by the different groups consulted, it is much easier to mobilise the population and the different stakeholders to resolve these problems. Some collective health problems not viewed as a priority by the various stakeholders may nonetheless prove fundamental and require an intervention. It is therefore particularly important to be able to justify and take responsibility for a decision to work on topics not considered a priority by the population.

In every case, keeping participants informed and communicating with them about the choices made mitigates any potential disappointment or frustration, if the problems voiced by people and particularly preoccupying them are not selected.

GENERIC EXAMPLE
CROSS-CHECKING BOTH METHODS

Cross-checking both prioritising methods – criteria-based and pair-wise –

has enabled the fact-finding team to highlight several priority collective health problems: malaria, HIV/AIDS, maternal mortality and gender-based violence.

The fact-finding team must now prioritise between one and three of these collective health problems. Malaria, HIV/AIDS and maternal mortality have been identified as priorities by these two methods. However, one group highlighted gender-based violence as a priority and this collective health problem is little documented by existing epidemiological data. It would therefore seem worth selecting it.

The maternal mortality rate in Libertalia is one of the highest in the sub-Saharan region and this collective health problem corresponds to one of MdM's priority areas. Moreover, MdM is already implementing several projects to combat malaria in countries bordering Libertalia, a disease which causes up to 18% of deaths in children under 5 years.

At the end of this initial stage of the diagnosis, three collective health problems have been chosen as a priority: maternal mortality, malaria and gender-based violence. In the follow-up to this example, maternal mortality is the collective health problem examined in detail but the approach is the same for the other collective health problems selected as a priority.

1.2D

IN-DEPTH ANALYSIS OF THE PRIORITISED COLLECTIVE HEALTH PROBLEMS

> Once the prioritisation process is complete, the next step is an in-depth analysis of the collective health problem(s) selected and of the associated **determinants.** This involves extending the initial macro analysis of the context to pinpoint the causes and consequences of each of the prioritised collective health problems.

1/ DEFINITIONS

Health **determinants** are **biological, behavioural and contextual factors** which have a positive (protective factors) or negative (risk factors) impact on the health of individuals or a population.

Lifestyles

Biological factors

Health problem

Context factors
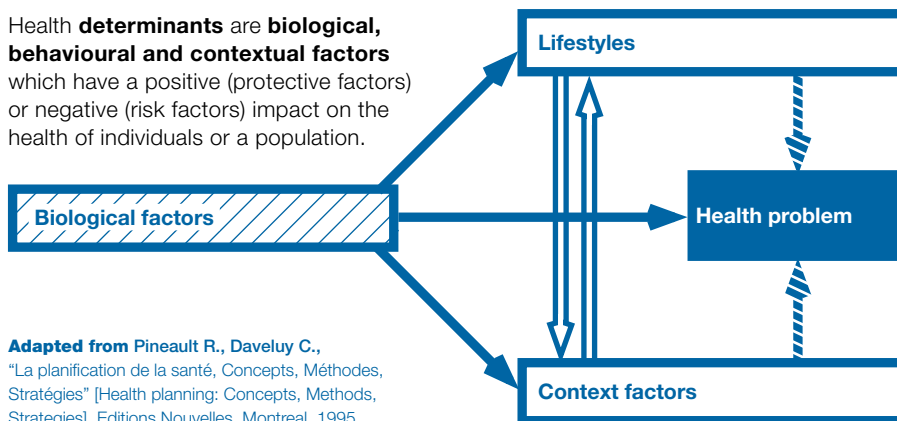
Adapted from Pineault R., Daveluy C., "La planification de la santé, Concepts, Méthodes, Stratégies" [Health planning: Concepts, Methods, Strategies], Editions Nouvelles, Montreal, 1995.

It is essential to differentiate between a **collective health problem** and a **determinant, that is to say the cause of the health problem.**

For example, if people are asked about the health problems they face, their response may be a lack of water. This is of course a problem, but the question is: What is its impact on health? It may be excess morbidity due to diarrhoeal illnesses for example. Lack of water is de facto one of the determinants contributing to water-related health problems such as diarrhoea.

Each determinant identified can:
→ Have a direct link to the health problem, such as abrupt weaning and malnutrition or risky sexual behaviours and STIs, or an indirect link, such as gender inequalities and resultant problems with access to healthcare and a consequent increase in maternal mortality;
→ Be an isolated factor (for example, tobacco as a determinant of lung cancer) or a combination of factors (for example, poor diet along with a lack of exercise can lead to cardiovascular diseases);
→ Expose people individually (active smoking) or collectively (passive smoking).

It is important to analyse all the determinants, even if there are some about which nothing can be done (e.g. sex or age).

2 / ANALYSING THE PROBLEM

Health is influenced by multiple factors which interact with each other. Causal links must be identified between the different determinants highlighted for every community health problem. As the analysis progresses, a **problem tree** (or several problem trees) is compiled. The determinants represent the "root" of the problem, the collective health problem the "trunk" and the consequences the "branches".

NOTE /
Compiling a problem tree or trees is a gradual process involving researching the direct and indirect determinants for each collective health problem in turn.

It may be of interest to bring together different stakeholders to compile a problem tree; when the diagnosis is being done in a situation where MdM already has a presence, the intervention team should be involved.

It is essential to ensure that all the major categories of determinants relating to the collective health problems selected are represented in the problem tree – **biological factors, lifestyle and context factors.** These must not be limited only to health determinants at the risk of incorrectly analysing the causes of the problem. Similarly, the existence or absence of medical treatments, techniques or approaches and the possibility or impossibility of putting them into practice represent contextual determinants which must be included in the problem tree.

The **fact-finding mission report** must set out a full analysis for each collective health problem which includes:

→ **A description of the problem:**
Who (number and type of individuals affected), **When** (seasonality) and **Where** (extent, activity, etc.). How the problem is perceived by the population and the sociocultural representations within a population (in France or abroad) contribute to an understanding of health problems and of the ways that groups or populations respond to them, including the notion of the care pathway.

→ **The causes of the problem:**
i.e. the determinants.

→ **The consequences of the problem:**
The health, social, psychosocial, economic, etc.

The causes and consequences represented in the problem tree must be clearly stated and must be the subject of a detailed report, normally referred to as a "narrative".

GENERIC EXAMPLE
COMPILING A PROBLEM TREE

To compile the problem tree, *(see next page),* the fact-finding team sought to **identify the causes and consequences of the high maternal mortality and morbidity rate.**

Principal causes of maternal deaths[32]:
→ Haemorrhage,
→ Septicaemia,
→ Eclampsia and problems relating to hypertension,
→ Obstructed labour,
→ Unsafe abortion.

Consequences: Excess maternal

morbidity, due to the high number of obstetric fistulas and chronic infections, results in an increased demand for treatment (higher expenditure on health and decreased productivity at work). Moreover, maternal mortality has a major impact on neonatal and infant mortality as a result of children not being cared for at home.
Haemorrhage, septicaemia, eclampsia and problems relating to hypertension as well as deaths from obstetric complications are all due to **contextual factors** (inadequate and delayed treatment for obstetric complications), **biological factors** (high prevalence of severe cases of sickle-cell anaemia) and **dietary habits** (regional diet which exacerbates anaemia and increases the risk of death from haemorrhage).

While it is difficult to influence biological factors, contextual factors offer some potential for intervention. To identify **bottlenecks in access to care[33]**, the following aspects may be examined: Does the problem affect -
→ Availability of health services?
→ Accessibility (financial, geographical or sociocultural) to these services?
→ Utilisation of health services?
→ Coverage of health services?

In the case of Libertalia, analysing the context has enabled the team to identify a health system which has been undermined by years of civil war. While treatment is free at

public health facilities, accessing it remains difficult in certain regions. There is a lack of qualified staff and frequent disruption to supplies of essential drugs. In addition, traditional practitioners are often turned to first by people who are ill.

Bottlenecks in the provision of treatment for obstetric complications therefore exist at several different levels:
→ **Poor coverage of consultations** for antenatal (ANC) and obstetric (Basic EOC and Comprehensive EOC) care;
→ **Poor utilisation of obstetric services** with high numbers of home births and using traditional birth attendants preferred;
→ **Difficult geographical access** to healthcare facilities;
→ **Lack of available Comprehensive EOC and incomplete Basic EOC services** resulting from out-of-date medical protocols, a lack of qualified staff and the absence of a referral system which in turn is due to there being no referral criteria or working ambulances.

Unsafe abortions are due to **contextual factors:** abortion being legal only in cases of rape or threat to the mother's life and requiring the agreement of two doctors, and the fact that there is no post-abortion care.
By analysing the context, the fact-finding team was able to identify several reasons for the numbers of unwanted pregnancies. Fertility is widely and positively promoted by religious leaders but the large size of households (or families),

inadequate birth spacing and the issue of early pregnancy have a damaging impact on the health of women and children. Moreover, the epidemiological diagnosis revealed that just 15% of women use a modern method of contraception and the perception analysis high-lighted a significant level of gender-based violence, gender inequality, a high incidence of early marriages and unmet family planning needs.

Poor coverage by family planning services can be analysed using the same elements as for treatment for obstetric complications:
→ **Utilisation:** Poor utilisation of FP methods as a result of the positive messages conveyed by religious leaders regarding fertility and the difficulty women have with discussing this question with their partner;
→ **Accessibility:** FP methods are supposed to be free but requests for payment have been sporadically reported. In addition, there is ignorance of FP methods;
→ **Availability:** Healthcare facilities run out of supplies of contraceptives and emergency contraception is not included on the list of essential drugs.

Compiling the problem tree has enabled the fact-finding team to identify causal links between the biological, behavioural and contextual determinants of a high maternal mortality rate, as well as the consequences. It is now a question of positioning: on which public health issue can Médecins du Monde take action and want to do so?

32. MdM, SRH care continuum training, 2012, available on Médecins du Monde intranet.

33. This model refers to the model for analysing access to the chain of healthcare developed by T. Tanahashi; see Tanahashi T., "Health service coverage and its evaluation", *Bulletin of the World Health Organization,* 1978, Vol. 56(2), p.295-303.

KEY

- Determinants
- Collective Health Problems
- Consequences

Excess neonatal and infant mortality

Catastrophic expenditure on health and productivity

Poverty Underdevelopment

High maternal mortality and morbidity

Increased need to seek treatment

High prevalence of severe anaemia linked to sickle cell

Haemorrhagic shock

Inadequate and late treatment of obstetric complications

Comprehensive EOC unavailable/ Basic EOC incomplete

Lack of qualified HR

Medical protocol out of date

Failures in referral system

Ambulance not operational

Absence of referral criteria

Poor rate of ANC1

Roads impassible in rainy season

Poverty Underdevelopment

High number home births (80%)

Traditional birth attendants consulted

High prevalence GBV

Gender inequality

Religious leaders promoting fertility

Poor geographical access to health facilities

High cost of public transport and not very reliable

High number unsafe abortions

Unwanted pregnancies

Pregnancies in close succession

Poor availability FP methods (no long term)

Ignorance of FP - Traditional FP practices not very effective - Taboo concerning injectables

Households' low purchasing power

Abortion legal only in rape cases or threat to mother's life + requires 2 doctors' consent

Teenage pregnancy

Poor access to FP methods

Emergency contraception not available

SUMMARY

THE KEY POINTS FOR IDENTIFYING, PRIORITISING AND ANALYSING COLLECTIVE HEALTH PROBLEMS

→ This stage is indispensable, even when the intended public health problem has been identified in advance, so that the choice made can be validated and compared with the reality in the field.

→ Collective health problems are identified using two complementary diagnoses – the epidemiological diagnosis and the perception analysis.

→ The collective health problems are **prioritised** on the basis of **predefined criteria** and are also **negotiated** between the various stakeholders.

→ Once the priorities have been established, a maximum of **three collective health problems** must be selected; their determinants are then analysed in-depth in the form of a problem tree.

→ The **fact-finding mission report** must include a comprehensive analysis of the priority collective health problems: a description of them and of their causes (determinants) and consequences. The causes and consequences must be represented in a problem tree and clearly explained in a detailed report (narrative).

1.3

IDENTIFYING PUBLIC HEALTH PROBLEMS AND POSSIBLE INTERVENTIONS

1.3AI
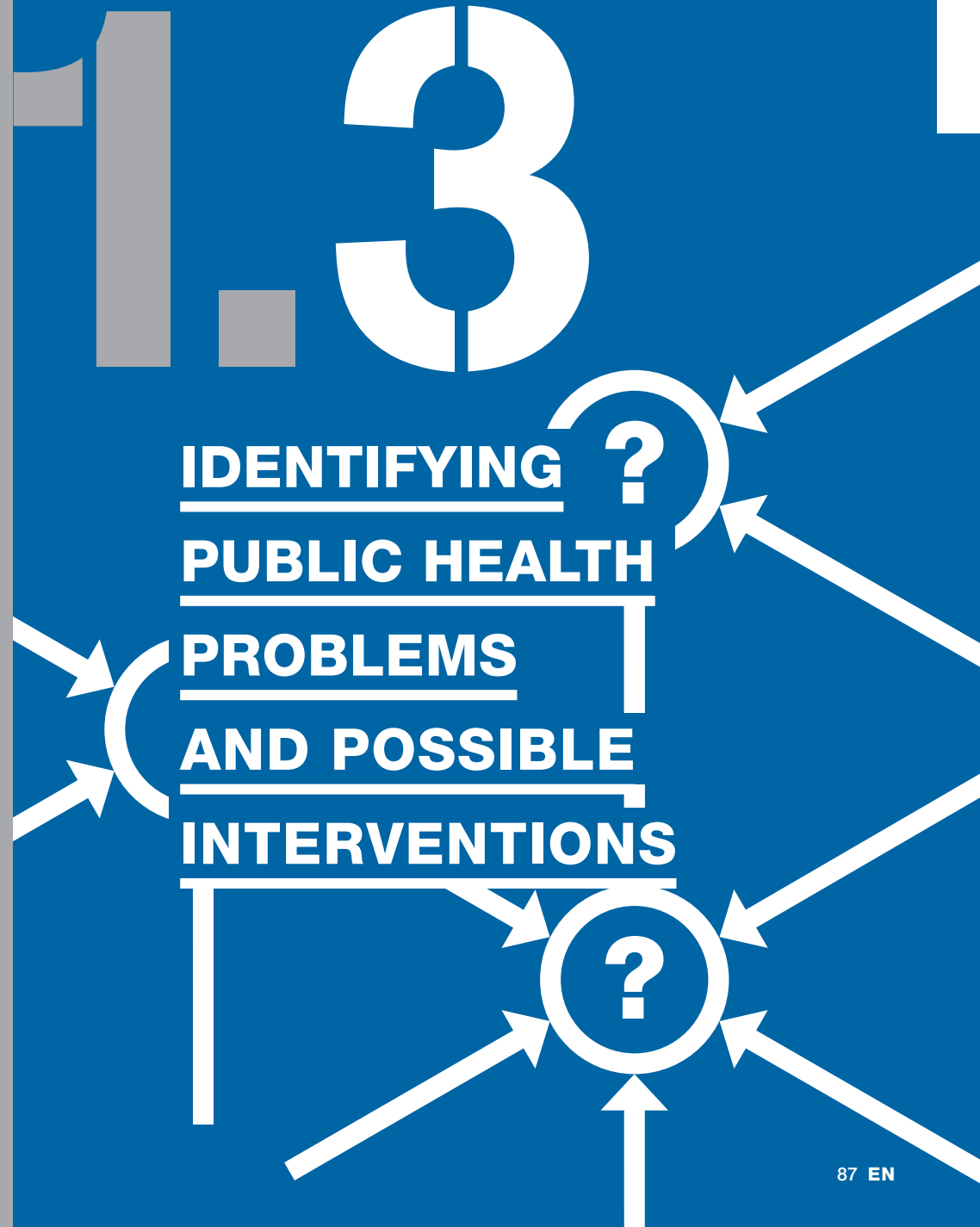
DEFINITION

> According to the definition adopted by MdM,
a **public health problem** is **either** a collective
health problem (meeting the criteria of magnitude,
severity and socioeconomic consequences)
or a determinant of this collective health problem.

1.3B

SELECTING PUBLIC HEALTH PROBLEMS

> Following prioritising, a maximum of three collective health problems have now been identified and an in-depth analysis has revealed their determinants and consequences. Each collective health problem therefore has a problem tree relating to it. On the basis of the tree, the public health problem or problems on which MdM wishes to focus can be identified.

The choice of one or more public health problem is a key moment in the diagnostic process and the point where the analysis carried out so far and the role MdM wishes to play in a country or area of intervention intersect. Several criteria play a part in the selection process which requires the involvement of numerous stakeholders (diagnostic team, partners, tripartite project management team (volunteer board delegate (RM)/desk/coordinator), medical advisers, HQ support services, etc.).

Most choices are implicit and the criteria employed vary considerably depending on the project as well as the people involved in it. Every effort must be made to **explain the choices made as clearly as possible.**

The criteria for selecting the public health problem(s) to focus on include:

→ Operational criteria,
→ Potential added value,
→ Opportunities,
→ Constraints,
→ Preconditions.

1 / OPERATIONAL CRITERIA

These are, for example:
→ Availability of trained human resources or the possibility of training them;
→ Funding possibilities;
→ Availability of material resources;
→ Logistics;
→ Legal framework;
→ Security and environmental risks;
→ Staff working conditions; etc.

2 / CRITERIA FOR TESTING POTENTIAL ADDED VALUE

The following may be indentified:
→ The possibility of a constructive partnership, the presence or absence of stakeholders and / or partners (synergy of interventions);
→ Potential sustainability;
→ Possibility of social change through intervention;
→ Possibility of documenting innovative practices;
→ Values and know-how of MdM;
→ Consistency with national / local health policy priorities;
→ Consistency with MdM priorities and strategies;
→ Social and cultural acceptability by the population concerned.

3 / OPPORTUN-ITIES, CONSTRAINTS AND PRE-CONDITIONS

The choice of public health problem is also made based on a project's chances of success in a given intervention context, which means the opportunities, constraints and preconditions involved[34]:

34. For more information, see "Manuel de planification des programmes de santé" [Handbook for Health Programme Planning], **MdM,** 2006.

→ **Opportunities:**
These are favourable factors for setting up and pursuing a project, which can be used as "levers" for action (e.g. willingness of the Haitian Minister of Health to integrate treatment for malnutrition into primary healthcare; willingness of the Minister of Health, with the support of the WHO, to put in place a programme of free obstetric healthcare; mobilising civil society on the issue dealt with by the project; etc.).

→ **Constraints:**
These comprise the unfavourable contextual elements which cannot be changed within time period t; these elements impose a "make-do" approach or oblige circumventing or adapting tactics to be adopted (e.g. absence of medical/paramedical staff in rural health centres; cholera epidemic which threatens to become chronic and to mobilise the already scant human resources, unstable political situation, armed conflict, chronic violence, community tensions, frequent population displacement, etc.).

→ **Preconditions:**
These conditions are crucial and without them a project cannot be implemented (e.g. in Haiti, the signing of a memorandum of understanding with the department of health in the area concerned and approval of the project by the Interim Haiti Reconstruction Commission, maintenance of the security situation, absence of any new major natural disaster which would undermine the healthcare system, etc.).

Identifying these elements can serve as a basis for drawing up a SWOT template (Strengths, Weaknesses, Opportunities, Threats) if necessary.

All criteria cannot always be applied simultaneously. For example, a goal of social change or advocacy may clash

with national policy priorities and/or social and cultural acceptability. Similarly, a project may involve a high level of risk which is nonetheless seen as acceptable in the light of the needs of the population and MdM's capacity to intervene. However, the selection criteria must be clearly stated, as they have consequences in terms of programming and implementing the project.

The intervention starting point needs to be placed at one of the various levels of the determinants. As has been seen above, some determinants are directly linked to the issue of health, while others are indirectly linked, and this is expressed in **a chain of determinants.** The more in-depth the examination of the root of the health problem, the less direct are the links with that problem, but at the same time the more the "root" in question may impact simultaneously on several of the problem's determinants and even on numerous collective health problems.

Direct intervention in the collective health problems may also be decided on and this decision depends in large part on the type of collective health problem identified. It is possible, for example, to take direct action on the number of cleft lips / palates or Noma tumours through reparative surgery. In contrast, attempting to reduce a mortality rate necessarily involves taking account of one or more determinants of this mortality: for example, in the case of maternal mortality, action must be taken on the coverage of obstetric care, treatment and prevention of sexual violence, coverage of family planning services, etc. In such cases, choices must be made.

CHOICE OF PUBLIC HEALTH PROBLEM

Collective health problem

Determinants

Public health problem

Deep-rooted causes
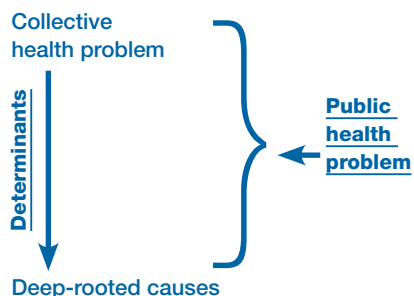
GENERIC EXAMPLE
SELECTING THE PUBLIC HEALTH PROBLEM

Following exchanges between the fact-finding team, desk officer, volunteer board delegate (RM), medical adviser and, where necessary, the subject-area advisers, the issue of unwanted pregnancies is chosen as the public health problem.

Several criteria were favoured

→ **Human and financial resources:** The project has to be carried out using limited resources and within a limited time period. As a result, it is difficult to intervene on the issue of treating obstetric complications requiring significant human (in terms of numbers and skills) and financial resources.
→ **Legal framework:** The restrictive legal framework makes a short or medium-term intervention on the issue of abortion difficult. Moreover, this issue is already being dealt with by the Marie Stopes International

organisation. It has set up a clinic where abortions are carried out under sufficiently safe conditions.
→ **Funding opportunities:** The issue of unwanted pregnancies seems to offer worthwhile funding opportunities.

Criteria for testing potential added value

→ **Consistency with MdM priorities and strategies:** The subject of sexual and reproductive health is one of MdM's priority areas.
→ **Presence of other stakeholders:** Treating obstetric complications is already covered by many stakeholders: SC-UK, MSF-B and Action Pour la Santé (a local NGO) at national level and SC-UK and Africare at regional and local level. MdM has already set up several projects on the issue of unwanted pregnancies. The subject of gender-based violence is also already being dealt with.
→ **Possibility of a constructive partnership:** There is the possibility of working with the local NGO AMPF on the subject of unwanted pregnancies. This organisation has expressed a wish to work with Médecins du Monde, has genuine ties to community networks and is fully committed to the sexual and reproductive health values defended by MdM.
→ **Social and cultural acceptability:** Focus groups and interviews carried out during the perception analysis have raised the problem of the high number of children in households.

This iterative examination process makes it possible to choose **one or more public health problems** on which to focus and can be used as a basis for:
→ Studying possible interventions,
→ Selecting the advocacy subject on which to concentrate where required.

1.3C
ANALYSING POSSIBLE INTERVENTIONS

1/ IDENTIFYING POSSIBLE INTERVENTIONS

Possible interventions need to be identified for each of the public health problems selected. The intervention options are sometimes limited to immediately responding to health needs associated with the public health problem. This, for example, is the case in certain emergency situations or for the initial phases of a project set up where the legal framework is highly restrictive.

EXAMPLES OF POSSIBLE INTERVENTIONS

→ Treating abortion-related complications without intervening directly in the causes of these complications.

→ Treating a cholera epidemic without working on the sanitary conditions in which the population lives.

In other situations, it may be preferable to take action much further upstream from the public health problem.
This is the case, for example, where it is a question of strengthening existing local activities or where a determinant at the start of the chain seems to be an important factor for change relating to the public health problem(s).

EXAMPLES OF POSSIBLE INTERVENTIONS

→ Improving FP services and access to them to prevent unwanted pregnancies where post-abortion care is available.

→ Improving the sanitary conditions for the population where medical treatment for the cholera epidemic is provided by the health services.

Each determinant of the problem tree thus becomes a factor in which one can choose to intervene in response to the public health problem selected. There are multiple ways to take action on a determinant

and some interventions enable several different determinants to be responded to simultaneously.

It is at this point, too, that the analysis of possible interventions must be discussed with interlocutors in the field.
For example, it is essential to identify the response methods envisaged by the population concerned and by potential partners.

NOTE /
For professionals, working with communities involves respecting the dignity of individuals, recognising their right to a viewpoint and their skills. This means viewing them not as "victims" or "beneficiaries" but rather as genuine "stakeholders". This change of perspective is essential to improve the degree to which projects are accepted.

EXAMPLES FROM THE FIELD

The partnership between MdM, New Vector and Hepa+ on the Harm Reduction project in Georgia[35]

In order to be successful, members of a partnership need a joint understanding of the issues, problems or opportunities, and most importantly a shared vision of what they hope to achieve together. Identifying the intersection of interests of the partners, and later, keeping a focus on the vision are key to building the partnership.

Community acceptance of the Haiti cholera project (2010-2011)[36]

It would seem obvious that there is greater acceptance when people have been consulted on and involved in a project. Sometimes choosing interventions which are less effective but more accepted by the people has a greater impact in terms of outcomes. The national approach to awareness-raising, for example, largely assigned responsibility for contamination to the people and the messages given out did not correspond to the population's general perceptions, with the result that prevention messages were fairly ineffectual as they were perceived as unreliable.

Next, a list of possible interventions for each determinant of the public health problem(s) is compiled and a selection made.

GENERIC EXAMPLE
IDENTIFYING POSSIBLE INTERVENTIONS

The fact-finding team has chosen to focus on the public health problem of unwanted pregnancies. Each determinant of this public health problem thus becomes a factor on which it is possible to take action to achieve the desired change.

35. Recommendations extracted from capitalisation and evaluation reports. These reports are available on the MdM intranet.

36. Recommendations extracted from capitalisation and evaluation reports. These reports are available on the MdM intranet.

Working with the local partner AMPF and using data collected during the focus group/interviews and MdM's SRH Guideline, the fact-finding team identified interventions that would allow action to be taken on each of the problem tree's determinants.

Poor access to FP methods

→ Carry out a sociocultural analysis to identify the sociocultural barriers to accessing family planning services and to using contraception;
→ Reinforce the status of women within the community to give them the power to take crucial decisions regarding their own health;
→ Train community stakeholders to facilitate the link between healthcare workers and communities in family planning services, etc.

Poor geographical access to health facilities

→ Build a road;
→ Create additional health facilities;
→ Train healthcare workers at community level to distribute contraceptives (after an initial medical prescription), etc.

Poor availability of FP methods

→ Ensure availability of a broad range of modern contraceptive methods for women, men and couples in FP services;
→ Strengthen FP services to make them culturally appropriate to women, their families and their communities;

→ Train and support staff in healthcare facilities to consolidate management of contraceptive supplies;
→ Promote double protection and offer male and female condoms;
→ Increase skills of health professionals responsible for FP services through training;
→ Set up appropriate, regular training supervisions of health workers in FP services;
→ Strengthen FP services to ensure they are suitable for teenagers and respond to their needs, etc.

Emergency contraception not available

→ Advocate in favour of including emergency contraception in the list of essential drugs, etc.

Ignorance of FP – traditional and ineffectual FP practices – taboo concerning injectable products

→ Increase knowledge and awareness of family planning, the different contraceptive methods, double protection and preventing STIs in both women and girls and men and boys;
→ Ensure that women know their sexual and reproductive health rights, notably access to family planning and the right to decide on the number of children to have, etc.

Religious leaders promoting fertility

→ Raise religious leaders' awareness of the importance of family planning;
→ Work with religious leaders to construct religious arguments in favour of spacing births;

→ Encourage broadcasting of positive radio messages from religious leaders about spacing births, etc.

High prevalence of GBV

→ Support formulating or strengthening of national policies concerning gender-based violence;
→ Improve reception, prevention, screening and treatment for those who are victims of gender-based violence;
→ Increase knowledge of human rights and gender-based violence among women/girls and men/boys;
→ Promote community involvement in the issue of gender-based violence;
→ Encourage social change and improvement in the status of women and girls within the community, etc.

Having identified possible interventions, the fact-finding team then constructs a decision tree.

2/DRAWING UP A DECISION TREE

Once possible interventions have been identified for each of the public health problems identified, it is necessary to establish:
→ **What already exists;**
→ **What** type of action **would be desirable;**
→ **Gaps** at the time of the analysis.

In fact, interventions are most often already in place: organisations and institutions are present and working in an area or neighbourhood. It is a question of MdM adopting a **complementary** position and of avoiding duplicating effort. MdM does not know how to do everything, is not able to do everything and nor does it wish to.
Analysing the context makes it possible to describe the stakeholders (individuals, groups or organisations) who may be associated with the MdM project. Formulating possible interventions means the stakeholders can be analysed in greater detail by taking into account what is already in place.

The decision tree is thus constructed on the basis of the following model:

STANDARD TEMPLATE FOR THE DECISION TREE
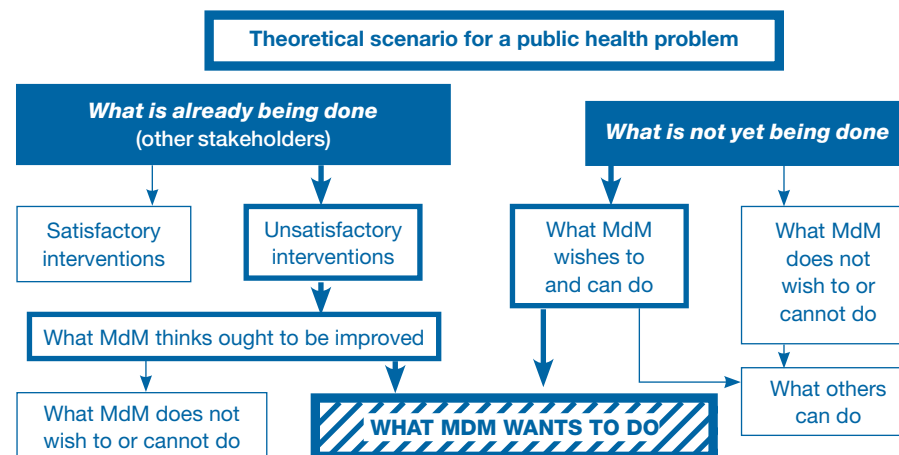
The information contained in the decision tree must be based on data collected, particularly regarding existing activities. Where possible, indicators of the outcomes of these activities must be obtained and, in every instance, whether an activity is seen as satisfactory or otherwise by beneficiaries and partners, along with MdM's view, must be documented and the arguments as to why provided.

A decision tree is thus constructed for each public health problem selected.

**GENERIC EXAMPLE
DRAWING UP A DECISION TREE**

In order to complement existing activities, the fact-finding team must find out which key inter–ventions have already been set up by other stakeholders (whether or not they are satisfactory) and which interventions it would, in MdM's view, be desirable to put in place. This analysis enables a decision tree to be constructed and potential gaps in information on existing interventions to be identified.

From this decision tree, it is apparent that the issue of GBV is already satis-factorily covered by other stakeholders. A recent study has shown an improvement in services offered to victims (reception, prevention, screening and treatment). Those working in this area are considering remaining over the long term and plan, during the next phases of their projects, to incorporate work on issues of gender and the place of women in Libertalia.

On the other hand, the partnership with AMPF, which is firmly rooted in the community, would enable action

to be taken on effective provision of free FP methods (community controlled system) and to undertake health education activities.

Interventions dealing with the availability of and access to modern FP methods in health centres are not considered satisfactory. It would seem important therefore to work on these aspects, while advocating the inclusion of emergency contraception in the list of essential drugs at national level.

The fact-finding team recommends the following interventions:
→ Ensuring availability of a broad range of modern contraceptive methods for women, men and couples in FP services;
→ Increasing and supervising health professionals responsible for FP services;
→ Increasing knowledge and awareness of family planning, different contraceptive methods, double protection, STI prevention among women / girls as well as men / boys and ensuring that women / girls know their sexual and reproductive health rights;
→ Advocating in favour of including emergency contraception in the list of essential drugs;
→ Raising the awareness of religious leaders, formulating arguments in favour of birth spacing and encouraging broadcasting of messages on this subject via community radio;
→ Ensuring the policy of free provision of FP methods is applied by setting up a community-based inspection system.

Unwanted pregnancies

What other stakeholders are already doing
→ Formulating and strengthening national policies on GBV
→ Treating and supporting victims of GBV
→ Community involvement in the fight against GBV
→ Raising awareness of human rights and GBV
→ Creating health facilities
→ Advice on and access to modern FP methods
→ Community distribution of FP methods

What is not yet being done
→ Appropriate health education on familiy planning for teenagers, women, their partners and communities
→ Access for women to emergency contraception
→ Referral and/or treatment at a Comprehensive EOC for sterilisation for women or men in accordance with national protocols
→ Increasing free provision in practice of FP methods
→ Involvement of religious leaders in support of FP
→ Road building

Satisfactory interventions
→ Interventions on GBV
→ Creation of health facilities
→ Community distribution of FP methods

Unsatisfactory interventions
→ Advice on and access to modern methods of FP

What MdM does not wish to do or cannot do

What MdM thinks ought to be improved
→ Advice on and access to modern methods of FP

What MdM can do and wishes to do
→ Health education
→ Advocating women's access to centre for Accident & Emergency
→ Involvement of religious leaders in support of FP
→ Free provision in practice of FP methods

What MdM does not wish to do or cannot do
→ Referral and/or treatment in a CEOC for sterilisation
→ Road building (outside MdM's remit)

WHAT MDM WANTS TO DO
→ **Health education**
→ **Advocate for access to Emergency Contraception**
→ **Advice and access to modern methods of FP**
→ **Involve religious leaders**
→ **Effective provision of free care**

What others can do
→ Referral and/or treatment in a CEOC for sterilisation
→ Road building

The success of an intervention does not depend solely on its theoretical usefulness in responding to identified health needs. All criteria must be considered to test its potential added value and the associated opportunities, constraints and preconditions. To assess its feasibility and sustainability in terms of the existing dynamics of the intervention context, it is particularly important to be aware of the strategies of stakeholders present in order to determine whether they converge, diverge or contradict MdM's own and to see how our organisation's actions fit in – possible partnerships, quality of the stakeholders, community participation, etc. It is also essential to analyse the risks associated with an intervention.

3 / ANALYSING EXISTING DYNAMICS BETWEEN STAKEHOLDERS

Some stakeholders support a project, others oppose it and yet others remain indifferent. These stakeholders wield varying degrees of power and accord different levels of priority to any action they take to support or oppose a project. Moreover, stakeholders may experience an affinity or hostility towards each other or may be completely neutral. This fact leads to alliances and/or counter-alliances involving varying degrees of consultation.

The following four questions may help identify potential stakeholders:
1. Who might be affected by the potential project?
2. Who has or might have an interest in seeing the situation change?
3. Who has or might have an interest

in seeing the situation remain unchanged?
4. Who exercises power in this situation?

The method recommended for this analysis is to categorise stakeholders in relation to their **interest** in a possible intervention by MdM and their potential **influence** over this intervention. A stakeholder may have an obvious interest in a project, or be indifferent or even hostile to it. In addition, depending on the weight carried by stakeholders in a given context (legal, religious, cultural, etc.), they will have a greater or lesser capacity to influence our action. This influence may be observed at different levels – political, operational or sociocultural.

Ultimately, the combination of both factors of influence and interest may represent an advantage or a threat to MdM. Each stakeholder present must therefore be closely studied in relation to the planned intervention.

**STANDARD TEMPLATE
FOR ANALYSING EXISTING DYNAMICS
*(See diagram on next page)***

Box A represents the stakeholders with little interest in and even a negative view (divergent or opposing strategies) of an MdM intervention and who have the capacity to negatively influence the pursuit of our actions. Particular attention must be paid to stakeholders in this box, as they could cause an intervention to fail. The way these stakeholders exert a negative influence must also be assessed, particularly if they have the potential to be violent.

Box B represents stakeholders who have little interest in and even a negative opinion (divergent or opposing strategies) of an MdM intervention, but whose influence on the pursuit of our actions is weak.

Box C represents stakeholders with a strong, positive interest in (convergent strategy)

STANDARD TEMPLATE FOR ANALYSING EXISTING DYNAMICS
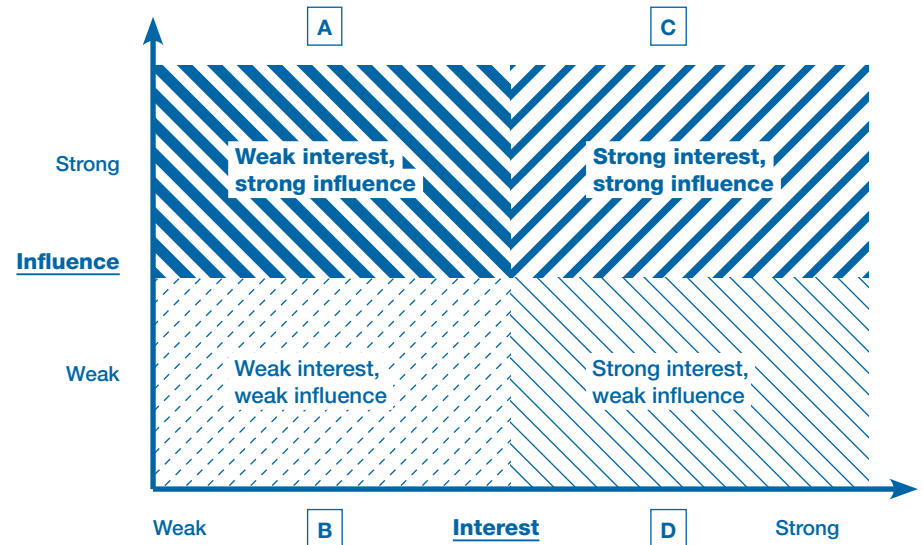
an MdM intervention and who may, as a result of their importance, have a positive influence on the pursuit of our actions. These stakeholders represent opportunities for an intervention.

Box D represents stakeholders with a strong, positive interest in (convergent strategy) but only a relative influence on the success of a project.
It is important not to overestimate the weight carried by these stakeholders relating to the intervention's chances of success and not to see them as opportunities.

Once the different stakeholders have been inserted into the template, it is possible to identify:
→ Possible risks to the intervention's success,
→ Potential partnerships between stakeholders.
It is important to note that a stakeholder may move from one box to another depending on the public health problem

selected or the interventions chosen. In our actions, we favour both the community approach and partnerships. With sustainability of our interventions being one of our aims, it is also important to identify in which segment of the template the community stakeholders and health authorities lie.

This analysis of stakeholders makes it possible in subsequent stages and phases *(See chapter on tracking/monitoring)* to define the strategies required to turn influential stakeholders with a negative view of the project in its favour.

GENERIC EXAMPLE
ANALYSIS OF INTER-STAKEHOLDER DYNAMICS ON THE SUBJECT OF UNWANTED PREGNANCIES

To find out whether the strategies of those stakeholders present are convergent or divergent with the

planned interventions or in opposition to them, the fact-finding team analyses inter-stakeholder dynamics.

Weak interest, strong influence
→ Head of local civil service
→ Religious leaders
→ Ministry of Finance

Strong interest, strong influence
→ Ministry of Health
→ Regional health authorities
→ AMPF
→ National media

Weak interest, weak influence
→ Health committee
→ Deputy head of local civil service

Strong interest, weak influence
→ Central pharmacy
→ Health centre director
→ Traditional birth attendants
→ Community health workers
→ Traditional women's groups

The Ministry of Health and regional health authorities have a recognised leadership role in developing health sector strategic plans and show great interest in actions developed by NGOs. Médecins du Monde enjoys a positive image and has been able to build a relationship of trust with these stakeholders. They therefore represent useful vehicles for advocating emergency contraception and genuinely support incorporating family planning into health sector strategic plans. AMPF has likewise a strong influence at district level.

In contrast, although they have considerable interest in the issues

supported by MdM, community health workers, traditional birth attendants and women's groups carry little weight in decision-making at district level.

Religious leaders have a significant influence both as regards their community and the regional health authorities. They have the capacity to revive existing divisions following the years of civil war the country has suffered. Most of them convey messages promoting fertility and could oppose a project they see as contrary to this stance. It would seem essential therefore to work on formulating arguments which are in keeping with religious precepts.

In the case of interventions which deal with more delicate and less consensual matters, it may be necessary to produce a specific and more detailed template. A stakeholder may in fact be in favour of a project overall but oppose one of its elements.

4 / ANALYSING RISKS

Before deciding on an intervention, it is necessary to assess the security constraints and risks potentially associated with it. For example, are there security constraints which limit staff travelling about in certain areas?

Risk analysis must be carried out in a structured and disciplined way. All human beings are inclined to be subjective and so there is a tendency to overestimate dramatic but infrequent risks and to minimise frequent and everyday ones. Moreover, it is very difficult to analyse risks in an unknown environment. We are also often subject to what is referred to as "boiling frog syndrome"[37], hence the importance of analysing risks on a regular basis.

Method and tools

A method and tools exist for analysing the risks in their widest sense which the project faces. While some risks seem self-evident – for example the risk of a car accident – it is recommended that the

37. The anecdote of the boiling frog recounts how if a frog is placed in boiling water it will react violently by jumping out the pot. Conversely, if it is placed in a pot of cold water, which is then gradually heated, the frog will end up boiling to death.

analysis be carried out in a group so that each member of the team can set out the concerns and limitations associated with the project or their particular job as they see them (e.g. being required to pass through two military checkpoints to reach work). There are several advantages to conducting an exhaustive exercise: it enables the team to reach agreement on the risks relating to the project as well as on the measures to take to limit these.

Security measures are complied more readily when understood by all. The group exercise also sets the analysis in context by referring to all additional information relating to each risk. For example, if it is stated that the risk of kidnapping is high, details must be given of recent kidnappings and how this phenomenon is likely to develop. Likewise, if it is indicated that the risk of being involved in a car accident is high, it needs to be explicitly stated that the nature of the project obliges the teams to travel many kilometres daily on badly maintained roads. The risk is not the same if just one vehicle is involved and used only in town or on motorways. The measures to take (over and above the basics such as wearing a seatbelt and obeying the rules of the road) are not the same in the two instances. In the former, particular attention is paid to driver training, good vehicle maintenance, providing a spare tyre and emergency kit and to the procedures to follow in the event of an accident – emergency number, nearest referral hospitals, etc.

Being seen as a target is the hardest risk to assess (and to accept). To take this risk into account, the team needs to have a good understanding of how MdM is perceived in the surrounding environment. Are its values as a humanitarian, impartial and independent organisation understood and accepted in the region/country? Is MdM perceived as a propagandist organisation promoting values which are contrary to those commonly

accepted (right to abortion and women's rights)? Press releases issued by MdM HQ may give the impression that the organisation takes sides in a conflict (by condemning abuses committed by a regime for example). Does a section of the population feel MdM's actions or recruitment are damaging towards them? Is a section of the staff unhappy with the salary policy or dismissal procedures? What might be the consequences of this discontent – a column in the local press, a prosecution or a grenade lobbed into the compound?

Before choosing an intervention, it is of course advisable to balance the risks taken against the benefits for the population. It is also recommended that a level of acceptable risk be determined. This is done by turning the issue on its head and asking: What is an unacceptable risk? Is it acceptable for team members implementing the project to run the risk of being killed, kidnapped or injured? The answer may be yes if the activities are a life-saving necessity for the population and if we have the capacity to respond. So, not only do measures to limit exposure to risk have to be put in place but also procedures to limit the consequences in the event of an incident.

**GENERIC EXAMPLE
ANALYSING RISKS**

The fact-finding team's analysis of the risks associated with the chosen interventions has highlighted a particular risk arising from advocating emergency contraception:
some stakeholders tend to confuse the messages relating to the issue of abortion with those concerning emergency contraception.
At regional and national level,

the subject of abortion is overly divisive and sometimes those stakeholders supporting the right to abortion are accused of wanting to import a model from outside with no respect from the culture of the country. It would therefore seem crucial to ensure messages are absolutely clear.

The choice of interventions also depends on Médecins du Monde's human, material and financial capacity to implement a certain type of intervention.

5 / TECHNICAL AND FINANCIAL ANALYSIS

The human and material resources required are not always identical and depend on the type of intervention chosen. Precise details are not given here of the human, material and financial resources required to implement a project, but instead support staff is encouraged to examine the technical and / or financial feasibility of the planned interventions.

**GENERIC EXAMPLE
TECHNICAL AND FINANCIAL
ANALYSIS**

International funding options for Libertalia are declining. However, sexual and reproductive health remains one of the best funded areas given the country's maternal, neonatal and infantile mortality. Most humanitarian action concerns obstetric care coverage. Adopting an approach

focusing on the issue of unwanted pregnancies seems to offer worthwhile funding opportunities.

From a logistics point of view, as mobile activities are planned in rural areas, sufficient stocks of contraceptives will be needed to guarantee continuity of these activities among the target population, particularly given that accessibility by road is much reduced during the rainy season.

NOTE /
An analysis of the interventions may lead to refining or reviewing the public health problem selected. This then requires a return to the problem tree and a re-examination of all the stages detailed up to this point.

1.3D

FINAL INTERVENTION SELECTION AND DRAWING UP THE INTERVENTION STRATEGY

▶ As with the choice of public health problem, the **choice of intervention** takes account of numerous explicit and implicit criteria. So it is fundamentally important to explain the choices made. Good communication means better understanding and sharing of choices within the same team, between teams, with partners and donors. This approach must be incorporated into the communication policy when it is being drawn up and helps ensure the project's consistency and validity. Drawing up an intervention strategy is the final stage of the diagnostic phase. This is the point at which the general data collection comes to an end and the **decision is taken to actually intervene** on a chosen, analysed public health problem.

The **intervention strategy** represents the synthesis of the principal elements of the diagnosis and must include **justification** of the decisions taken: why a particular public health problem has been chosen in a given context; why a particular intervention approach has been proposed (in relation to possible partnerships, stakeholders, constraints and opportunities, etc.); what the **potential added value** of the intervention is, etc.

In order to guarantee that information is shared over the long term, it is important to describe the intervention strategy and to justify it in the fact-finding mission report. The intervention strategy can include the technical and financial constraints associated with certain types of action. It must also mention points on which to remain vigilant, so that the intervention can go ahead in complete safety for staff, partners and service users.

Lastly, it must give the order of magnitude of the **population targeted by the intervention.** This involves evaluating the different types of beneficiaries who will be affected by the chosen intervention – general population in the intervention area, target population, direct and indirect beneficiaries[38].

The choices made at this stage will be reviewed – during project programming in particular – in the light of further, subsequently available information.

38. See this guide's chapter on project programming for definitions of the different types of beneficiaries.

SUMMARY

KEY POINTS IN IDENTIFYING PUBLIC HEALTH PROBLEMS AND POSSIBLE INTERVENTIONS

→ The choice of public health problem and interventions is where analysis of a context and the positioning sought by MdM come together.

→ The choice of public health problem must take account of what is already being done: it is a matter of adopting a complementary approach and not of duplicating effort.

→ The choice of public health problem must take account of what we know how to do.

→ The possible public health problem and the interventions must be reviewed in relation to operational criteria, potential added value, opportunities, constraints and preconditions.

→ The choice of public health problem and intervention must be communicated to stakeholders involved in the analysis process and must be understood by the partners.

→ At the end of this stage, the intervention strategy is drawn up and described in the **fact-finding mission report.**

ANNEXES INCLUDED ON THE CD-ROM – PART 1 – DIAGNOSIS

– **Request for executive committee approval of fact-finding mission**
– **Terms of reference template for fact-finding mission**
– **Fact-finding mission report template**
– **Stakeholder diagnosis (interest/influence matrix)**
– **Diagnostic tool: SWOT analysis**
– **Diagnostic tool: Donors mapping**
– **Diagnostic of community participation**
– **Risk analysis grid**
– **Diagnosis of partners**

2.

PROJECT PROGRAMMING

LOGFRAME: THE BARE BONES OF A PROJECT

Good, looks like it's holding up...

...Now to put some flesh on it!

General objective

Specific objective

Sources of verification

Indicators

Costs

Results

Activities

Risks & Assumptions

Preconditions

Resources

PROJECT PROGRAMMING

Definition

Project programming represents the second phase of the health project cycle. It specifically corresponds to the **designing** of a project, i.e. a **series of coherent actions aimed at achieving precise objectives.**

Project programming represents the second phase of the health project cycle. It specifically corresponds to the designing of a project, i.e. a series of coherent actions aimed at achieving precise objectives.

The programming phase must be consistent with the diagnostic data collected and the chosen intervention strategy. The intervention strategy includes justification for the decisions taken: why a particular public health problem has been chosen in a given context, why such an intervention approach has been proposed (possible partnerships, players/stakeholders, constraints, opportunities, etc.), what the potential added value of the intervention is, etc. The size and extent of the intervention's target populations are also included, as well as issues to bear in mind relating to security and/or resources.

It is therefore essential, during the project programming phase, to rely on the **report of the fact-finding mission** finalised during the diagnostic phase.

In addition, the programming must be carried out wherever possible in collaboration with populations, institutional partners and other stakeholders present in the area of intervention.

Five stages may be identified during the project programming phase:

→ Defining objectives and results;
→ Defining indicators for objectives and results, as well as their sources of verification;
→ Defining activities in relation to identified results;
→ Defining resources and costs;
→ Defining risks and assumptions and preconditions.

These various stages are summarised in the logical framework. It ensures that project programming can proceed in a **logical and structured** way, verifying at every stage that the intended actions are consistent with the defined objectives and that the resources relating to them are adequate.

The logical framework is in some ways the skeleton of the project, which must then be fleshed out with a detailed narrative, explaining the project and justifying the choices made, both in the reference document and in funding applications.

FOCUS ON
LOGICAL FRAMEWORK

Widely used by those involved in international solidarity work and frequently requested in funding documents, the logical framework is often perceived as "just more donor paperwork". The logframe needs to be seen for what it is, namely a tool to aid action. In this sense, it is not about using the logical framework in a mechanical or constrained way but about developing it by taking account of context and implementation. The aim of project programming is not simply to complete a logical framework or funding document but to consider a project in all its dimensions. In this way, producing the logical framework is a valuable exercise. As well as meeting donors' require-ments, it provides a framework for discussing a project and offers a synthesised vision of it. This is why the logical framework incorporated into the reference document is much more comprehensive and detailed than the one used when applying for funding.It is not a matter of ticking boxes but rather of providing a framework for issues that need to be considered. Hence, it is essential to involve potential partners in developing a logical framework and the same applies to the majority of tools described in this chapter.

AN EXAMPLE FROM THE FIELD[39]

The Harm Reduction (HR) project in Georgia

For the partnership, participatory tools ensure interactive participation between MdM and its partners. First and foremost, participation ensures joint design of and joint decision-making about joint activities. Participatory planning and review mechanisms further help to clarify and define the roles, responsibilities and accountabilities of the programme partners and ensure that all actions are based on a shared vision. Finally, they facilitate learning about one another, encourage open communication among staff and between partners, resolve conflicts and thus help to ensure accountability and transparency. They therefore ensure a commitment to building and nurturing the partnership.

The use of these tools is not over-complicated for the small NGO and helps to structure the planning and review processes, an important capacity-building measure that substantially facilitates collaborative decision-making and planning in the future.

39. Recommendations extracted from capitalisation and evaluation reports. These reports are available on the MdM intranet.

Logical framework development stages

The logical framework brings together the various dimensions of a project. Each of the elements described in this tool relates to a different stage and to specific project programming documents.

S2AP recommends that the logical framework and related documentation are compiled in a specific **order** (as shown by the numbers written in the boxes). This order corresponds to **the stages of project programming.** It is important to have finished discussing and considering the intended objectives and results (the project's ultimate goal) before defining the way of attaining these (i.e. the itinerary or path to follow). It is nevertheless essential, during the compiling, to crosscheck both horizontal and vertical consistency and coherence.

Exchanges between field staff, desk officer, volunteer board delegate (RM), medical adviser and specialist subject advisers help define points 1 to 12.

Once the overall structure of the project has been defined, the desk officer, with the help of field staff (if already in place) and support services, produces details of the operational aspects by defining points 13 to 15.

Intervention strategy	Indicators	Sources of verification	Risks and assumptions
General objective 1	4	5 (Monitool)	/
Specific objective 2	6	7	11 — Opportunities constraints and preconditions (SWOT)
Results 3	8	9	12
	Resources	**Costs**	**Preconditions**
Activities 13	14	15	10

Problem tree / Decision tree

Gantt Chart · Budget

FOCUS ON
AIM OF PROJECT PROGRAMMING

In the same way that an itinerary shows in advance which places to pass through in order to reach a given destination, programming helps define the direction and course envisaged for a project.

The idea of an itinerary does not mean the route to get to a destination cannot be changed or the destination altered in response to what may occur en route. Often, the fact of having envisaged different possibilities before setting out is an invaluable aid when it comes to making subsequent choices.

The same applies to project programming. It provides the opportunity to ask what it is we want to achieve and the route we aim to take to do so. Once the project is underway, the objectives and expected results, as well as activities and allocation of resources, can be refined or modified.

Depending on the decisions which need to be taken, it is essential to involve the stakeholders concerned. Obviously, a change to the objectives or expected results is a more significant decision than changing an activity. Similarly, it is important to ensure that, when the logical framework is modified while the project is underway, there is no resulting inconsistency between any of its various elements.

2.1
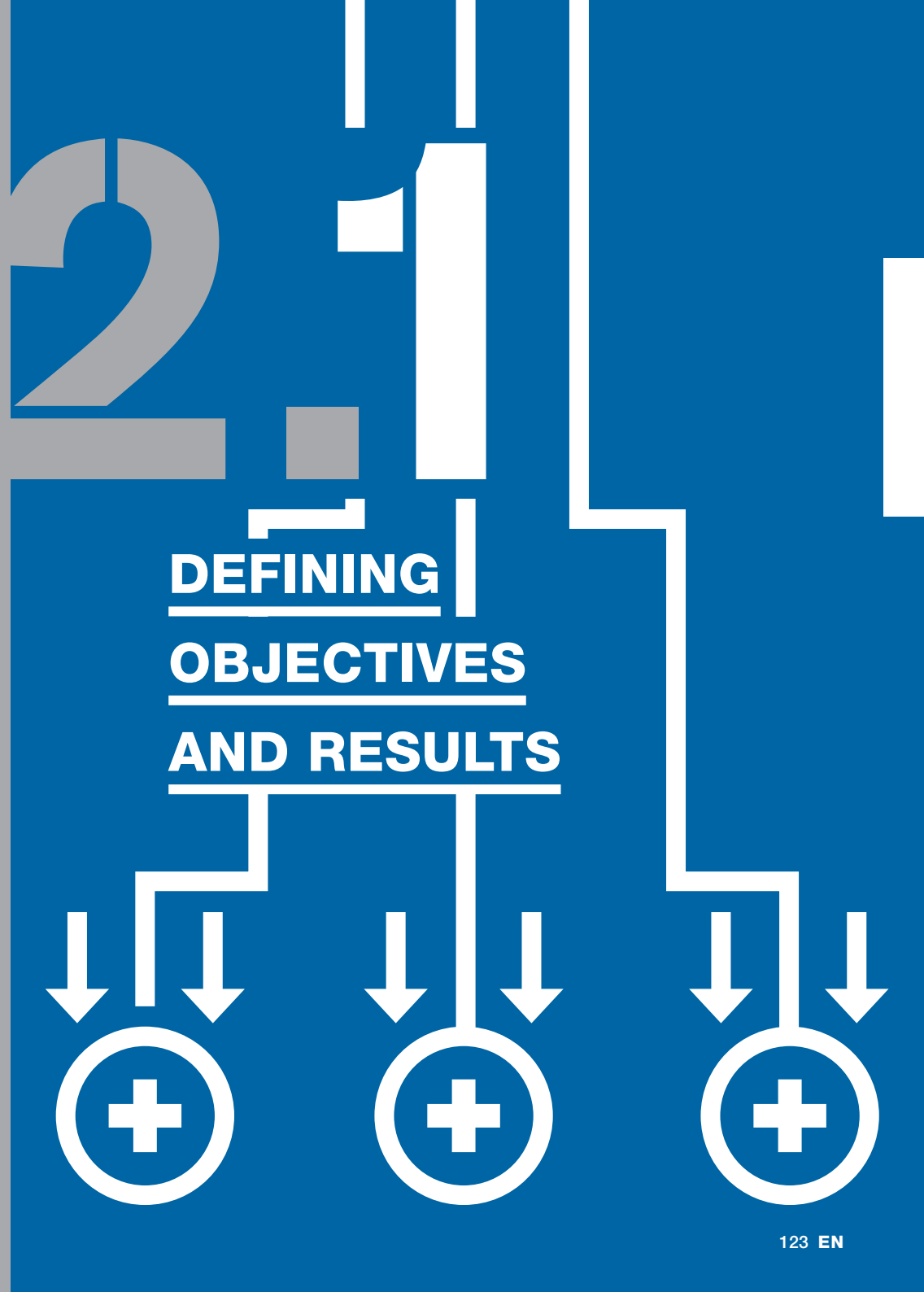
DEFINING OBJECTIVES AND RESULTS

DEFINING OBJECTIVES AND RESULTS[40]

> By the end of the diagnostic phase, a public health problem has been selected and an intervention strategy put forward in the fact-finding mission report. Formulating project objectives and results implies transforming the public health problem selected into objectives and expected results.

40. The terminology of the logical framework differs from that used in the context of the CPBOARESE, a planning method which was the subject of the "Manuel de planification des programmes de santé" [Handbook for Health Programme Planning], published by **MdM** in 2006. Here the general objective cannot be attained within the context of the project alone. The specific objective of the logical framework corresponds to the general objective of CPBOARESE; and the results correspond to secondary or specific intervention objectives.

2.1A

GENERAL OBJECTIVE

> The general objective describes the actions the project is intending to contribute to as a way of improving the health of the general population. For example, **contributing to:** Attaining a Millennium Development Goal (MDG)[41] and/or a Sustainable Development Goal (SDG), Reducing mortality at national level, Reducing prevalence of HIV/AIDS nationally, etc.

NOTE /
The general objective relates to all desired long-term consequences for the general population (i.e. impact) and is therefore diverse and complex. To take just one example, the "target population" is not the same as the general population. Hence the reason the general objective cannot be attained within the context of a single project.

The MdM model provides for **a single general objective.**

Verbs of action in the infinitive are used when formulating the general objective. The wording must explicitly state the situation to be achieved and must indicate:
→ The location (country or regions concerned),
→ The population(s) concerned by the change sought,
→ Without however specifying the duration of the action.

The objective **does not give figures:** details of targets are given in terms of selected indicators.

EXAMPLES FROM THE FIELD
General objective wording

Uruguay

To increase access to integrated, good quality sexual and reproductive health services for women facing an unwanted pregnancy in five Latin American countries based on the Uruguayan experience.

Haiti

To contribute to reducing morbidity and mortality associated with the cholera epidemic in Haiti.

Pakistan

To contribute to reducing morbidity and mortality in the population affected by the conflict in Pakistan.

2.1B

SPECIFIC OBJECTIVE

> The specific objective is the objective which is central to the project. It describes what the project wishes to **accomplish** in response to the chosen public health problem prioritised during the diagnosis (whether it be a collective health problem or a determinant). The specific objective relates to the desired short and medium-term outcomes for the health of the target population.

The MdM model provides for **a single specific objective.** It is at the core of the project and attaining it will be the focus of the project evaluation.

As with the general objective, **verbs of action in the infinitive** are used for formulating the specific objective.
The wording must explicitly state:
→ The situation to attain, specifying the duration and location(s) of the project;
→ The target population(s).

The objective **does not give figures:** details of targets are given in terms of selected indicators.

The **duration** of the specific objective must be **equivalent to that of the project.**

EXAMPLES FROM THE FIELD
Specific objective wording

Laos

To increase the quality of and access to preventative and curative healthcare for pregnant women and those of child-bearing age as well as children under 5 years in the districts of Moonlapamok, Sukuma, Champassack and Khong in Champassack Province within four years.

Haiti

To provide quality healthcare over the period of one year

for cases of cholera and to reduce the prevalence of the epidemic within the populations of the Port-au-Prince urban area and the department of Grand'Anse.

Pakistan

To provide access to full primary healthcare over one year to people affected by the conflict in fourteen villages in the districts of Swabi and Buner in NWFP.

FOCUS ON
ESTIMATING NUMBERS OF BENEFICIARIES OF AN INTERVENTION
Some definitions

→ **Geographical coverage, catchment population:** General population in the intervention area and catchment area
→ **Target population:** Persons potentially affected by the intervention (e.g. PLWHA in the project intervention sector)
→ **Direct beneficiaries:** Persons directly affected by the intervention (e.g. PLWHA treated as part of the project)
→ **Indirect beneficiaries:** Persons in contact with direct beneficiaries and who may benefit from the impact of the intervention (e.g. families of PLWHA)

Health professionals within facilities supported and/or partners (health officials, nurses, midwives, etc.) are not indirect beneficiaries but key resource persons, except where the project is purely training-based

in which case they represent direct beneficiaries.

Where possible, the number of beneficiaries calculated is separated into age and gender.

GENERIC EXAMPLE
ESTIMATING NUMBERS OF BENEFICIARIES

The example given here is further developed as the generic example in the chapter on "Diagnosis". Using the existing fact-finding mission report on the project in Libertalia as a starting-point, the Médecins du Monde project team has to set about programming the project. The number of project beneficiaries must now be specified.

Catchment population: Population of the 10 communities covered by the intervention = 390,314 people

Women of child-bearing age: 22.09% of the total population (official Ministry of Health figure)

Target Population: Women of child-bearing age = 390,314 x 22.09% = 86,220 women of child-bearing age

Direct beneficiaries: Women of child-bearing age accessing FP = 86,220 x 30% (MdM target) = 25,866 women

Indirect beneficiaries: Families of women accessing FP = 25,866 women x 7 people per household = 181,062 people

2.1C

RESULTS

> Results describe what the project must **produce** to attain the specific objective. They contribute to the project's general objective. The results are obtained by implementing a certain number of activities.

The generic term "result" in reality encompasses two terms:
→ "Output" which refers to products arising from implementing activities.This may relate to products of the activity itself (e.g. training carried out) or to output generated directly in people, organisations or health facilities (e.g. increased knowledge).
→ "Outcome" which relates to short and medium-term changes achieved by the combination (either in sequence or in parallel) of activities and/or circumstances with **an effect on the health of the target population.** For example, an outcome may involve a change of practice, an altered perception, a modification to health services and access to and usage of these, a change in legislation, etc.

Whether it is a matter of output or outcome, not all results play the same role in attaining the specific objective.

Some changes demand time and securing them may go beyond the context of a single project. Hence, from the outset it is worthwhile incorporating the project into a long-term strategy by examining the links which will enable the desired changes to be achieved. This involves reviewing the analyses conducted on the basis of problem trees and extending the notion of a **results chain.** *(See diagram opposite)*

The project results are formulated largely on the basis of MdM's desired and potential involve-ment and the level at which this is possible.

Results are formulated in the **passive form.** The wording must explicitly state:
→ The desired change and the timescale (particularly if this is shorter than the duration of the project),
→ The target population(s).

Results **do not give figures:** the targets set are specified in terms of the selected indicators. Therefore the period during which the indicator will be measured and at the end of which the goal should be attained is specified.

The **duration** required to achieve a result is **not always identical to that of the project.** It may be less than or equal to it. A project may have several components which are implemented simultaneously or in succession.

Results	Specific objective	General objective

Direct and immediate output	Short and medium term outcome	Short and medium term outcome	Long-term impact

Concerning:
→ Reorganising health services
→ Formulating public health policies
→ Acquiring individual skills
→ Creating supportive environments
→ Reinforcing community action

On the health of the target population

On the health of the general population

GENERIC EXAMPLE
THE DEFINITION OF RESULTS

In Libertalia, products needed for emergency contraception are not included on the nationally defined list of essential drugs. MdM wants to make it more readily available in the health facilities it supports in the district of Saapland. The following two results may be envisaged:
→ National protocols for family planning services including access to emergency contraception are put in place and circulated within two years.
→ Access to emergency contraception is ensured for populations of the 100 communities in the district of Saapland during one year (final year of project).

As regards the general and specific objectives, results are formulated on the basis of the problem tree and intervention strategy defined during the diagnostic phase. Possible interventions may therefore be expressed in terms of the **five areas of the Ottawa Charter.**

According to the Charter, health promotion is a process which provides individuals and populations with the means to improve their health:
→ By ensuring better control over health determinants;
→ By acting on their environment or by evolving along with it.

Health promotion is both a concept and a set of strategies and brings together the issues of public health and community participation. These two aspects are fundamental to MdM's projects. Health promotion also focuses on examining health-related determinants (social, political and economic change, etc.) and on stimulating effective public participation.

NOTE /
Health promotion means taking action simultaneously in all five intervention areas listed in the Ottawa Charter, which are:
1. Healthy public health policy;
2. Supportive environments

(geographical and physical but also economic, including access to health prevention and health services);
3. Community action;
4. Personal skills;
5. Health services.

These five areas represent a **conceptual framework** (and not a tool) shared by all those at MdM for examining and drawing up projects (i.e. defining results). At the project programming phase, it is important to consider the five areas listed in this model (even if the decision is taken not to implement all of them) and to plan **partnerships** with responsibility for certain elements. It is nonetheless important for all five areas to be examined as failure to do so risks leaving a project incomplete and/or unable to respond effectively to the public health problem identified.

For a project to be effective, realistic and operationally feasible, it is desirable to work on **a minimum of three areas** of health promotion and **a maximum of six results** for a specific objective (there may be two results for one area). Depending on the size and/or complexity of the project, the specific objective may be split into sub-outcomes.

This global, multi-sector approach also makes it possible to introduce an advocacy element, which covers the area relating to a healthy public health policy.

FOCUS ON
WHY SHOULD MÉDECINS DU MONDE UNDERTAKE ADVOCACY?[42]

Dispensing care and providing testimony are sometimes insufficient to bring about change. Advocacy is therefore indispensable to enable an organisation to attain its objectives and to realise its vision over the long-term.

The basic principles of advocacy are as follows:
→ To know precisely what it is one wishes to change;
→ To know who has the power to effect the desired change;
→ To equip oneself with the necessary information and tools to convince decision-makers to effect the change sought.

What types of change are sought?
In principle, there are three directions the sustainable change sought can take:
→ Adopting new policies to improve the health of populations;
→ Challenging policies considered to be against the interests of the populations concerned;
→ Ensuring compliance with existing but unenforced policies or regulations.

Testimony *versus* advocacy
Providing testimony forms part of a factual, one-off approach, used to describe a situation or to raise the profile of an issue, but its primary mission is not to secure change (even if indirectly it helps to do so). Thus, in most cases, the testimony provided

serves to raise public awareness of a situation or issue (specifically issues of access to health) and may also constitute formal proof in support of an advocacy strategy or in the context of legal decisions (for example during trials conducted by the International Criminal Court).

Advocacy, in contrast, takes the form of implementing proactive strategies to influence decision-makers in order to force the introduction of concrete solutions to the problem identified.

Communication *versus* advocacy
While the advocacy approach requires the use of communication tools to convey the organisation's messages and recommendations to decision-makers and the general public, it is not limited to this aspect alone. It also includes many other activities with no direct link to the media, such as lobbying decision-makers, forging alliances with partners and gathering expertise from our fields of intervention.

Similarly, communication is not always undertaken for advocacy purposes.

GENERIC EXAMPLE
THE DEFINITION OF OBJECTIVES AND RESULTS ON THE BASIS OF THE FACT-FINDING MISSION REPORT

The fact-finding mission report provides the following information:

Public health problem selected:
Unwanted pregnancies

The public health problem concerns women of child-bearing age

(86,220 women of child-bearing age in the 10 communities targeted by the project). 15% of them use modern contraceptive methods. Unwanted pregnancies may lead to unsafe abortions and obstetric complications and even result in increased maternal morbidity and mortality. The principle determinants identified are: poor access to modern FP methods, lack of availability of FP methods, poor geographical accessibility of healthcare facilities, ignorance of FP accompanied by general inefficacy of traditional FP practices and injectable products being taboo, absence of emergency contraception from the national list of essential drugs, large numbers of religious leaders promoting positive image of fertility, prevalence of GBV and gender inequality.

Interventions envisaged

→ Ensuring availability of a wide range of modern contraceptive methods for women, men and couples at FP services.
→ Supervising and strengthening the capacities of health professionals in charge of FP services.
→ Increasing knowledge of family planning, different contraceptive methods, double protection and prevention of STIs in women/girls as well as men/boys, and ensuring that women/girls know their sexual and reproductive health rights.
→ Advocating in favour of including emergency contraception on the list of essential drugs.
→ Raising the awareness of religious leaders, constructing arguments

---

42. For more information about formulating an advocacy strategy, consult the **MdM** introductory document "Advocacy Training", 2011, available on intranet in French, English and Spanish.

in favour of spacing births and encouraging broadcasting of messages on this subject via community radio.
→ Ensuring the policy of free FP methods is applied by establishing a community-based monitoring system.

The objectives and expected results are defined based on the problem tree (below) along with the interventions proposed by the fact-finding mission report.

General objective

In the case of the project in Libertalia, "unwanted pregnancies" was chosen as the public health problem. By consulting the problem tree, it is possible to identify that the long-term impact of this problem is an increase in maternal morbidity and mortality.

The general objective is formulated as follows: To contribute to reducing maternal morbidity and mortality in Libertalia.

Specific objective

The fact-finding mission report would suggest that the most relevant action to reduce levels of unwanted pregnancies would be to increase FP services offered and demand for them, from the point of view of what has already been done by others, the project's resources and the risk analysis.

The specific objective is formulated as follows: To reduce the number of unwanted pregnancies in the district of Saapland by increasing FP services offered and demand for them over 3 years.
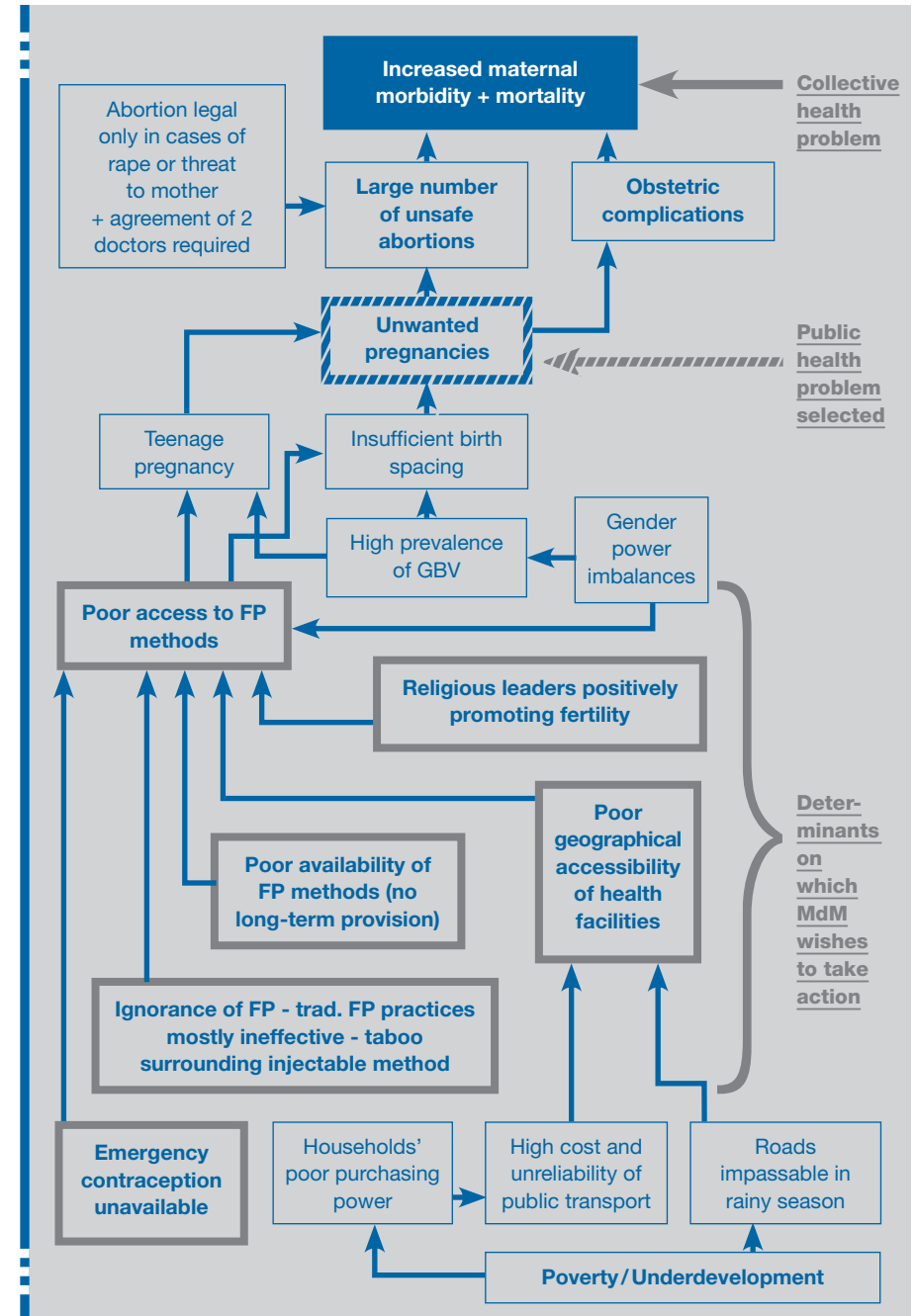
Problem tree determinants which are the focus of intended action	Analysis of possible interventions based on areas of Ottawa Charter	Description of results
Poor availability of FP methods (no long-term provision)	**Reorienting health services** (to improve the range of family planning offered)	Good quality FP services are offered by heatlhcare facilities in Saapland district over 3 years.
Poor access to FP methods (free in theory but paying in practice)	**Creating supportive environments** (reducing barriers to accessing family planning services)	A control mechanism for ensuring free access to FP services is put in place within 3 years.
Emergency contraception unavailable (not on list of essential drugs)	**Building healthy public policy** (supporting formulation or strengthening of national family planning policies)	National protocols for family planning services, including access to emergency contraception, are put in place and circulated within 2 years.
Ignorance of FP – Traditional FP practices mostly ineffective – taboo surrounding injectable method	**Developing personal skills** (promoting individuals' awareness and strengthening individuals' means to exercise control over their rights and health)	Family planning knowledge and practices among the population of the 10 communities in Saapland district are consolidated over a period of 3 years.
Religious leaders positively promoting fertility	**Strengthening community actions** (promoting involvement of religious leaders around issue of family planning)	Religious leaders in the 10 communities of Saapland district are made aware of the importance of family planning and encourage the use of FP services within 3 years.
Poor geographical accessibility of healthcare facilities	**Strengthening community actions** (promoting community involvement around issue of family planning)	No result formulated: AMPF (national family planning organisation) is already using community-based distribution of FP methods.

IN SUMMARY

KEY POINTS IN DEFINING OBJECTIVES AND RESULTS

→ **1 general objective** formulated using **verbs of action in the infinitive:** long-term desired outcomes and consequences, i.e. impact on the health of the general population

→ **1 specific objective** formulated using **verbs of action in the infinitive:** short and medium-term desired outcomes for the health of the target population

→ **Maximum of 6 results** (representing a minimum of 3 areas of the Ottawa Charter) formulated in the **passive voice:** desired short and medium-term changes to attain a specific objective (i.e. output and outcome).

2.2

DEFINING INDICATORS AND SOURCES OF VERIFICATION

2.2A

DEFINITION

> **An indicator** is a quantifiable measurement which describes a **state** or a **change of state** by comparing it over time. It **reveals disparities** in relation to other comparable elements or in relation to norms, standards or measurements/targets fixed in advance.

Not everything is easy to measure. However, the option of comparing different values of an indicator over time or in space provides valuable information about several elements. The subjects being quantified may be quite diverse depending on the information sought, and do not just concern technical or epidemiological aspects.

FOCUS ON
INDICATORS WHICH CONSIDER
SOCIOCULTURAL ELEMENTS[43]

Those programming a project identify and select the most appropriate indicators for the context from the array of indicators covering sociocultural elements.

Examples of indicators:
→ Percentage of consultations where the patient's privacy is assured by appropriate methods (presence of a dividing curtain, option of being seen by someone of the same sex, etc.).
→ Percentage of attended births where the patient's choice of birth position is respected.
→ Percentage of births where the patient's wishes regarding the placenta are taken into account.

It is essential to gauge **the opinions and perceptions** of those with whom and for whom we are working. For MdM, the key issue is to complement rather than substitute for others. The indicator may therefore measure how serious a collective health problem is felt to be, the level of community participation, the level of service-user satisfaction, etc.

43. To find out more or to access more examples, refer to the guide "Access to Healthcare. Sociocultural Determinants", **MdM**, 2012, available on the MdM website in French, English and Spanish.

Similarly, it is important to measure not only **the quantity but the quality of the services offered.** For example, the "number of consultations" measures how many consultations are carried out, while the "number of consultations carried out according to national and/or international quality norms" measures how good they are.

2.2 B

INDICATOR LEVELS

> There are several levels of indicator relating to project monitoring.

→ **Impact indicators** measure **the long-term outcomes and consequences for the health of the general population.** This level of indicator only applies if required by donors as part of their funding application format. It is in fact not specifically useful for monitoring projects, as it does not reveal changes produced in the short and medium-term of the intervention. Moreover, changes measured over the long term cannot be attributed to MdM's action alone. They may be positive or negative, a direct or indirect, intended or unintended consequence of a project.

→ **Outcome indicators** measure **the short and medium-term outcomes for the health of the target population.** They result from a successive or simultaneous combination of activities or circumstances. It is important to distinguish between intermediate outcomes (short and medium-term) measured by outcome indicators and long-term outcomes (5 years and more) measured by impact indicators.

→ **Output indicators** measure what is produced by implementing activities. These products may be the result of the activity itself or may be an output directly generated in individuals, organisations or healthcare facilities.

For example, the results of a health education activity may take several forms: IEC materials created (product of the activity), number of awareness-raising sessions organised (product of the activity), increase in trainers' skills (direct and immediate result in key resource persons) and increase in knowledge of target population (direct and immediate result in people targeted).

**FOCUS ON
CLARIFYING THE SEMANTICS**

The terminology associated with the outputs and outcomes of an action is not fixed and differs from one stakeholder to another and even within the same stakeholder, and from one document to another. This fluid terminology can sometimes lead to confusion but is mainly the result of translation issues. The three levels comprising output, outcome and impact are in fact common to the different stakeholders.

Some equivalents:

English terminology	MdM French translation	EC French translation	AFD (French development agency) translation
impact	**impact**	impact	impact
outcome	**effet**	résultat	effet
output	**résultat**	réalisation	réalisation

FOCUS ON
IS A RESULT ALWAYS MEASURED BY AN OUTPUT INDICATOR?

Everything depends on the type of result.
Results describe what the project ought to produce to attain a specific objective. They fall into two categories:
→ Products resulting from implementing activities and measured using output indicators;
→ Short and medium-term changes achieved by the combination of activities and/or circumstances (i.e. outcome) and measured by outcome indicators.

For example, the results of training relating to obstetric complications carried out with traditional birth attendants, in order to encourage referrals, may be measured by:
→ **Output indicators:** Number of training sessions carried out with traditional birth attendants and number of traditional birth attendants who know of 3 types of obstetric complications and

their risks (improving knowledge);
→ **Outcome indicators:** Number of pregnant women referred by traditional birth attendants (changes to referral practices).

More often than not, **MdM's logical framework contains only outcome and output indicators.** Impact indicators can be incorporated at the request of donors, but do not have any great project-monitoring value.

Each objective or result described in the logical framework may be linked to **several indicators.**

NOTE /
The set of indicators relating to outcomes and outputs is listed in the Monitool and therefore there is one document for monitoring all indicators associated with a project.

Intervention logic	Indicators	Sources of verification	Risks and assumptions
General objective	**Impact indicator** → **Long-term** outcomes and consequences for the health of the **general population**		
Specific objective	**Outcome indicator** → **Short and medium-term** outcomes for the health of the **target population**		
Results	**Outcome indicator** → **Short and medium-term** outcomes for the health of the **target population**		
	Output indicator → **Products** resulting from implementing activities or the **direct and immediate** results these produce in people, organisations and healthcare facilities		
Activities	**Resources**	**Costs**	**Pre-conditions**

GENERIC EXAMPLE
DEFINING MONITORING INDICATORS

Having defined objectives and expected results, the project team then defines the monitoring

indicators. Below is what helped the team choose the indicators for monitoring results 3 and 5. The method is the same for the project's other results and objectives.

Result 3: National protocols for FP services, including access to emergency contraception, are established and circulated within 2 years

Advocacy activities should lead to emergency contraception being included in the list of essential drugs within 2 years, so that it is incorporated into national protocols.

How the action is progressing can be monitored in relation to the expected result on the basis of what is directly produced by implementing the activities **(output indicators):**
1. Number of quarterly meetings with the national health authorities and partner institutions
2. Number of quarterly meetings with national health authorities and partner institutions that raise the issue of emergency contraception
3. Number of instances the issue of emergency contraception is raised in writing or orally with national health authorities and partner institutions

This progress can also be monitored using the short and medium-term outcomes of advocacy activities for the health of the target population **(outcome indicators):**
4. Number of health facilities supported by MdM offering emergency contraception (expected outcomes if advocacy objectives are achieved)

The team must select from among these indicators and their choice will depend on several factors:
→ Relevance of the indicator for monitoring attainment

of the objective or result;
→ Possibility of comparing its values with other sources of data;
→ Availability of information needed to calculate it;
→ Relevance of information provided for the intended interlocutor (Is the information meaningful?).

Indicator 1: Monitors the frequency of meetings held as part of advocacy activities. However, does not reveal whether the advocacy objective is any closer to being attained.

Indicator 2: Specifies the number of meetings needed to reach the advocacy objective. It may be thought that the more meetings that are held which raise the issue of emergency contraception, the more the health authorities and partner institutions will pay attention to it. However, this indicator only measures the fact that meetings are being held, while the planned advocacy activities are broader in scope.

Indicator 3: Provides information on the number of instances the issue is raised in writing or orally; this establishes whether the expected advocacy-related output is closer to being attained. However, in contrast to indicator 2, it is not limited to meetings but also takes account of the instances in which the issue is raised in writing.

Indicator 4: Gives precise indications of the outcomes of successful advocacy action. If emergency contraception is included in the list of essential drugs, MdM must ensure that it is indeed available at the healthcare facilities it supports.

The team selects indicators 3 and 4. The former monitors direct output of advocacy activities and the latter provides precise details of the outcomes of these.

Result 5: Religious leaders in the 10 communities of Saapland district are made aware of the importance of family planning and encourage the use of FP services within 3 years

The activities are not yet defined in detail but the plan is to undertake awareness-raising with religious leaders to develop arguments in support of family planning that are in line with religious precepts. Radio broadcasts involving religious leaders must go out to the 10 communities in Saapland district to ensure the messages are shared.

How the action is progressing can therefore be monitored in relation to the expected result on the basis of several indicators:
1. Number of awareness-raising workshops organised with religious leaders (product of the activity itself);
2. Number of religious leaders made aware of family planning issues (product of the activity itself);
3. Percentage of religious leaders with a knowledge of at least 3 key messages on spacing births (output directly resulting from the awareness-raising activity with religious leaders);
4. Percentage of religious leaders with a knowledge of at least 3 modern contraceptive methods (output directly resulting from the awareness-raising activity with religious leaders);

5. Number of radio broadcasts in the presence of religious leaders and conveying positive messages about spacing births (output directly resulting from the awareness-raising activity about sharing messages promoting birth spacing).

Indicator 1: Monitors running of awareness-raising sessions but does not provide information about the number of religious leaders involved or the quality of the awareness-raising. As this indicator relates to MdM activities, there are few sources of comparison. On the other hand, it is easy to calculate, as the information is directly available in MdM's activity reports and is accessible to a large number of interlocutors.

Indicator 2: Presents the same advantages and disadvantages as the preceding indicator but also provides information on the number of religious leaders involved in awareness-raising.

Indicator 3: Gives information on the quality of the awareness-raising through an improvement in participants' knowledge. However, an improvement in knowledge does not necessarily lead to a change of practice and this indicator does not provide information about effective message-sharing and about birth spacing. It may be calculated for religious leaders taking part in awareness-raising sessions (testing pre and post awareness-raising).

Indicator 4: Presents the same advantages and disadvantages as the preceding one. However, what is being

measured here is the development of knowledge of FP methods, linked more indirectly to an anticipated change of discourse. It is therefore less relevant for monitoring the progress of the action in terms of the desired output.

Indicator 5: Gives information on the sharing of messages by religious leaders; it is easy to calculate using reports issued by radio stations. It is meaningful and accessible to all.

On the basis of this analysis, the team chooses indicator 5.

2.2C

DRAWING UP INDICATORS

1/ INDICATOR HEADING

The indicator heading should make clear what is being measured.

The indicator does not itself **give figures** but includes a **baseline** and **one or more targets**. The baseline corresponds to the initial value of the indicator. The target is the value set as an objective to attain within a given time.

An indicator may be associated with one or several targets. If the indicator is associated with a single (final) target, the date by which it is hoped to attain it does not need to be specified. It is equivalent to the length of time set to attain the result or objective relating to the indicator.

However, an indicator may also be associated with several targets corresponding to different stages of the project (intermediary targets). For example, in the case of a three-year project, targets may be defined for the end of the first and second years. This information may be included in the reference document and used for funding applications relating to different stages of the project, as, for example, for a funding application for one year of a three-year project. Fixed deadlines

for attaining intermediary targets must therefore be specified.

Determining a baseline and target requires a realistic reading of the fields of intervention, something which is not always straightforward given the deadlines set or data available at the start of a project.

Defining the baseline is done using primary and secondary data collected during the diagnostic phase. Where information is lacking, other secondary data may be added during the project programming stage:
→ **National statistics:** National Health Information System/Health Information System, census, etc.
→ **International statistics:** Published by the United Nations agencies (for example Unicef Multiple Indicator Cluster Survey (MICS), the WHO's global statistics, demographic health surveys (DHS)) or by NGOs. It is important to set this data within the context of the intervention.
→ **Research by universities, institutes,** etc**.**
→ **Routine health service data, health centre records,** etc.
→ **Information given by the media** (for example by the national and local press).

FOCUS ON
WHAT IF THE BASELINE
IS UNKNOWN?

It regularly happens that the baseline is unknown at the project programming stage which sometimes has to be accomplished fairly quickly before all the data can be assembled or verified. It is recommended that targets be set all the same.

Knowledge of the fields of intervention and what can be achieved become increasingly clear as the project progresses. The targets established at the outset might be revised (up or down) or the resources allocated to attaining these targets adjusted. Targets which seem inappropriate may indicate over-ambitious objectives and/or inadequate resources for the objectives set. Conversely, targets too close to the baseline and so virtually attained from the beginning of the project beg the question of whether the project – which is expected to aim at a real improvement in the indicators – is relevant. It is therefore essential to examine the targets set and to adjust these where necessary. This brings us back to the notion of flexibility in the project programming and in its key tool, the logical framework, which must not be set in stone and must be capable of evolving.

Care should however be taken not to make these revisions too frequently (and we will return to this point in the chapter on monitoring).

Using a frame of reference
to set ideal targets

A frame of reference provides the basis for fixing a maximum possible value for an indicator and may be determined from a collection of sources:

→ **Reference data / International benchmarks:** These international norms are the result of work carried out at international level (MDG,[44] WHO norms, Sphere Project, etc.) and are intended to define the norms and standards for a certain number of subjects. This data indicates agreed satisfactory performance levels. However, these standards should also be viewed with caution *(see inset)*. In addition, they do not incorporate the diverse range of projects implemented and the complex nature of the fields of intervention. It is often more appropriate to refer to national norms which take account of the realities of the country, even if they too are sometimes subject to political contingencies.

→ **Published and unpublished studies:** These occasionally represent the only available sources for understanding the order of magnitude of certain subjects.

→ Information available in project documents or **prior and/or similar experiences.**

Defining targets depends on the results it is hoped to achieve. The target or targets must be fixed in relation to the situation which exists in the area of intervention (i.e. the baseline), with the ultimate goal being the frame-of-reference ideal. This is then adjusted in relation to what may realistically be achieved by the MdM intervention, the resources available, the capacities of MdM and/or project partners and the duration of the project.

---

44. In some regions, the MDG are extremely basic and not particularly ambitious; in such cases, it is not recommended to use them as benchmark data.

DEFINING A TARGET

Frame of reference defined in terms of benchmarks and prior and/or similar experiences

Target of the indicator

Baseline - Basic value

GENERIC EXAMPLE
DEFINING A TARGET

Number of instances the issue of emergency contraception is raised in writing or orally with national health authorities and partner institutions

→ **Baseline:** This indicator depends entirely on activities conducted by MdM. The baseline is therefore equal to 0 at the start of the project (no approach on the issue of emergency contraception is made before the project starts).

→ **Target:** 2 per quarter. MdM sets the goal of raising the issue of emergency contraception with national health authorities and partner institutions twice per quarter.

Number of health facilities supported by MdM offering emergency contraception

→ **Baseline:** 0. To date, emergency contraception has not featured on the list of essential drugs. It is, as a result, not available in healthcare facilities.

→ **Target:** 10. In the district of Saapland, MdM supports 10 healthcare facilities.

Number of radio broadcasts involving religious leaders and conveying positive messages about birth spacing

→ **Baseline:** This indicator is entirely dependent on activities conducted by MdM. The baseline therefore equals 0 at the start of the project (no radio broadcast on the theme of FP has involved religious leaders).

→ **Target:** 15. MdM's objective is to raise the awareness of 2 religious leaders per community, equivalent to 20 leaders. It seems realistic to aim for radio broadcasts with 15 of them.

Examining the ideal situation to attain enables questions to be posed as to the meaning of the action and the criteria used to judge its effectiveness. This is particularly important when referring to internationally established standards. Some are drawn from scientific studies (for example, vaccination rates to provide the population with maximum protection) and do constitute an ideal goal. However, there are other standards which, far from being neutral, imply a particular view of development or humanitarian aid.

FOCUS ON
SOME OF THE DEBATES
SURROUNDING AID EFFECTIVENESS

Development effectiveness
At an international level, the Millennium Development Goals (MDG)

adopted in 2000 establish a certain view of development and a general framework for assessing aid effectiveness. While international consensus existed regarding the "ideal situation" to attain, it was a matter of "acquiring the means" to attain it. International debates on aid effectiveness have thus crystallised around the issue of aid management and the five principles set out in the Paris Declaration in 2005: ownership, alignment, harmonisation, results and mutual accountability.

The main criticism directed at the Paris Declaration by civil society organisations (CSOs) is that it only dealt with the bureaucratic aspects of aid management, thereby depoliticising the issues. The CSOs therefore set about "an exercise in 'de-bureaucratisation' of the development and international cooperation discourse to clarify notions of effectiveness and development."[45]

Led since 2008 by the Open Forum for CSO Development Effectiveness, this process led to adoption of the International Framework for CSO Effectiveness and the eight Istanbul principles. Development is thus perceived as a process aimed at putting populations in the position of being able to choose. The "ideal situation" now refers to notions of strengthening capacities and of participation or empowerment. In the first case, aid effectiveness relates to tangible outputs. In the second, it refers to the notion of process.

Humanitarian aid effectiveness

A further debate arose out of the Sphere Project and its attempt to standardise humanitarian aid effectiveness. "The minimum standards describe conditions which must be achieved in any humanitarian response in order for disaster-affected populations to survive and recover in stable conditions and with dignity."[46] This approach has a tendency to view any crisis described as "humanitarian" as being the origin of so-called "humanitarian" and relatively homogeneous needs, whatever the specific nature of the intervention contexts. This means the effectiveness of the response of NGOs and other aid providers may be judged on the basis of needs met. Any such approach should match the minimum standards listed in the Sphere handbook as closely as possible.

Several forms of criticism have been directed at this pragmatic approach to the humanitarian response:[47]

→ **Technical criticisms:** The prescribed norms do not take account of the diversity of intervention contexts (they apply only to what are virtually non-existent conditions) and the problems particular to the humanitarian response (capacity to adapt in order to reach

vulnerable populations or to avoid the pitfalls of instrumenta-lizing humanitarian aid, etc.). Moreover, by developing a single response, the norms which have been laid down run the risk of reducing the capacity for innovation.

→ **Legal criticisms:** The Sphere Project tends to create a link between international humanitarian law (IHL) and technical standards. This raises the question as to what legal basis there is to this link and its possible applications.

→ **Political criticisms:** A response is "humanitarian" when it responds to the principles of humanity, impartiality and independence. Operational choices do not therefore come simply from technical criteria but also from the ethical standpoint adopted and from political negotiations.

In the case of the Sphere Project, aid effectiveness relates to the capacity to meet "humanitarian needs" by matching minimum standards as closely as possible. In the second approach, aid effectiveness relates to the capacity to respond to ethical, political and technical objectives of the humanitarian action.

2 / INDICATOR SELECTION AND QUALITY CRITERIA

The number of indicators must be limited for their analysis to be possible.

45. Bergamaschi Isaline, "Agenda de Paris & Efficacité de l'aide: Bilan d'expériences et grandes tendances dans les pays en développement", study carried out for Coordination Sud, Paris, October 2007, p.58.

46. The Sphere Project, "Humanitarian Charter and Minimum Standards in Humanitarian Response", 3rd edition, 2011, p.5.

47. Grünewald F. & De Geoffroy V., "The dangers and inconsistencies of normative approaches to humanitarian aid, Summary of reflections raised", Groupe URD, 2000 and Orbinski J., "On the meaning of Sphere standards to States and other humanitarian actors", MSF, 17 April 2008.

NOTE /
Not all the important elements (equity, level of influence, legitimacy, reputation, freedom of expression, strengthening capacities, etc.) can always be easily measured; moreover, all those that can be measured are not necessarily important (number of dressings, number of training days, number of flyers distributed, etc.).

It is preferable to use indicators **which are part of the National Health Information System** (NHIS) to avoid duplicating the data gathered and to enable the indicators selected to be compared with national data. This also avoids creating parallel health-data collection systems and instead helps reinforce existing systems.

An indicator must be **objectively verifiable (OVI)**. This means that the information gathered must not depend on the opinion and prejudices of the data collector. In other words, two different people must collect the information needed to calculate an indicator and must arrive at the same conclusions. Comparing indicators calculated using different sources or different methods could lead to incorrect conclusions. Objective verification requires details of all the information needed to replicate the collection and calculation of the indicator:

→ The frequency of data collecting: **When** is the information needed to calculate the indicator collected?

→ The method of calculating the indicator: **How** are the indicator numerator and denominator calculated?

→ The sources of verification (data collection materials): **Where** is the information needed to calculate the indicator available?

→ The person or persons responsible

for collection and analysis:
Who is in charge of collecting
the information needed to calculate
the indicator and **Who** is in charge
of analysing the indicator?
→ Reasons for the collection:
Why is the indicator being calculated?
→ The person or persons to whom
the analysis is addressed:
For whom is the indicator calculated?

> **NOTE /**
> All information on the full range
> of project indicators is contained
> in the Monitool Indicator Summary.
> Only the indicator headings,
> baselines, targets and sources
> of verification are detailed
> in the project's logical framework.

Together, this information provides
a means of responding to the quality
criteria of other stakeholders,
often using the example of the **SMART**.
The SMART indicator is:
→ **Specific:**
It does not change unless what it is
measuring varies;
→ **Measurable:**
Its value can be determined in relation
to a benchmark;
→ **Attainable:**
The target one wants to achieve
is realistic (but note that it should
not be too comfortable either);
→ **Relevant:**
It is chosen in a way that is
appropriate to the problem posed;
→ **Time-bound:**
It is defined in terms of a given period.

An indicator with a well-defined heading
is specific and relevant. The baseline and the
targets combined with it make the indicator
measurable, attainable and time-bound.

3 / SOURCES OF VERIFICATION

It is essential to examine the sources
of verification (data collection materials) when
selecting the indicators. For each indicator
formulated, the **location and format**
of information available relating to the various
developments, changes, etc. being measured
should be identified and determined.

> **NOTE /**
> A proper balance therefore has to be
> found between what one is looking
> to measure and the availability
> of the data.

If there is no guarantee of providing
the indicator information (because,
for example, the project partner would
not be able to communicate the data
expected), it is better to reformulate it.
For example, data collected by filling
out written records cannot be used as
a basis when the majority of community
stakeholders are illiterate. In such
instances, another method of data
collection would have to be devised.

Sources of verification may be **internal**
to the project (reports, etc.) or **external**
(statistics, studies, etc.).

Internal sources of verification correspond
to **primary** data (collected directly
by teams in the field):
→ Direct observation;
→ Direct measuring (taking blood pressure,
temperature, etc.);
→ Focus groups and in-depth
individual interviews;
→ Population-based surveys using tools
such as questionnaires, etc.

External sources of verification are
secondary data (received second-hand
and collected by another body):
→ National statistics: NHIS/HIS, census;
→ National and international statistics
published by the United Nations
(for example Unicef Multiple Indicator
Cluster Survey (MICS), demographic
and health surveys (DHS)), surveys
published by NGOs, etc.;
→ Research by universities, institutes, etc.;
→ Routine health service data;
health service records, etc.;
→ Information issued by the media
(for example, local and national press).

It is important to diversify the sources of
verification and to have a balance between
external and internal verification (primary
and secondary data) for all the indicators
selected, giving preference, as has already
been seen, to indicators which are part
of the NHIS.

Examples of sources of verification:
→ Admission records, transfer records,
birth records, Prevention of Mother-to-
Child Transmission (PMTCT) records,
immunisation records, consultation
records and patient files;
→ Health centre stock lists;
→ Midwives' college diplomas,
Ministry of Health certificate;
→ MdM activity reports, minutes
and supervision reports;
→ KAP survey and population survey;
→ Observation during supervision;
→ Results of written tests following
training, etc.

GENERIC EXAMPLE
SOURCES OF VERIFICATION

**Number of instances emergency
contraception has been raised**

**in writing or orally with national
health authorities and partner
institutions**
Calculated based on MdM activity
reports, minutes of meetings
and meeting reports

**Number of healthcare facilities
supported by MdM offering
emergency contraception**
Calculated on the basis
of supervision reports

**Number of radio broadcasts
involving religious leaders
and conveying positive messages
about birth spacing**
Calculated on the basis of reports
supplied by radio stations

IN SUMMARY

KEY POINTS FOR DEFINING INDICATORS AND SOURCES OF VERIFICATION

→ **Identify the baseline** for each indicator;

→ **Identify the ideal frame of reference to attain** (does a given activity make it possible to work towards an objective/a result);

→ **Define the intermediate and final targets to attain** and specify attainment dates;

→ **Identify sources of verification** (data collection materials) and give preference, in so far as is possible, to existing sources of verification (NHIS/HIS, etc.).

2.3

RISKS
AND ASSUMPTIONS
AND PRECONDITIONS

RISKS AND ASSUMPTIONS

There's no risk of sunstroke here.

2.3A

RISKS AND ASSUMPTIONS

> These are external factors which may positively or negatively influence the success of a project and which are outside the direct control of the project manager. The risks and assumptions must be identified as part of the specific objective and the results.

These factors vary in type:
→ **Geographical** factors, security factors, etc.;
→ **Sociocultural** factors (acceptability of the project by a population, etc.);
→ **Institutional** factors (organisation of the health system, positive attitude of the authorities towards projects, etc.);
→ Etc.

**GENERIC EXAMPLE
RISKS AND ASSUMPTIONS**

The project team has defined several risks and assumptions in relation to the context and the risk analysis, which may play a part in attaining the project's objectives and results.

For example, the specific objective "To reduce the number of unwanted pregnancies in Saapland district by

increasing FP provision and demand for it over 3 years" can be attained if:
→ Political and social stability is maintained;
→ The free healthcare policy is maintained by the Ministry of Health and regional health authorities and continues to include FP services;
→ Security conditions in the region do not deteriorate and travelling is feasible.

2.3B

PRECONDITIONS

> Preconditions include all conditions which must be met for the project to start.

They may vary in type:
→ **Geographical:**
Populations must be accessible;
→ **Human:**
Human and material resources must be adequate to allow for activities to be carried out, skills must correspond to the projects being implemented, etc.;
→ **Legal:**
Record-keeping in the country, the signing of a MoU for example, must be carried out;
→ **Financial:**
Signing of a funding contract, agreement of the Executive Committee to launch the project with private donor funding, etc.

Maintaining satisfactory conditions for MdM staff, partners and service users does not come under the heading of preconditions but instead under risks and assumptions.

NOTE /
It is not always simple to distinguish between risks and assumptions and preconditions as these concepts occasionally deal with the same factor. For example, maintaining an agreement with the supervisory bodies may represent a precondition for the start of activities but may also be considered as a risk and assumption as it is also likely to influence the project's implementation.

GENERIC EXAMPLE
PRECONDITIONS

The project team has defined several preconditions relating to the context and risk analysis, which are prerequisites for the launch of the project:
→ An MoU is signed with the Ministry of Health,
→ Contraceptives are available at national level,
→ Religious leaders are ready and willing to engage in dialogue with MdM.

IN SUMMARY

KEY POINTS FOR DEFINING RISKS AND ASSUMPTIONS AND PRECONDITIONS

→ **Identify risks and assumptions**
underlying achievement of results and objectives;

→ **Identify preconditions**
which must be met to begin the project.

2.4

DEFINING
ACTIVITIES

HOW TO KEEP TO TIME

GANTT DIAGRAM

2.4A

ACTIVITIES

> The activities are the tasks which must be accomplished to attain the results envisaged. We are now at an **operational** level.

Project/support activities are operational tasks to accomplish to achieve the desired results. While project activities are directly linked to target populations, support activities correspond to "what goes on behind the scenes" to ensure the project is properly managed. These roles include coordinating, planning, team management, communication, administrative, financial, logistical or legal management, etc.
It is essential not to overlook them: the success of a project depends in large part on all these activities dovetailing properly.

Only the most important project activities are shown in the logical framework. The Gantt chart covers all activities, both project and support.

1 / FORMULATING ACTIVITIES

Activities are formulated using **action verbs in the infinitive.**

Detailed answers to the questions "How many", "How" and "For how long" must be provided when setting out the activities.

2 / STAGES FOR DEFINING ACTIVITIES

Defining the activities ties in with the intervention strategy established during the diagnostic phase. Some areas of intervention can be identified in advance on the basis of their added value, operational criteria, opportunities, constraints and preconditions. It is now a question of refining this analysis to specify the activities which will help attain the expected results and objectives.

Each expected result requires:
→ Identifying and setting out the activities planned (project and support);
→ Choosing from several possible options depending on feasibility, opportunities, constraints and risks;
→ Verifying the consistency of each activity:
  – **Within the project** (internal consistency): All the activities must enable the results to be achieved and all expected results must be realised by implementing the activities (vertical strategy);

– **Outside the project** (external consistency): Activities must complement and be consistent with those developed by other stakeholders.

Identifying (project and support) activities which may be envisaged must be based on a situation analysis.
The approach is the same as for the initial diagnosis. The following questions therefore need to be asked:
→ Which activities have already been undertaken? What has not yet been done?
→ Which points could be improved? Is it relevant to contribute to them and how?
→ Would it be better to carry out the activity in another location?
→ What activities may usefully be added to those already implemented?

The activities are chosen from among several possibilities in relation to several criteria:
→ **Operational criteria:**
Availability of human resources who are already trained or who could be trained; availability of funding sources; availability of material resources, logistics, legal framework, security and environmental risks, working conditions for staff, etc.
→ **Potential added value of each activity:**
Possibility of a constructive partnership, potential synergic relationship with other stakeholders, possible sustainability, participation in social change, possibility of documenting innovative practices, MdM's values and know-how, consistency with national/local health policy priorities, consistency with MdM priorities and strategies, social and cultural acceptability by the population concerned, etc.;
→ **Opportunities:**
Factors supporting implementation and pursuit of an activity and which may be used to leverage action;
→ **Constraints:**
Elements of the context which are unfavourable, which cannot be changed

in a time period *t*, which require "making do" or drawing up strategies to circumvent or adapt (e.g. Are there security constraints limiting staff mobility in certain areas?);
→ **Risks** to MdM staff, partners and service users associated with implementing certain activities (e.g. risk of being taken for a target, risk of being badly perceived, etc.).

The criterion of "simpler and cheaper" is important but it is not the only one to bear in mind. Attention should be paid to the fact that all the criteria cannot always apply simultaneously. For example, an activity which has social change or advocacy as its objective may run counter to national policy priorities, social and cultural acceptability or an acceptable level of risk.

The degree to which the activities are detailed makes it easier subsequently to appreciate which resources need to be mobilised and how much time is required to carry out the project.

Care should be taken not to overlook support activities needed by some project activities. The view of the support staff is therefore particularly valuable for avoiding certain mistakes and surprises at the project implementation stage. For example, an immunisation campaign does not just involve administering vaccines: this activity demands major logistical resources, such as cold chain, storage of vaccines, etc.

FOCUS ON
ADJUSTING ACTIVITIES

The activities are selected during the project programming phase but it is still usual to adjust these during the project implementation

phase. Activities may be modified, supplemented or stopped at the point the project is set up and once it is underway. These changes reflect the changing context, decisions taken following evaluations, etc., and are a necessary process of adapting to the field.

Activity reports give an account of these changes and the reasons for them. These reasons must be sufficiently clearly stated.

It is important that oversight reports mention the activities carried out, the strengths and the problems encountered. It is essential to detail, too, whether the preconditions identified actually exist, etc. Accurate reports represent an effective record of the project and ensure that lessons can be learned from actions already carried out and the quality of future projects improved.

2.4B

ACTIVITY SCHEDULE OR GANTT CHART

> The Gantt chart is a timetable for carrying out the activities, which offers a summary overview of the project over time. It is one of the most important project management tools.

It is used to:
→ **Organise and visualise all activities** over time (duration and/or frequency of activities);
→ **Prioritise timescales** (activities which can be undertaken at the same time and others which must be spread over time);
→ **Organise and visualise human and material resources** allocated to the activities and check whether these are adequate and consistent.

> **NOTE /**
> Support activities must also appear on the chart. The preparatory phase for setting up the activities (for example, establishing a logistics base) must not be overlooked.

This tool has numerous advantages. It makes it possible to:
→ **Be realistic** in sharing out and planning the work load (support activities);
→ **Have oversight** of the activities and measure progress achieved;
→ **Have a global perspective** to use as a basis for both internal (monthly review meetings) and external communication (oversight of the activities with project partners).

> **NOTE /**
> Beyond its primary function as a guidance tool, the Gantt chart is a communication and management tool, linking all members of project teams.

The level of detail in the Gantt chart depends on how it is intended to be used, who it is aimed at and the duration of the project. A very simple flow chart may be sufficient but will not be operational; too detailed a Gantt chart becomes unmanageable and is no longer of any value.

A good balance therefore needs to be struck. It is possible to have a global Gantt chart covering the whole of a project or an annual one to measure progress and a monthly schedule and/or a more detailed schedule per activity for the team.

The general Gantt chart:
→ Makes it possible to visualise activities for the whole project;
→ Is forwarded to the donor with the funding application.

The detailed Gantt chart (for internal use) **incorporates:**
→ Project activities;
→ Support activities (e.g. review of vehicles, reports to submit, procurement plan, etc.);
→ Leave, holidays (religious festivals and New Year), HQ meetings, changes in human resources, visits by desk staff / volunteer board delegate (RM) or others, rainy season, etc.

The detailed Gantt chart gives as extensive a breakdown as possible of each activity in order to predict as accurately as possible the resources needed to carry it out.

**FOCUS ON
DRAWING UP THE GANTT CHART [48]**

> **Stage 1:**
> → Draw up a list of project activities;
> → Provide a breakdown of activities.
>
> **Stage 2:**
> → Analyse activities to put in chronological order;
> → Determine which activities may be simultaneous;
> → Estimate the duration

of each activity and beginning and end dates;
→ Estimate frequency of activities which are not continuous.

Stage 3:
Construct the chart by putting:
→ **Along the X-axis:**
The time period governing the chart: for example, a Gantt chart can easily be drawn up every six months for the team's activities as a whole. For the period selected, important local festivals, periods of reduced activity (staff unavailable due to leave or training), etc. can be marked out per month;
→ **Along the Y-axis:**
The activities involved.

Stage 4:
Using the chart, determine whether the activities can be carried out within the initial timescale given. If this proves impossible, then:
→ Increase the number of resources to successfully complete the planned activities within the deadline initially set;
→ Spread the implementing and running of activities out over time.
In both cases, check in advance that the increase in resources or the implementation time does not involve too much additional cost.

A few simple rules can ensure the chart's legibility:
→ A different colour or symbol can be used for each person responsible for the activities;
→ To indicate visually what has been achieved, boxes may be blacked out, or marked with a different colour, etc.

48. Extract from "Manuel de planification des programmes de santé" [Handbook for Health Programme Planning], **MdM**, 2006.

GENERIC EXAMPLE
DEFINING ACTIVITIES

In the project to tackle unwanted pregnancies in Libertalia, an awareness-raising workshop was planned with religious leaders to develop arguments in favour of family planning which were in keeping with religious precepts.

This activity may be broken down in to several sub-activities:
→ Identifying the 20 religious leaders with links to communities in the district of Saapland;
→ Assessing the initial level of knowledge of leaders identified;
→ Preparing training content (defining learning objectives, defining and designing modules and creating teaching materials);
→ Organising training (planning, location, transport, catering, equipment, etc.);
→ Organising the workshop;
→ Evaluating the workshop.

On the general project chart, each activity is positioned as follows:

Activities	Person Resp.	04/14	05/14	06/14	07/14	08/14	09/14	10/14	11/14	12/14	01/15	02/15	03/15	04/15
Preparing an awareness-raising workshop for religious leaders on family planning issues	Head of base Head of IEC	■	■	■	■	■	■							
Organising an awareness-raising workshop for religious leaders on family planning issues	Head of IEC						■	■	■	■	■	■	■	■
Creating awareness-raising materials for Health Education activities	Head of IEC						■	■	■	■				

On the detailed chart, each activity is positioned as follows:

Activities	Resp.	04/14	05/14	06/14	07/14	08/14	09/14	10/14	11/14	12/14	01/15	02/15	03/15	04/15
Preparing an awareness-raising workshop for religious leaders on family planning issues	Head of base Head of IEC	■	■	■	■	■	■							
Identifying the 20 religious leaders with links to the communities in the district of Saapland	Head of base Head of IEC	□												
Assessing the initial level of knowledge of leaders identified	Head of base Head of IEC		□											
Defining learning objectives	Head of IEC			□										
Defining and designing modules	Head of IEC			□										
Creating teaching materials	Head of IEC				□									
Organising an awareness-raising workshop for religious leaders on family planning issues	Head of IEC						■	■	■	■	■	■	■	■
Organising the awareness-raising workshop	Head of IEC						□							
Holding the awareness-raising workshop	Head of IEC							□						
Evaluating the awareness-raising workshop	Head of IEC								□					
Creating awareness-raising materials for Health Education activities	Head of IEC						■	■	■	■				

The team studies the chart and decides to defer creating awareness-raising materials for Health Education activities. Between September and November 2014, the Head of IEC is already fully occupied organising and evaluating the awareness-raising workshop for religious leaders. The creation of Health Education materials is put back until 2015.

The Gantt chart may be adjusted throughout the period the project is being established. Where this happens, it is important to justify the changes made and to preserve the initial chart. Comparing the different Gantt charts is useful, too, during the monitoring and evaluation phases.

IN SUMMARY

KEY POINTS
FOR DEFINING THE ACTIVITIES

→ **Identifying the activities** (project and support) which respond to the objectives and expected results;

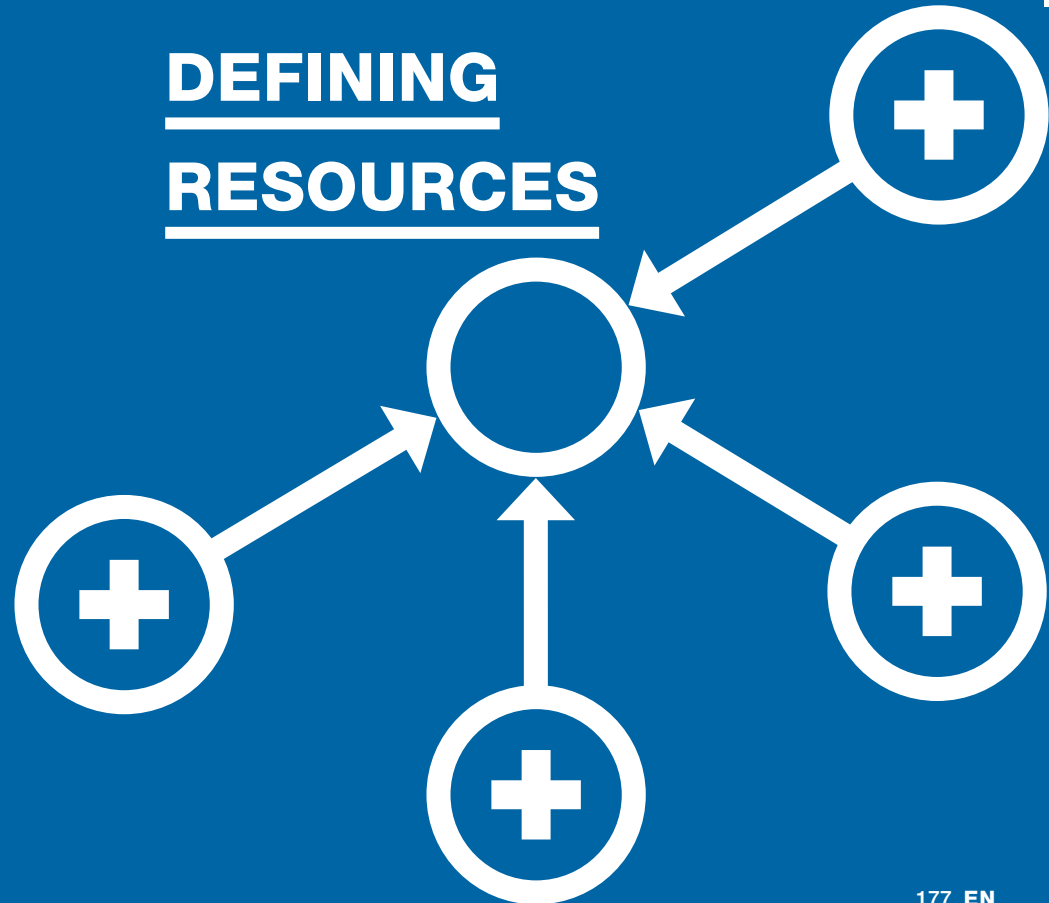→ **Choosing** from the different options and explaining those choices;

→ **Formulating** activities using action verbs in the infinitive;

→ Organising and visualising all project activities on a **Gantt chart;**

→ **Prioritising** timescales.

2.5

DEFINING

RESOURCES

DEFINING RESOURCES

2.5A

DEFINITION

> Resources are the "means mobilised in order to carry out a project". They are determined on the basis of the activities planned.
Budgeting for a project is **expressing in figures the value of the** (project and support) **activities planned in terms of the material and human resources** needed to implement them in a timely manner.

There are two major types of resources.
Human resources correspond to every individual, whether in-country national or foreign national, volunteer or paid staff, participating in a project. Only those human resources involving costs for MdM are included in the project budget: salaried staff (foreign and in-country nationals) and volunteers (foreign and in-country nationals) to whom an allowance is paid.

Material resources are all tangible assets – equipment, tools, buildings, drugs, etc. – needed to carry out a project.

Resources are currently classified into **7 separate categories** (MdM's budget format):
1. **International staff**
2. **National staff**
3. **Monitoring/evaluation:** Costs relating to monitoring/evaluation elements of a project (for example involving capitalisation, evaluation, auditing, etc.)
4. **Conferences and seminars:** Costs relating to organising or participating in conferences and seminars. It may also refer to training organised by HQ.
5. **Programmes:** Costs relating to project activities (for example, medical, training, health education, general expenses, etc.)
6. **Logistics and transport**
7. **Administrative and communication costs**

NOTE /
General budgeting for resources appears in the logical framework. The detailed budget appears in MdM's budget-building tool.

2.5B

STAGES FOR DETERMINING RESOURCES

> Drawing up a budget involves quantifying the financial resources needed to carry out the planned activities. The timely availability of material and human resources is crucial for implementing the project. Future needs therefore have to be identified in as much detail as possible.

Most importantly, this is team work which involves:
→ **The whole field team where there is one:** Coordination team (general coordinator, medical coordinator, logistics coordinator and administrative coordinator), project team (doctor(s), nurse(s), person in charge of community health, etc.) and support team (administrator and logistics officer);
→ **HQ:** Desk officer, desk assistant and finance officer.

1/ IDENTIFYING RESOURCES

During this stage, the **resources** are identified which will enable the planned project or support **activities** to be carried out. All the necessary resources must not only be listed but also described (quantity and nature) to make assessing their cost easier later on. Identifying the resources is team work: for example, the view of a logistics officer is essential to identify the material resources needed to carry out the activities.
For each activity identified in the logical framework and on the Gantt chart, it is necessary to:
→ Identify and set out the resources envisaged, ranking them in order of importance for carrying out the activities;
→ Choose from among the several options;
→ Estimate their cost;
→ Verify consistency of resources specified;
→ Summarise resources needed.

NOTE /
Although resources are identified activity by activity, throughout the exercise it is important to look at options for pooling resources with other activities and/or projects in the same geographical area in order to avoid endlessly duplicating them.

**GENERIC EXAMPLE
IDENTIFYING RESOURCES**

The head of IEC together with the logistics officer and administrator has identified the following resources for organising the awareness-raising workshop for religious leaders:
→ Human resources: 1 workshop facilitator (MdM staff),
→ Material resources: 1 room for 5 days, transport for participants (2 journeys per day for 5 days for participants and facilitator), catering for participants (1 lunch per person for 5 days), accommodation for participants (5 nights' dinner, bed and breakfast per person) and teaching materials.

2 / SELECTING RESOURCES

Several possible options may exist for each resource and these are selected on the basis of general and specific technical criteria, opportunities, constraints and preconditions.

The general selection criteria used may be:
→ **MdM's internal quality criteria and procedures:** policy relating to pharmaceutical product quality, procurement procedures, local or international purchasing, salary scale, etc.[49]
→ **Acceptability:** IEC material must be appropriate for the target populations; the catering organised for a training event must be suitable, drugs must bear an International Common Denomination (ICD) rather than a commercial trademark, etc.
→ **Feasibility:** Type of vehicle for reaching remote villages in the rainy season, size of room for training a given number of participants, etc.
→ **Availability:** Local or international purchasing and delivery deadlines.

The specific selection criteria may be:
→ **Value for money for a specified minimum quantity:** Licensed drugs, durability of equipment, etc.,
→ **Rent or invest:** Whether to rent or buy a vehicle will depend on the length of the project or on donor regulations, etc.,
→ **Using and promoting local resources:** Height gauges or examination tables would, in preference, be ordered from a local carpenter rather than procured internationally, etc.
→ **Sustainable development:** Waste management for example.
Constraints are aspects of the context which may lead to the exclusion of certain options: rainy season, distance between site of activities and MdM base, presence of component suppliers in the country, donor regulations, etc.

49. These documents are available on the MdM intranet.

Opportunities correspond to factors which support one choice over another: presence of an approved drug procurement centre in the country or region, the possibility of duty-free imports, the possibility of obtaining donations of equipment, collaboration with other partners, etc.

Lastly, **preconditions** are those which must, without fail, be met for one choice to be made over another: security, authorisation by the authorities, etc.

**GENERIC EXAMPLE
SELECTING RESOURCES**

To be able to run an awareness-raising workshop for religious leaders, the team needs a room.
There are some possible options:
→ Hiring a room
→ Setting aside a room in the MdM offices for awareness-raising/training

Given the volume of awareness-raising and traininwg activities in the project in Libertalia, the team, with the agreement of MdM support services, chooses to set aside a room on the MdM premises.

---

3 / ESTIMATING THE COST OF RESOURCES

Once the necessary resources have been identified and the whole team has carried out the necessary negotiations and adjustments, a sum must be allocated to each resource. It is important to take account of direct costs as well as the resource's inherent costs.

This stage is principally dealt with by the administrators, administrative coordinators and finance officers but the rest of the team may also be called on. For example, the view of the logistics officer is particularly relevant for all logistics, transport and communications expenses, notably for assessing the quality of the resources envisaged for the project.

The **MdM budget-building tool** is particularly useful at this stage to ensure nothing is omitted. It is also essential to refer to the reference document and procedures relating to each resource (procurement procedures, salary scales, daily allowances for training events, etc.).

Setting a budget for resources largely depends on the choices made. For example, the cost of transport varies depending on the option selected – to rent or purchase –, the type of vehicle chosen, etc. The amounts given must be justified and the budgetary choices explained. **All budgets must therefore be accompanied by a budget narrative,** as a record of the criteria applied.

4 / VERIFYING CONSISTENCY

The budget is a financial breakdown of the activities planned during the advance phases of project programming. At this stage, it is important to check the overall consistency of the various elements.

Comparing the Gantt chart and the budgeting tool ensures that the resources earmarked will enable the actions specified to be carried out.

By cross-checking activities and resources, the latter can be adjusted and their use **optimised.** The time periods allocated for each of the activities appear on the Gantt

chart. If a resource is mobilised for two different activities during the same period and is subsequently no longer used, it is preferable to delay implementing one of these activities. Where the activities envisaged demand too much in the way of resources, it is also feasible to look at reducing the activities while checking on the implications for the results.

2.5C

REFERENCE BUDGET AND ANNUAL REFERENCE BUDGET

> Once the resources have been defined, checked for consistency and their cost estimated, a reference budget and an annual reference budget are built.

1 / REFERENCE BUDGET

The budget is drawn up using MdM's **budget-building tool.** Each category of resources – international staff, national staff, monitoring and evaluation, conferences and seminars, programming, logistics and transport, administration and communication costs, as well as associated costs, are detailed per tab.

A summary tab provides the **reference budget for the project as a whole.** This budget is the basis for a breakdown of donor budgets according to predefined formats (some donors for example ask that budgets be categorised by results) and the periods involved.

The reference budget must be as complete and detailed as possible in order to facilitate donor fundraising, annual MdM budgets, etc.

When properly constructed, this budget maintains the project's overall consistency while facilitating the search for funding. Thus, for example, costs not covered by external funding are easily identifiable and specific budgets may thus be drawn up in relation to needs.
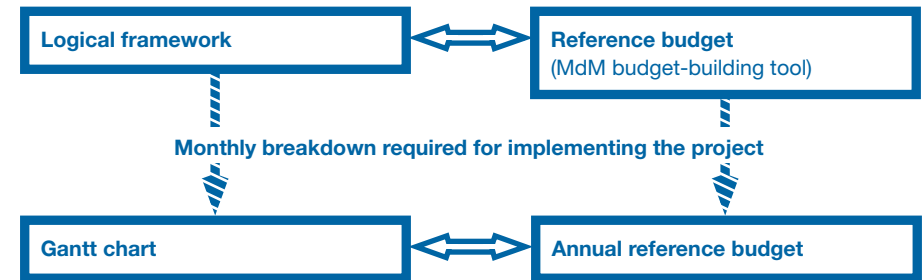
Once the budget is drawn up for the whole period of the project, a monthly breakdown must be produced to measure how it is being applied over time.

2 / ANNUAL REFERENCE BUDGET

The reference budget corresponds to the financial resources needed (over a period of between two and four years) to carry out the project as described in the reference document.

When creating the annual MdM budget, the reference budget is broken down by calendar year. This involves setting out the budget per year (annual reference budget) and per month (monthly budget).

The costs are posted according to how the planned activities are divided up over time (Gantt chart). As with the Gantt chart, the estimated budget must be particularly detailed for the first 12 months of the project. The following years are adjusted as the project activities are implemented.

| Logical framework | ⟷ | Reference budget (MdM budget-building tool) |

Monthly breakdown required for implementing the project

| Gantt chart | ⟷ | Annual reference budget |

3 / MDM BUDGETARY YEAR

The MdM budget is set for the calendar year. All projects are therefore requested to present their budgets for this time period, i.e. January to December.

Drawing up a **monthly** budget can therefore prove to be a great help if the reference budget for a project is not set according to the calendar year (e.g. in the case of a project which begins and/or finishes in April).

PROJECT Reference budget

| April 2014 | April 2015 | April 2016 | April 2017 | April 2018 |
| Year 1 | Year 2 | Year 3 | Year 4 |

MDM Budgetary year

| 2014 | 2015 | 2016 | 2017 | 2018 |
| Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
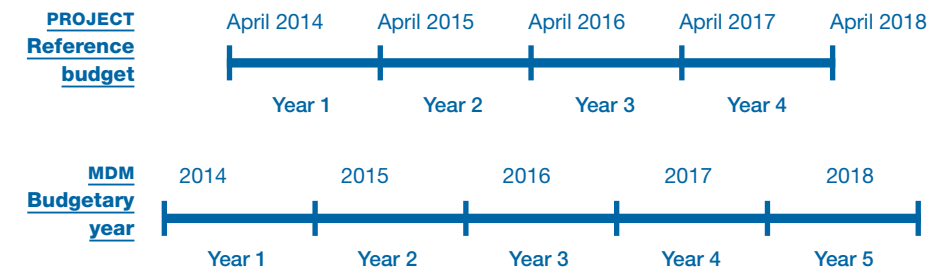
MAKING THE MOST OF LOCAL RESOURCES

It seems you find your way using forest fruits...

It's called a Blackberry you idiot.

MDM
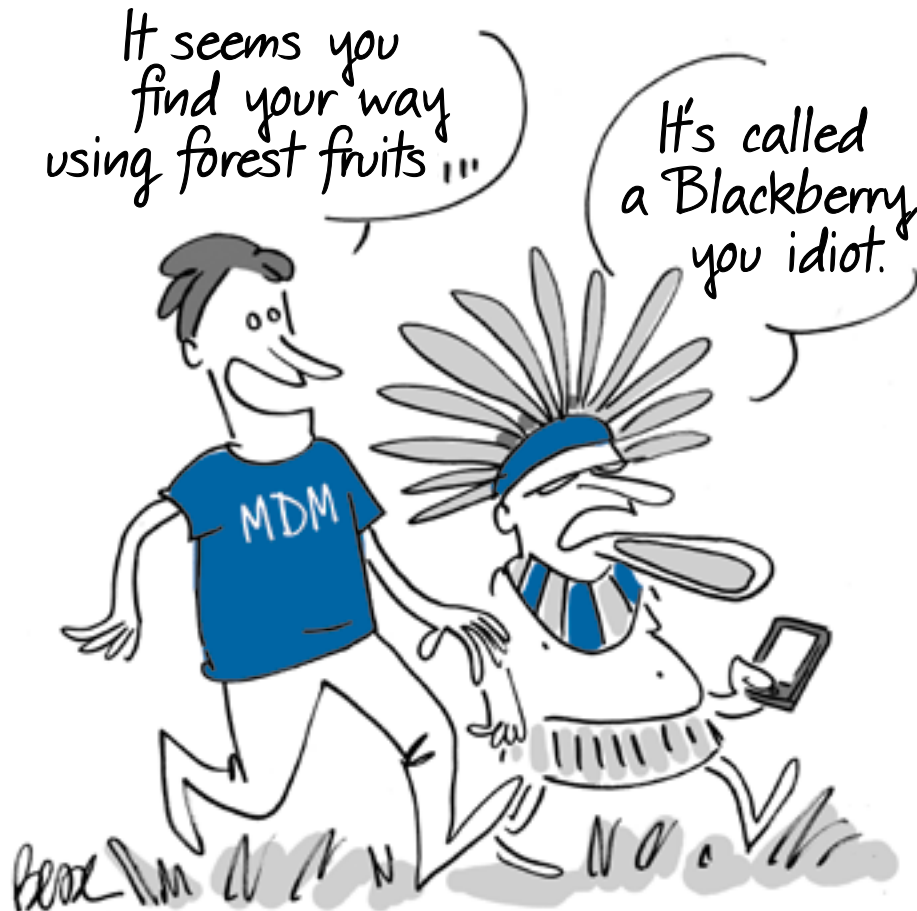
IN SUMMARY

KEY POINTS FOR DEFINING RESOURCES

→ **Identify resources** needed to carry out project and support activities;

→ Examine **possibility of pooling** resources;

→ Select from different options and **justify choices made;**

→ **Estimate costs** for each resource (direct and inherent costs);

→ **Draw up a reference budget** using the MdM budget-building tool;

→ **Each month draw up a budget based on the annual reference budget.**

Once the logical framework
has been drawn up and completed
in the order indicated, it is important
to check for consistency.

1 / Checking for vertical logic
→ Will the resources which can be
   mobilised enable the activities to be
   implemented if the preconditions
   are met?
→ Will the activities planned achieve
   the expected results if the risks and
   assumptions are complied with?
→ Are the expected results in reality
   those which will enable the project
   to attain the specific objective
   if the risks and assumptions are
   complied with?
→ Does the specific objective respond
   to the public health problem
   selected for a given population?
→ By achieving the specific objective
   set, what general objective will the
   project manage to attain?

2 / Checking for horizontal logic
→ Have the indicators and sources
   of verification been defined for each
   objective, result and activity?
→ Have the risks and assumptions
   been defined for every objective
   and result?
→ Have the preconditions
   been defined for the activities?

ANNEXES INCLUDED ON THE CD-ROM – PART 2 – PROJECT PROGRAMMING

– **Country strategy template**
– **Concept note template**
– **Reference document template**
– **Project presentation sheet template**
– **Project or strategy presentation in Executive Committee template**
– **Schedule/Gantt chart model**
– **Reference budget model and budget-building tool**
– **Budget narrative template**
– **Checklist for verifying proposals and reports**
– **Tracking grid for donor relations**
– **Financial plan model**
– **Monitool: Indicator Summary**
– **Partnership agreement template**

3!

PROJECT TRACKING/ MONITORING

PARTNERSHIP: CLARIFY RESPONSIBILITIES

It's OK!
I have the vaccines!

Don't you
have you
the needles?

MDM

APS

PROJECT TRACKING/MONITORING

> The programming is finished, the project has been approved by MdM's decision-making bodies and the funding required for activities to start has been secured: we are now at the project implementation phase.
This phase comprises two stages: **setting up** the project and defining a tracking/monitoring system; **implementing** the project, whether relating to the activities or to tracking/monitoring. Both processes feed into each other: at the project setting-up stage there is a corresponding parallel stage for defining the tracking/monitoring system. The process of implementing the project itself runs parallel with the process of implementing its **tracking/monitoring.**

SETTING UP
Project launch

IMPLEMENTATION

DEFINING the system of
TRACKING/MONITORING

TRACKING/
MONITORING
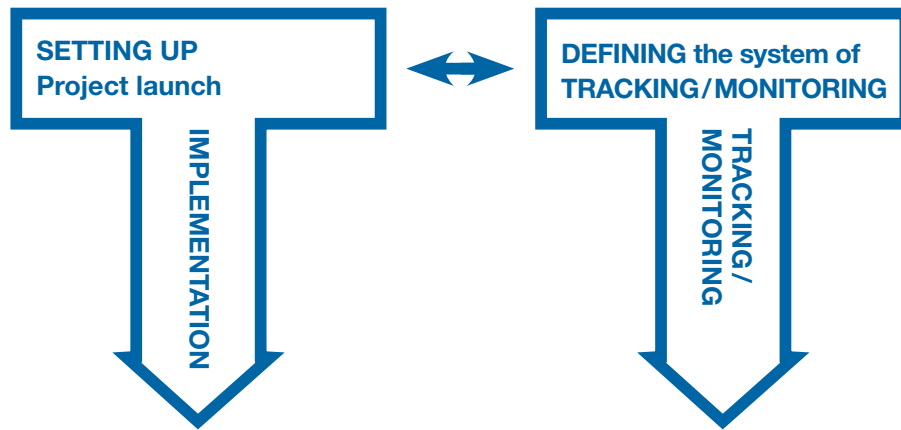
Setting up (launching) and implementing the project involve carrying out the project in an intervention context. The setting-up stage is crucial to the success of the project and relies on several elements:
→ Previous planning phases (diagnosis and programming);
→ MdM's institutional know-how;
→ The individual know-how of each of the members of the team managing the project.

This chapter begins by describing the major issues relating to setting up and implementing a project but does not dwell on these, as the object here is not to cover all the issues a project may face on a daily basis. These issues largely depend on the intervention context, the theme of the project, the obstacles encountered, etc.

This chapter therefore essentially focuses on the concepts and techniques of tracking/monitoring which are indispensable for keeping the project on track while it is being set up and implemented. Having clarified the tracking/monitoring concepts and definitions, particular attention is then paid to the monitoring system, to setting it up and to the different areas for its use. Monitoring must lead to decision-making.

3.1
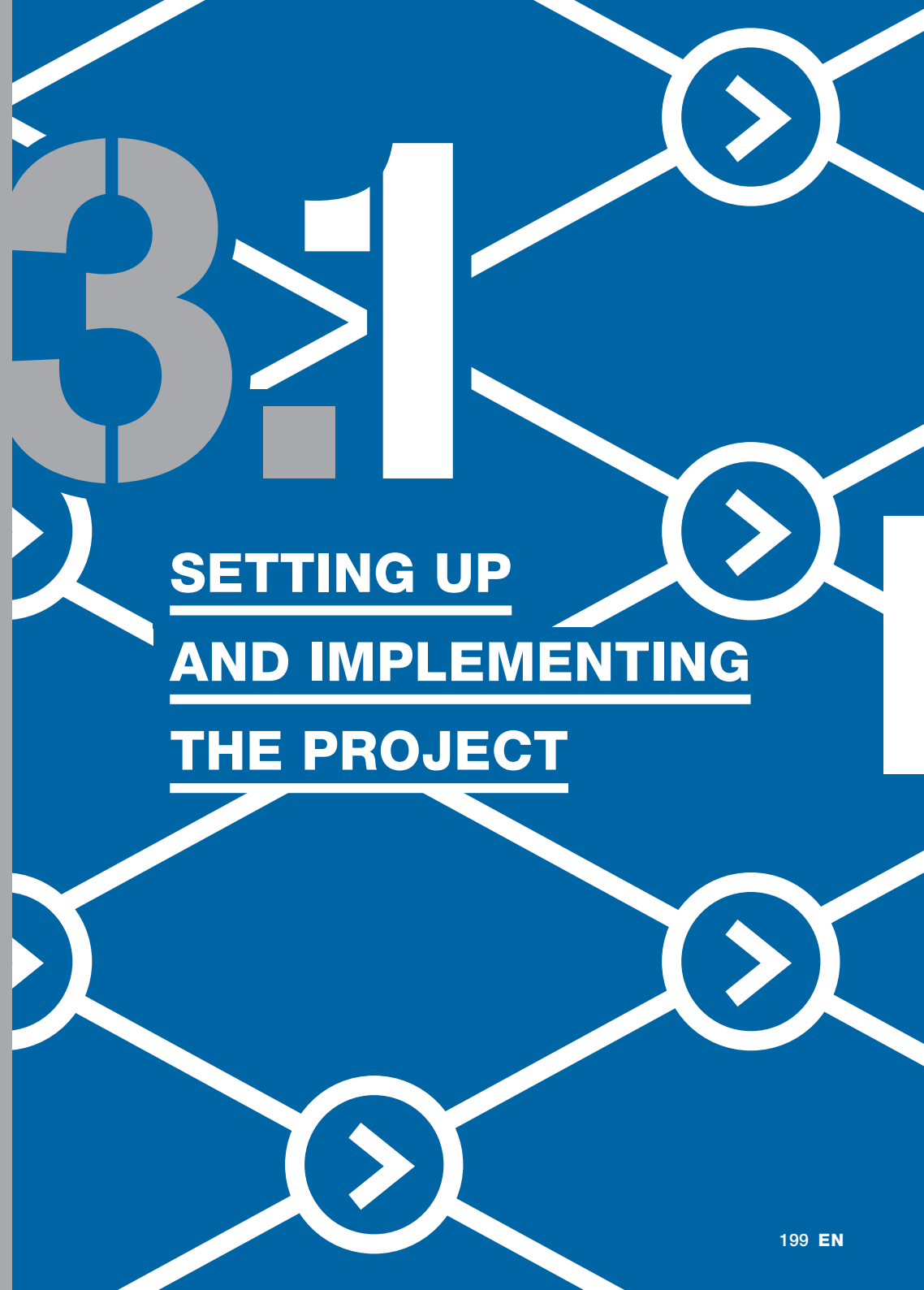
SETTING UP AND IMPLEMENTING THE PROJECT

ESTABLISH A CLIMATE OF TRUST

3.1A

SETTING UP THE PROJECT

> In theory, setting up begins once the project programming is finished. In practice, the start of the project is often postponed due to funding delays, recruitment difficulties or problems with obtaining permissions, for example. In an emergency situation, the opposite applies and setting up the project may begin at virtually the same time as the programming.

NOTE/
In the Handbook for Health Programme Planning, the setting up of a project was defined as "implementing a project, that is to say, integrating it into a given organisational context".
Today, the terms "adequacy" and "adaptation" are used by MdM to reflect the idea of embedding a project in a given context.
For MdM, the use of the term "setting up" refers to the launch phase of a project.

The successful setting up or launching of a project relies on ensuring the project's **adequacy in relation to its context.**

The need to make adjustments goes beyond focusing on the technical aspects of the project activities.

1. On the one hand, the nature of an intervention is not the only element associated with its **effectiveness:** the environment in which an intervention take place is an essential factor to consider too when explaining the outcomes observed. There is a direct correlation between the degree to which a project is established and the quality of that process and the project's effectiveness.

2. On the other hand, the need to adjust a project to its context is a key factor in an approach designed to ensure an intervention is **sustainable.** By systematically analysing the risks facing staff, users and partners, we can ensure not only their security but the robustness of the intervention.

3. Lastly, implementing activities and making the necessary contextual adjustments are processes which must be documented, especially where there is the intention to **replicate** an effective project in another context. This is particularly relevant for innovative projects and action research.

> **NOTE/**
> Setting up the project is an activity which is not described in the logical framework but which prepares the way for introducing the activities. It is an important stage which must be scrupulously carried out as it significantly influences a project's success.

The launch of the project is the point at which we gradually begin to introduce the activities and to mobilise our intervention capacities. This is a key moment: setting off on the right foot contributes to a project's success, while poor choices can damage MdM's credibility with the various stakeholders.

There are several important points to consider during the setting-up phase:

1 / UPDATING PROJECT INFOR- MATION AND REFINING PROJECT PROGRAMMING

Apart from in emergency situations, the point the activities start may be several weeks or months after the fact-finding mission or diagnostic phase. It is therefore necessary to return to the elements gathered during this phase (contextual factors, analysis of stakeholders, opportunities and constraints, etc.) and to adjust them according to any changes observed. The information contained in the **reference document must be updated.** In potentially rapidly evolving emergency situations, analysis needs to be conducted on an ongoing basis.

The situation may have become more favourable (developing possible new alliances, means of transport facilitating access to care, availability of skilled staff, etc.) or less favourable (ministry of health adopting a new position, a coup d'état, security risks preventing travel, epidemic, etc.).

It is during this phase, therefore, that the risk analysis grid must be methodically completed using information contained in the reference document, information which was reviewed and re-analysed when the project was set up.

The project planning may then be refined by:
→ Finalising the Gantt chart (adding details of the activities);
→ Finalising the budget and verifying the adequacy of the resources;
→ Finalising the Monitool[50] which must be completed before the project is launched;
→ Finalising the reference document;
→ Putting in place the risk analysis grid and reliable sources of information.

2 / ESTABLISHING A CLIMATE OF TRUST AND MOBILISING SUPPORT FOR THE PROJECT

A period of several months may be required in advance of the start of the project to establish a climate of trust and to enter into a dialogue with the different interlocutors and stakeholders. The project launch affords a special opportunity for mobilising the field team, forging links with the stakeholders identified as potential allies, identifying new stakeholders, creating contacts with undecided parties and reviewing the position of stakeholders who were not in favour of the project.

Mobilising team members around common goals is essential for a shared vision of the project and its objectives. This may also provide a time for the team to share expectations and fears, as well as for avoiding any lack of understanding or frustration. In a partnership approach, clarify the roles and responsibilities of each party from the outset. This is crucial for avoiding any misapprehension, conflict or frustration. Unlike a subcontracting relationship where it is a matter of "getting things done" by others, a partnership presupposes a collaborative relationship in which all the players find themselves on an equal footing with the others. The setting-up phase is, in this respect, essential for building a relationship of trust between partners.

In a community approach, the project launch is the point at which links are forged on a day-to-day basis between stakeholders, interests at stake are negotiated and consensus emerges. Remember that it is difficult to ask individuals to participate in a project if they have not been in a position to contribute to its devising.

At this stage, we need to ask what the populations' main objectives and motives are for getting involved in implementing and tracking the project. We must also find out who will do what and how the responsibilities will be divided out among the stakeholders. Care must be taken not to overload individuals and to ensure that the project will not affect their capacities and their other commitments within the community or their personal life. "Foreign" forms of organisation cannot be imposed without running the risk of poor ownership and a failure to embed the actions properly. Lastly, attention must be paid to managing the project's resources. Community stakeholders may come under severe pressure from their immediate circle to use these resources for purposes other than those defined by the project. Much thought should therefore be given to resource management and responsibilities. These factors may in fact increase the exposure and insecurity of community stakeholders.[51] This last point must be incorporated into the risk analysis grid.

3 / COMMUNICAT- ING ABOUT THE PROJECT

Communication takes place firstly **within the team** supporting the interventions. Once again, the emphasis is on clarifying the goals pursued: defining everyone's roles and responsibilities, identifying adjustments made during setting-up, etc.

50. The Monitool contains all the indicators linked to a project's outputs and outcomes and this is developed in the pages to follow.

51. For more information, see the handbook entitled "Working with Communities", **MdM**, 2012 available on the MdM website in French, English and Spanish.

During the setting-up phase, it is equally crucial to communicate about the project and the planned activities **with the different stakeholders** (central government, local health authorities, other international and local NGOs, United Nations agencies, etc.). Good communication avoids misunderstandings and – if the situation allows – increases the project's visibility. The project must not only be known but also understood. A project which is understood has more chance of being accepted and therefore of attaining its objectives.

FOCUS ON
THE ACCEPTANCE APPROACH:
A SECURITY PERSPECTIVE AND STRATEGY[52]

How humanitarian organisations and their staff are perceived by the communities in which they intervene is a major security factor. Professionals sometimes assume that communities know what a humanitarian organisation, its work and its mission are. They also think that once the organisation has been presented and introduced to communities, access to populations, participation, approval, goodwill and protection are a given, simply by the nature and virtue of their actions. And yet the concept of humanitarian aid, although it might seem obvious, is not a universal one and is far from being familiar to all. Furthermore, as current affairs regularly show, in some regions of the world this aid or its representatives are not welcome and, in certain situations, they are even the direct targets of violence. The reasons for these attacks are often external to the organisations themselves. Most of the time the problem lies in the fact they

are categorised alongside government politicians, armed forces, specific population groups, etc. It is therefore vital to be well perceived by the population in order for an organisation to attain an acceptable level of security. For a large number of organisations, "acceptance" now commonly refers to the perceived best strategic approach in terms of security. The aim of an acceptance approach is to "reduce or remove threats by increasing the acceptance (the political and social consent) of an agency's presence and its work in a particular context[53]". It is essential, however, to be aware that this is an active process which involves establishing and constantly maintaining the agreement of all stakeholders. This requires social and political skills in the field of interpersonal relationships and communication. There must be an ability to develop key messages relating to the mission, objectives and project. These key messages must be known and understood by all staff. And of course the action must comply with the way it has been presented. This acceptance strategy eliminates or reduces a proportion of the threat. Moreover, a comprehensive range of risks must be examined for protection and deterrence measures to be introduced where necessary. Only sound prior analysis of the risks (and stakeholders) can allow the optimum and appropriate combination of acceptance, protection and deterrence strategies to be put in place.

53. Humanitarian Practice Network, "Good Practice Review. Operational security management in violent environments", Number 8 (New Edition), HPN at the Overseas Development Institute, London, 2010.

52. MdM, "Working with Communities", 2012.

4 / PUTTING SUPPORT ACTIVITIES IN PLACE

This stage corresponds to carrying out so-called "support" activities which will enable the different facets of the project – which are extremely diverse in nature – to be implemented:

→ **Obtaining permissions:** registering expatriates, Memorandum of Understanding (MoU), licences relating to specific items of equipment such as VHF radio, etc. The MoU is an essential element to put in place from the start of the project in order to establish each partner's role and responsibilities *(see chapter on programming)*.
→ **Locating business premises** and accommodation, and setting up and equipping these.
→ **Recruiting** medical, logistics and administrative staff (drawing up job profiles, interviewing, etc.) and training MdM staff.
→ Hiring vehicles, purchasing equipment, etc.
→ Ordering drugs or consumables (nationally or internationally).

At this stage, a certain number of specific tools are available on the Médecins du Monde intranet (administrative and logistical procedures, risk analysis grid, security factsheets, etc.). Although the support activities do not appear in the logical framework, they must be incorporated into the detailed Gantt chart and described in the reference document.

UPDATE YOUR DATA

According to my information, this is where the Plains of the Lame Bison start...

3.13

IMPLEMENTING THE PROJECT

> A successfully established project brings together all the various elements for implementing it effectively. Its implementation involves developing the different activities defined in the logical framework by mobilising the human, material and financial resources available within the deadlines given (Gantt chart). Particular attention needs to be paid to the support activities which facilitate the task of carrying out the different activities.

The decision has been taken in this guide not to develop the implementation stage - which is specific to each project - but instead to concentrate on the principles and stages of tracking/monitoring *(see next section)*. These ensure the smooth implementation of a project and enable the activities to be adjusted where necessary.

SUMMARY

KEY POINTS FOR SETTING UP AND IMPLEMENTING THE PROJECT

→ **Setting up** a project is the stage at which its adequacy in relation to its context is established. This is an essential stage for ensuring any project is implemented in a secure and sustainable manner.

→ **Setting up** a project provides an opportunity to refine the programming, establish a climate of trust, mobilise in support of and communicate about the project and put in place the support activities required to launch the project.

→ **Implementing** a project involves developing the activities planned in line with the deadlines given and the resources available.

3.2

TRACKING: CONCEPTS AND DEFINITIONS
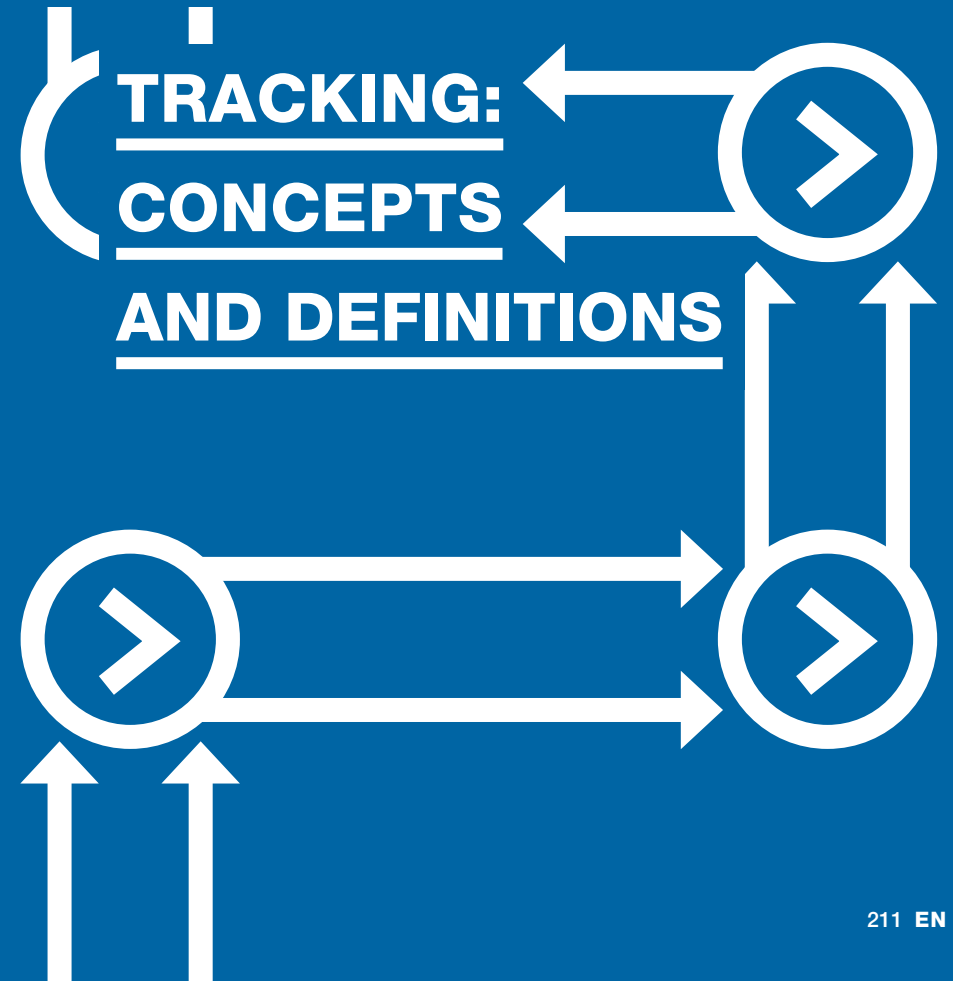
DON'T DROWN IN DATA

TRACKING : CONCEPTS AND DEFINITIONS

> Once the process of setting up the project has been finalised and it is underway, continuous tracking is required to maintain and adjust its course. The tracking, ideally planned as from the programming phase, is again refined during the setting-up and implementing of the project, ensuring the system is effective and appropriate. Not only does tracking allow the project to be analysed and adjusted at precise moments but it also feeds into the communication and advocacy activities.

3.2A

DEFINITIONS

1 / DATA, INFORMATION AND KNOWLEDGE

Data is defined by the Oxford English Dictionary as "Related items of (chiefly numerical) information considered collectively, typically obtained by scientific work and used for reference, analysis or calculation".[54] A piece of data is therefore a raw element which is not interpreted or contextualised. As such, data can be difficult to interpret.

Once rendered intelligible, data becomes information. **Information** is therefore data which has been interpreted and contextualised in relation to other data.

NOTE /
From "data" to "information":
"10° Celsius" is a piece of data which in itself has no precise significance. For it to become information, it must be combined with other data: place, date, etc. "On 01/01/13, it was 10° Celsius in Paris" is a piece of information.

Knowledge represents that which is known, a body of learning, of "science". It is also the capacity to present oneself, a way of perceiving external reality. Knowledge is formed from available and accessible information.

2 / DATABASE

A **database** is a collection of data systematically organised to facilitate access to and analysis of it. Whatever the means used to store the data – paper, computerised system, etc.[55] – the fact that the verified data has been organised and structured is what characterises a database. Databases are most often computerised.

3 / INFORMATION SYSTEM VERSUS TRACKING SYSTEM

These two systems need to be distinguished.
→ An **information system** is an organised system of (human, material, etc.)

resources destined to collect, structure, process, analyse and distribute information. For example, the Médecins du Monde intranet is an information system but not a tracking system.
→ A **tracking system** is an information system devoted to observing a project in all its forms (observing the situation, activities, resources, outputs and outcomes) and is aimed at helping **decision-making.** It is not intended for amassing information "just in case" or "just to know" but in order "to take action".

4 / TRACKING AND MONITORING

Broadly speaking, the concept of tracking/monitoring refers to permanent and continuous surveillance of a situation, individual, process, etc. Transposed to the context of health projects, it refers to the **systematic and continuous examination** of the situation and its evolution: contextual factors, notably risks to staff, beneficiaries and partners as well as to the viability of the project and to stakeholders. It concerns the various dimensions of the project:
→ Activities (including support activities);
→ Resources (financial, human and logistical);
→ Outputs and outcomes (health and services produced).

In the literature and in practice, the terms "tracking" and "monitoring" are used interchangeably. However, in the context of this guide, distinguishing between these two terms is considered essential:
→ Project **tracking** relies on a coherent group of elements ranging from data-collection tools (registers, patient records, etc.), activity reports, visit reports and field support documentation, minutes

of meetings, epidemiological surveillance, etc. to the analysis undertaken and the decision-making resulting from it.
→ **Monitoring** is a central element of tracking. It is based on indicators defined in advance and measures the **progress** and **evolution** of the project towards the expected **outputs** and **outcomes.** The Monitool is an essential tool in the MdM monitoring system.

The tracking system as a whole, therefore, ensures that project implementation is progressing as planned and continues to be adequate for the context. For example, it observes the smooth-running of activities, the maintenance of satisfactory security conditions for MdM staff, partners and users, the identification of new opportunities for action, etc.

When a disparity is observed between the project and its context, the project must be **adjusted** in terms of its objectives, activities, resources, security procedures, etc.

All these elements are meaningful too for analysing the monitoring system indicators and for facilitating decision-making.

TRACKING
Based on a coherent information system

MONITORING
Based on predetermined indicators

---

54. OED online, Oxford University Press, February 2014.

55. Paper databases: all patient records, consultation register, training register, etc.
Digitised databases:
Excel spreadsheets, Access databases, etc.
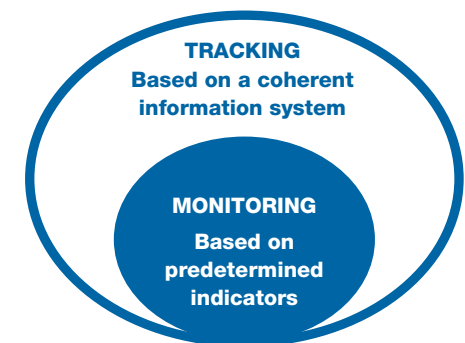
3.2B

OBJECTIVES OF TRACKING

> The main problem is **to sift out which information** we really need and not simply to accumulate as much information as possible.

The information must always respond to a specific question and its intended use must always be borne in mind to avoid wasting time. By examining how the information is going to be used, it is possible **to anticipate the time needed** to collect and analyse the data required for a project to proceed.

A tracking system responds to a wide variety of project management concerns and needs by:
→ Reflecting a situation at a given moment;
→ Observing developments in the local situation;
→ Reassessing the risks to project staff, users and partners;
→ Comparing different groups at a time t (different health centres, different communities, etc.);
→ Measuring changes over time for the same group;
→ Making comparisons with a reference value (norm, standard, etc.) or a target;
→ Documenting the extent to which the activities have been implemented and the resources deployed (cf. activity reports addressed at teams, donors and partners);

→ Identifying problems and alerting staff to these;
→ Helping with everyday decision-making and defining strategies;
→ Adjusting the project;
→ Providing material for advocacy planned by the project;
→ Helping identify operational research needs;
→ Preparing an evaluation, etc.

These different points provide a **"snapshot"** and analysis **of the project at a given moment t.** It is thus possible to ascertain:
→ How the project is developing in relation to the evolving situation;
→ The extent to which the activities have been carried out;
→ The quantity of resources used;
→ The project's outputs and outcomes.

This "snapshot" also subsequently enables the project **to be managed and adjusted** and the different stakeholders to be provided with the elements needed for communication or for developing an advocacy message.

3.2C

TRACKING SYSTEM CHARACTERISTICS

1/ TRACKING THE CONTEXT

As has been mentioned above, tracking may involve several facets of a project, particularly context, resources, activities and outputs/outcomes.

Tracking the context ensures that the project is adequate in terms of its environment and that it minimises the risks taken by MdM staff, partners and users. It also makes it possible to grasp opportunities and to anticipate constraints relating to the project's objectives. For example, health policy developments must be tracked or a risk analysis carried out regularly. This tracking is also particularly important for advocacy action.

Tracking contextual factors

When reviewing the context, it is the **changes** in relation to the initial situation occurring throughout the term of the project which are of interest. This process also provides documentation for grey areas

in the initial diagnosis (more detailed knowledge of the social organisation, cultural aspects, etc.).

Tracking therefore involves reviewing the groups of contextual factors *(see chapter on Diagnosis)* and identifying the elements among them which relate to the project being implemented and which are to be regularly examined. It is not enough when tracking the project to repeat what is already known: instead it means detailing more accurately how different aspects of the situation are **evolving** or improving **understanding** of these.

The object is also to analyse the context, highlighting new constraints or opportunities for the project.

The contextual elements must be regularly reviewed and updated in relation to the changes observed. Significant changes must be described in the **monthly coordination reports.**

TRACKING SOCIOCULTURAL DETERMINANTS

Local stakeholders' participation and consideration of sociocultural elements both in the method of tracking and of interpreting the data are fundamental to the relevance and running of the project. In measuring how the activities and results of a project are progressing and evolving, this systematic and continuous scrutiny must also identify any drift and adjust the activities accordingly. The attention paid to the social and cultural aspects must enable the practices of humanitarian stakeholders and, consequently, the expectations of donors to be modified in order to adhere more closely to the reality experienced by the populations and to their aspirations. […]
For a project to succeed, it is essential to describe accurately and in detail all the elements, particularly the sociocultural ones, which have contributed to its implementation in order to pinpoint levers and barriers and to identify what is specific to the local situation.

REGULAR RISK ANALYSIS

The evolving social and political situation must be analysed for the risks which might arise for the project or individuals. For example, political upheaval such as a coup d'état could destabilise healthcare facilities, unleash a crime wave, make access to care more difficult for a section

of the population, etc. By monitoring the situation in which a project is set, events can be anticipated and operational methods adapted to suit the consequences.

A good information network, regular reporting, a wide and diverse network of interlocutors, a review of local and national press, systematic monitoring of incidents and an updated risk analysis grid provide an accurate picture of the situation and the risks which staff, users and partners might face.

Particular attention is paid to observing stakeholders *(see below)*, notably in analysing the capacity/willingness to cause harm of certain groups or individuals, with scant interest in the project and considerable influence on decision-making.

Tracking stakeholders

For tracking stakeholders, it is useful to refer once more to the matrix drawn up during the analysis phase *(see chapter on Diagnosis).*

This tool is extremely valuable. As well as analysing the dynamics existing at the time of the diagnosis, it allows these to be monitored and strategies to be adopted so that the situation develops more positively for the projects concerned.

In an ideal situation, it is important that stakeholders,
→ With a considerable interest in and favourable opinion of the project, have a strong influence and carry significant weight;
→ Showing little interest and even a negative opinion, have a weak influence.
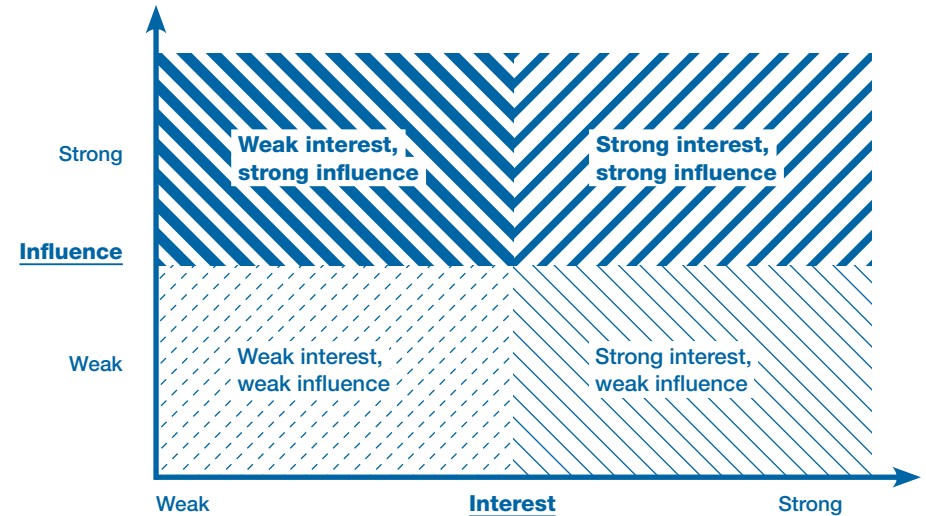
At the time of programming, **one of the objectives set may be to modify existing dynamics,** in which case it must be formally incorporated into the logical framework presented in the reference document and must be combined with the actions needed to attain it.

For example, particular attention must be paid to the stakeholders who have no interest in and even a negative opinion (divergent or contradictory strategy) of an MdM intervention and who have the potential to influence (positively or negatively) the carrying out of our actions (case A). It is possible for an intervention to fail due to such stakeholders. Meetings and awareness-raising or advocacy activities can therefore be planned to explain the project and to find ways of improving the image these stakeholders have of our interventions. Ideally, all stakeholders should be in favour of the project (case C).

If this is not possible, their power to influence must be reduced or "neutralised" (case B), so that their unfavourable opinion does not pose a risk to the project. In all instances,

the potential risk posed by these stakeholders should be analysed and, if their "intent to harm" cannot in any way be modified, ways should be examined to at least lessen the impact.

An effort must also be made to maintain the considerable interest of influential stakeholders (case C). One poorly conveyed message or a decision taken unilaterally by us could affect the trust certain partners have in our actions, and thus even their support.

Few actions are required regarding stakeholders with little interest and influence (case B), but it is essential to ensure throughout the tracking process that the influence they do exert remains minimal.

While it is always pleasant and satisfying to work with stakeholders who have a considerable interest in our projects, even if their influence is only minimal (case D), it is equally important not to devote too much energy and resources to this work. These stakeholders are often our traditional allies and show great enthusiasm for our projects. Their mobilisation is therefore

important but must not be achieved at the expense of negotiations or dialogue with stakeholders who have a significant positive (case B) or negative (case A) influence.

Regularly updating this table reveals whether:
→ The status of certain stakeholders has changed,
→ New stakeholders have appeared (as is commonly the case in emergency situations),
→ Our actions have produced the results expected,
→ These potential changes represent a positive or negative development for our actions.

Tracking community participation

As has been previously emphasised, community participation is a concept which underpins all of MdM's actions. Once the intervention strategy has been defined, it is therefore important to further refine the diagnostic information relating to community participation.
The tools for measuring the degree of participation should subsequently be put in place. These tools are updated throughout the project implementation/tracking phase.
5 main strands of community participation are selected and explored:

MEASURING COMMUNITY PARTICIPATION RELATING TO HEALTH

The 5 areas	NIL = 1	POOR = 2	MODERATE = 3	GOOD = 4	EXCELLENT = 5
Assessing needs	An assessment of health needs is imposed from outside and from a professional and medical perspective.	The medical point of view prevails, combined with an "educational" approach. The community is beginning to express its needs. These are examined by health professionals.	Health needs are assessed by the local health chief who actively represents the views of the community.	Health needs are assessed by the health committee which actively represents the views of the community.	The community is directly involved in assessing health needs.
Leadership	Leadership in health is provided by health professionals without community participation.	The health committee is not functioning, but the local health chief works independently of interests groups.	The health committee functions under the direction of an independent local health chief.	The health committee is active and takes the initiative.	The health committee represents the full, diverse range of interests within the community and supervises the activities of the local health chief.
Organisation	There is no health committee made up of community representatives.	There is a health committee imposed by the health services but it is a nominal or inactive one.	There is a relatively active health committee.	The health committee actively collaborates with other community organisations.	Existing community organisations are involved in electing members of the health committee.
Mobilising resources	Resources are mobilised by health professionals via health authorities' operational budgets.	Resources are mobilised by health professionals via health authorities' operational budgets and some occasional contributions from the community. The health committee does not decide how the sums raised are used. Neither the community nor the health committee has any control over expenditure.	The community, via the health committee, takes part in periodic and equitable fundraising. The health committee takes part in decision-making concerning the use of the sums raised. Neither the community nor the health committee has any control over expenditure.	The community, via the health committee, takes part in periodic and equitable fundraising, in decision-making concerning the use of the sums raised and in controlling expenditure.	The health committee ensures that funds are regularly and actively mobilised. It consults the community regarding allocating funds. It is transparent regarding funds collected (regular information meetings). It rigorously controls expenditure.
Management	The health services are managed by the health authorities. The local leader of the health services is supervised solely by health professionals.	The local leader of the health services manages provision independently with some health committee involvement. The leader is supervised solely by health professionals.	The health committee is self-managing but does not supervise the local leader of the health services.	The health committee is self-managing and is involved in supervising the local leader of the health services.	The health committee is responsible for the local leader of the health services and actively supervises this individual.

EXAMPLE OF TRACKING THE LEVEL OF COMMUNITY PARTICIPATION (RIFKIN SCALE)
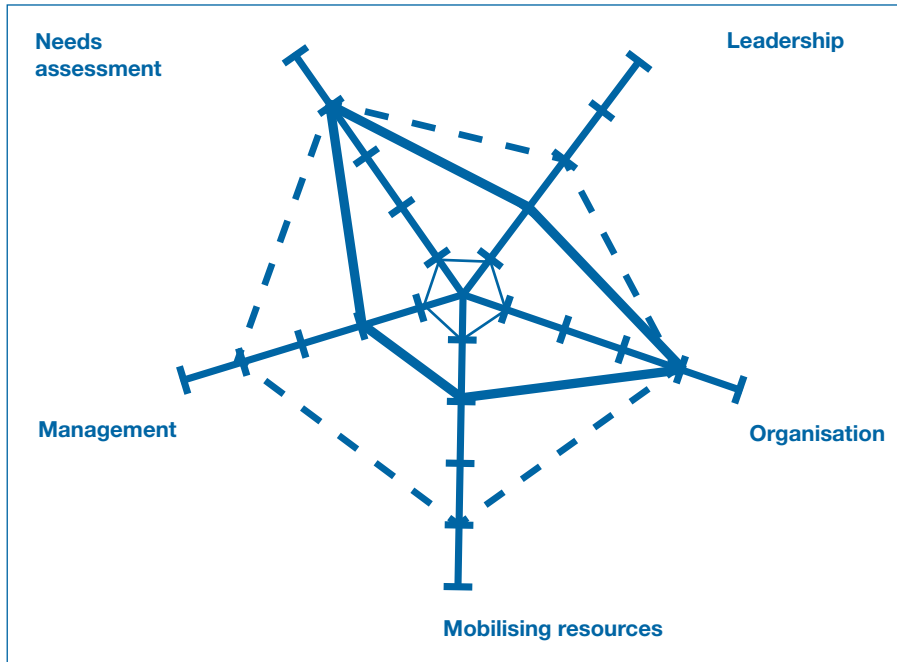
→ **Leadership:**
initiative taken by the community;
→ **Organisation:** participation in project planning and in actions;
→ **Mobilising resources:** decision-making, contribution made by users, types of resources (human, material, financial);
→ **Management (of the project):** Making decisions and carrying them out;
→ **Needs assessment.**
These strands are then presented in a so-called **"spider diagram"**[56], a measuring tool developed by Susan Rifkin[57]. Each strand on the scale comprises 5 levels which are themselves defined in the table above.

56. This diagram is presented in greater detail in the annex included in the CD-Rom.
57. **Rifkin SB**. "Primary Health Care: on measuring participation". Soc Sci Med 1988 ; 26(9): 931-940.

In this example, the first, **thin solid-line polygon is the baseline** and every aspect of community participation is weak.

After one year of the project's activities **(thick solid-line polygon),** the "organisation" and "needs assessment" strands of community participation have been increased. Certain health workers and community leaders have become involved in promoting the Minimum Service Package (MSP) and defining the health education themes. They have also taken part in health education planning sessions with health professionals. These same community health workers have become involved in assessing needs and the adequacy of the MSP. The health committee's participation has remained moderate.

This stage reveals which strands have shown good progress and which have hardly developed. The reasons why some have not progressed (delays in implementation, activities inadequate in relation to the context, etc.) must be sought and adjustments made in order to consolidate those areas where progress has been least.

By the **end of the project (dashed-line polygon),** all the strands have been strengthened and there is a good level of community participation, with the exception of "leadership" which will need further support, given that the ultimate aim is for MdM to withdraw and the activities to be sustainable.

2 / TRACKING ACTIVITIES

Tracking activities refers to observing the tasks and actions implemented as part of the project. The status of the activities is regularly checked to ensure it corresponds to what was predicted and explanations are given as to why certain activities are ahead or behind schedule.

Tracking activities over time

The Gantt chart is the most useful tool on which to rely for tracking activities over time *(see chapter on Programming)*. Certain questions need to be asked such as:
→ Are the activities being implemented in accordance with the Gantt chart?
→ Have certain activities not been put in place? If so, why?
→ Have new, unscheduled activities been put in place? If so, why?
→ Is the quality of the activities satisfactory?
→ Etc.

Extreme vigilance is required here and it is important not to neglect the tracking

of "support" activities, as they may have a significant influence on implementing "project" activities. For example, a longer-than-planned recruitment process can leadto significant delays in carrying out the project activities. Similarly, a failure to allow realistic deadlines for obtaining permissions from the administrative authorities can prevent a project activity being implemented.

NOTE /
Do not forget to quantify the time needed for team management in the support activities!

The Gantt chart is modified to show the extent to which the activities and the planned adjustments have been carried out. In doing so, it is important to justify the modifications made and to retain the initial Gantt chart. Comparing the different charts can be useful in subsequent monitoring or evaluation. It may also facilitate the programming phase of future projects.

Tracking activities in terms of resources consumed

Tracking activities must also take account of the resources consumed. It is necessary to establish whether the activities have been carried out using the resources planned for the purpose.

It may, for example, be worthwhile asking the following questions:
→ Have certain activities consumed more or fewer resources than planned? If so, why?
→ Is the overconsumption of resources having an impact on other activities?
→ Etc.

For this, it is essential to rely on rigorous resource tracking.

3 / TRACKING RESOURCES

Tracking the financial, human and material resources generally involves examining the following:

→ **The introduction and use of tools and procedures** for managing / tracking resources: Gantt chart, tracking (individual and team) human resources, budget follow-up, management and tracking of supplies, inventoried items and equipment, etc.
Have the tools and procedures allowed for been put in place? Are they being used? If yes, are they satisfactory? If no, why not?

→ The **quality** and **quantity** of the resources deployed over a period and their suitability for the "project" and/or "support" activities.

Tracking administration

The object is to track the organisation's recording procedures, tax exemption procedures, procedures for signing partnership approvals or agreements (Memorandum of Understanding), requests for visas and work permits, rental contracts and their renewal, etc.

Tracking human resources

At all times it is important to know precisely when employment contracts begin and end so as to be able to anticipate requests to extend a contract or to recruit staff and to avoid having periods when human resources are lacking, which could result in certain activities being suspended.

This type of administrative tracking must be accompanied by a review of:

→ The project's organisation chart (to verify that the distribution of tasks and responsibilities within the team is still appropriate);

→ The content of job specifications (to verify that job descriptions and profiles still match needs, or whether they need to be modified);

→ The training needs of different members of the team to increase skills or promote internal mobility;

→ Whether there is a good understanding of employment law (to know the different types of contracts and their conditions for renewal or otherwise); etc.

Tracking finance

Comparing the **annual reference budget** with the **actual budget** (expenditure recorded in the accounts) provides an overview of how the project is progressing financially. The proportion of the budget used at a specific date t is, for example, an important indicator for project management.

Thus, midway through the project, one might reasonably expect half the budget to have been spent. However, knowledge of the project must also be brought to bear in refining this analysis: large investments (vehicle purchase, payment of 12 months' rent in advance, procuring drugs for several months, etc.) may have been made at the start of the project and therefore the proportion of budget used at the midway point will be greater than 50%.

Budget follow-up is also aimed at assessing the disparities between what was forecast (budget) and what was actually realised (accounts), and at explaining these in relation to the context and implementation of activities. When disparities are observed, they must be analysed and explained in a narrative as part of the monthly coordination report.

Tracking must also focus on the **financial plan,** the object being:

→ To verify that contractual arrangements have been correctly anticipated (reporting in particular);

→ To diagnose, in a timely manner, potential failures to anticipate requirements, which could prevent important payment dates being identified and consequently prevent additional financial opportunities (for example, calls for proposals) being exploited.

Tracking logistics

Tracking logistics comprises three areas:
→ Tracking procurement (orders, purchases, transport etc.);
→ Tracking inventoried items;
→ Tracking equipment.

In the same way that potential gaps in human resources that could lead to certain activities being suspended must be anticipated, it is essential to ensure that adequate logistical resources are always available by setting up rigorous monitoring of stocks and supplies. This also avoids stockouts and excess stockpiling which could lead to losses (e.g. supplies of date-expired drugs) or overspend relating to overstocking.

Certain tools exist for organising this tracking[58] but what is especially required is a sound knowledge of needs and procurement procedures and this demands the involvement of administrators and logistics providers.

Moreover, it is currently obligatory within MdM to track equipment (vehicle fleets, communication and IT equipment, etc.). The aim is to obtain a complete and accurate "snapshot" of equipment within a project to ensure, for example, its maintenance and to secure

specific documentation for certain equipment (radio licences, insurance certificates, etc.).

4 / TRACKING OUTPUTS AND OUTCOMES USING THE MONITORING SYSTEM

The rest of the chapter deals with tracking outputs and outcomes.

58. Tools for tracking supplies and equipment are available on the Médecins du Monde intranet.

IN SUMMARY

KEY POINTS FOR THE TRACKING SYSTEM

→ **The objectives of the tracking system** are:
- To ensure the adequacy of a project in relation to its context;
- To know the extent to which a project has progressed at a given moment *t* (activities, resources, outputs and outcomes);
- To manage and adjust a project;
- To provide the elements required for communication or putting together an advocacy action.

→ **Tracking the context** corresponds to reviewing:
- Contextual factors (importance of factors linked to the health system, to sociocultural determinants and to risks for MdM staff, partners and users);
- Stakeholders;
- Community participation.

→ **Tracking the activities** is done over time (Gantt chart) and by taking account of the resources consumed (tracking resources).

→ **Tracking the resources** corresponds to reviewing:
- **Administrative resources:** Permissions, contracts, etc.;
- **Human resources:** Recruitment, training, employment law, etc;
- **Financial resources:** annual reference budget and actual budget, financial plan;
- **Logistical resources:** Supplies, inventoried items and equipment.

→ **Tracking outputs and outcomes** is done using a monitoring system.

→ **The tracking system is put in place when the project is set up and continues to operate while** the project is being implemented.

It requires **regular exchanges** within the project team on the one hand and between the project team and other stakeholders on the other; it must be **documented in writing** (minutes of team meetings, monthly coordination reports, etc.).

→ Reporting thus enables different tracking information to be **centralised** and enables **valuable knowledge for decision-making** to be drawn from this.

3.3

STAGES IN DRAWING UP AND USING A MONITORING SYSTEM
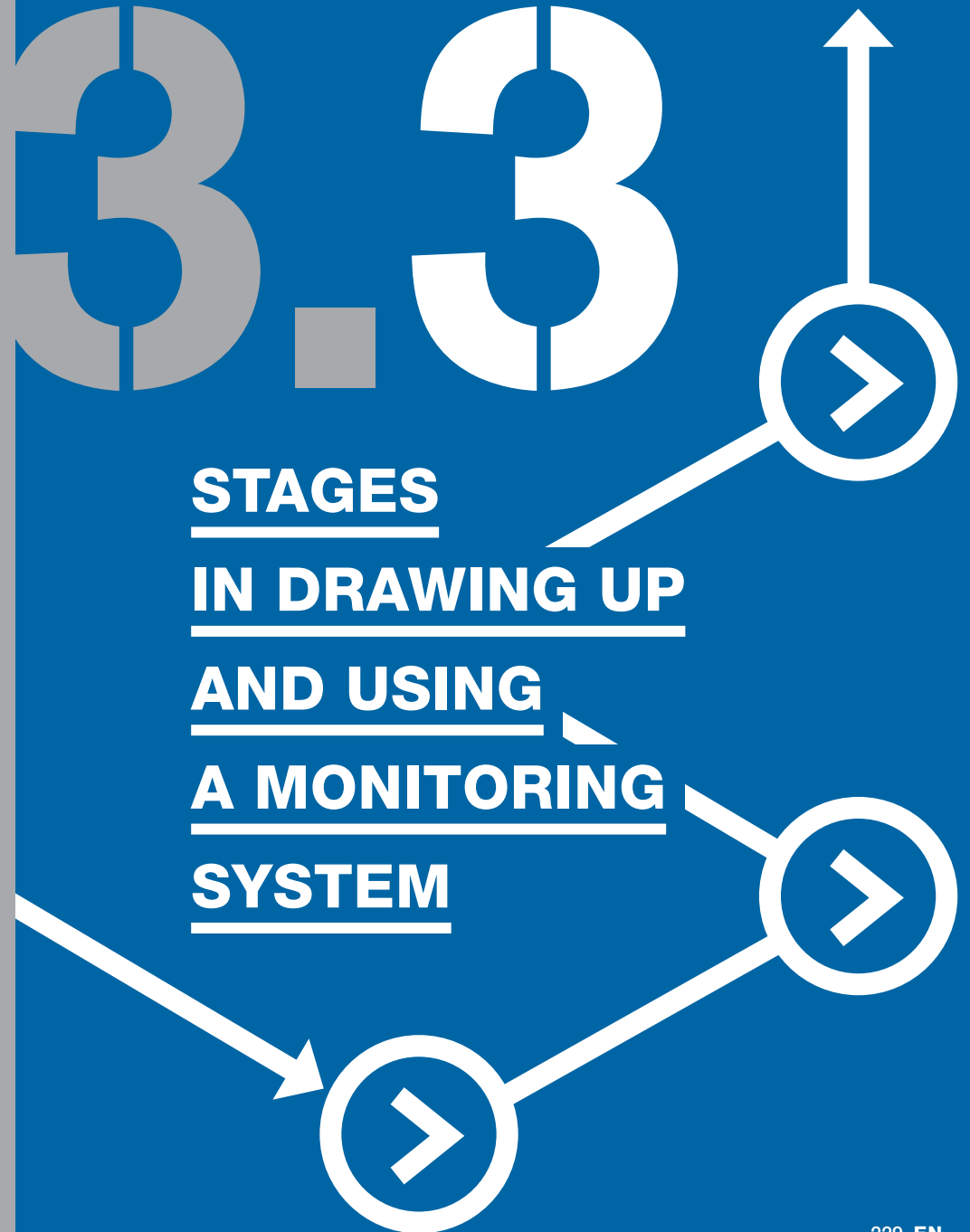
STAGES IN DRAWING UP AND USING A MONITORING SYSTEM

> As with the other components of the tracking system, the monitoring system must be planned as from the programming phase; it is then refined during the phases to set up and implement the project. It monitors progress towards the objectives and expected results and allows any necessary adjustments to be made.

3.3A
CLARIFYING ITS OBJECTIVES

> The main objective of the monitoring system is to **track the outputs and outcomes of the project.** The fact of knowing whether the project is progressing towards realising its objectives and achieving its results enables action to be taken to correct any possible drift.

NOTE /
A database for providing patient follow-up care does not constitute a monitoring system as such. For this to be the case, it would have to contribute to calculating the indicators chosen to monitor the project's outputs and outcomes and to taking action accordingly.

Building and deploying a monitoring system is the responsibility of an individual identified in advance (general, medical or programme coordinator or monitoring officer), but all those involved in managing the project must play a part in drawing it up and using it.

During the programming phase, a certain number of indicators are selected to track the project's progress towards its objectives and results. When the project is set up, each project reference indicator must be reviewed to check for relevance and feasibility and to accurately determine the monitoring system which will be put in place.

3.3B
DRAWING UP THE MONITORING SYSTEM (REFLECTED IN THE MONITOOL)

1/ SELECTING A LIMITED NUMBER OF THE MOST RELEVANT INDICATORS

The first question to ask is: What is it we want to measure?

Achieving a result or an objective may be measured in numerous ways. It is therefore important on the one hand to be quite clear about what we are seeking to show through the collection of data and, on the other, to choose from among the numerous alternative indicators.

Knowing what we want to measure enables the correct measuring tool to be chosen.

To take a very simple example, if we wanted to measure temperature, the appropriate tool would be a thermometer. It would be absurd to use a stethoscope, blood-pressure monitor or scales.

If no thermometer is available, another means of measuring temperature must be found, for example how a person feels, signs of perspiring, electricity consumption for heating or air-conditioning, etc. But the absence of a thermometer does not in any way justify the use of other, inappropriate measuring tools. The same reasoning applies to indicators: not everything measures the same thing.

Indicators are chosen depending on:
→ Availability of data – at national, regional and local level, from partners / institutions and internally – and the feasibility of collecting it;
→ What other stakeholders use (for comparability);
→ The complexity of the data and how it is understood by the different interlocutors.

Which data is available?

The majority of MdM projects are aimed at **supporting and strengthening health systems.** Consequently, MdM prefers, in so far as is possible, to use **existing information processes and systems** within healthcare facilities, partner organisations and institutions, even when they are incomplete or of average quality. This offers several advantages:
→ Creating parallel data-collection systems can be avoided and, instead, existing systems can be strengthened and thereby made more sustainable;
→ Identifying the verification source can be made easier (elements in an already existing data-collection toolkit), as can the collecting itself;
→ Comparisons can be drawn with data held nationally, regionally, etc.

> **NOTE /**
> The National Health Information System (NHIS) is therefore the point of departure for defining an appropriate monitoring system.

In emergency situations where the NHIS is not usually functioning, we refer to the Early Warning Surveillance and Response in Emergencies (EWARN) system which is a standardised and simplified system of data collection focusing on communicable diseases and set up in health facilities during the emergency phase.

The S2AP indicator catalogues[59]
are extremely useful for providing definitions of indicators, the method of calculation

59. These catalogues currently exist on the subject of Sexual and Reproductive Health, the Management Cycle of Pharmaceutical Products and Basic Health Care.

and how they can be used to take decisions. Featuring a "comments" column, which gives important information on the relevance of this or that indicator, these catalogues notably provide a means to:
→ Supplement the NHIS indicators to assist with selection;
→ Fill any gaps in the NHIS.

Where projects include specific themes (e.g. mental health) or where we are looking to measure phenomena which are not directly concerned with health (e.g. advocacy, respect for human rights, etc.), it is also possible to refer to existing literature, studies or similar experiments conducted by other organisations or within MdM's international network in order to identify relevant indicators.

FOCUS ON
VERIFICATION REQUIRED
BEFORE CHOOSING AN INDICATOR

> When an indicator is chosen to measure a phenomenon, it is important to verify on the one hand that it correctly measures the phenomenon concerned (Does this indicator actually enable me to measure what I want to know?), and on the other hand that the data required to calculate it is available.
>
> Establishing whether the information required to calculate the indicator is available avoids choosing indicators which are impossible to collect or which would demand excessive resources and energy for the analysis required of them. In the case of innovative projects, it may be worthwhile developing specific databases to provide information about as yet little-known phenomena.

> But usually, it is entirely possible and desirable to make do with what already exists. On the one hand, this provides an opportunity to strengthen the health information systems (NHIS/HIS) in partner organisations/institutions and, on the other hand, to free up time and resources for the analysis.

Quelques questions à se poser pour interroger la disponibilité des données:
→ What information is available to us?
→ What data collection does this involve?
→ If the information is not available, how can the data be obtained?
→ Which instruments or elements of a data-collection toolkit, if any, need to be created?

Which indicators are used by other organisations, projects, etc.?

Looking for possible comparisons involves identifying standard indicators used by others.

FOCUS ON
WHY USE STANDARD INDICATORS?

> "The use of standard indicators provides us with valuable measures of the same indicator in different populations, permitting triangulation of findings and allowing regional or local inconsistencies and differences to be noted and addressed. This helps to direct resources to regions or sub-populations with greater needs

and to identify areas for intensification or reduction of effort at the national level, ultimately improving the overall effectiveness of the national response. The use of standard indicators also ensures comparability of information across countries and over time. In designing their own evaluation activities, projects should also bear in mind the national standard for indicators in that field. Projects may have their own information needs that conform to a rigorous evaluation design. However, whenever possible they should choose indicators with standard references, e.g. reference periods, numerators, denominators collected consistently over various time periods that would allow the data they collect to be fed easily into the national M&E system, and compared over time[60]."

Several sources of data must be examined by the project team for a choice to be made from among the different options:
→ **Indicators from the National Health Information System** (NHIS/HIS);
→ **International indicators** (international statistics, Sphere indicators, etc.);
→ **Cross-wise thematic indicators** determined for MdM's priority themes (currently Harm Reduction and Sexual and Reproductive Health);
→ **Lists of indicators** sometimes imposed by donors, consortiums, etc.

60. WHO, UNAIDS, UNICEF, the World Bank, USAID, CDC, the Global Fund to Fight AIDS, "Tuberculosis and Malaria, Monitoring and Evaluation Toolkit", HIV/AIDS, Tuberculosis and Malaria, 2004.

Which indicators can be read and understood by our interlocutors?

"Meaningful information" will not necessarily always be the same thing and will depend on the interlocutor. Who the information is destined for is therefore a factor to take into account when choosing the indicators for the monitoring system.

For example, when reporting on the effect of free attended childbirth on health service use, the ministry of health may be particularly sensitive to changes in the rate of attended childbirth or the number of maternal deaths. Politicians may be fairly indifferent to these figures and prefer financial measurements which show that free attended childbirth does not result in overspend by the health system overall (fewer patients delaying seeking medical care).

The following questions may help guide thinking:
→ How are we going to analyse the indicators collected?
→ Who are we going to share the information with, internally and externally?
→ What type of information are those it is aimed at most sensitive to?

NOTE /
It is important to limit the number of indicators ultimately selected:
→ Providing data for an indicator usually requires information to be included for several variables (increasing the data-collection workload);
→ Any indicator selected must be analysed periodically (weekly in

the first months of an emergency then monthly, quarterly or annually). Data is not provided for an indicator simply "to know" but in order "to act".

GENERIC EXAMPLE
SETTING UP THE MONITORING SYSTEM

Funding has been secured for the project to tackle unwanted pregnancies in Libertalia. The Médecins du Monde project team now has to put a monitoring system in place based on the existing logical framework.

For monitoring result 3

"National protocols for (FP) services, including access to emergency contraception, are established and circulated within 2 years" – two indicators have been chosen:
1. Number of instances the issue of emergency contraception is raised in writing or orally with national health authorities and partner institutions;
2. Number of health facilities in the district offering emergency contraception.

The project is to run for three years and MdM hopes to achieve the advocacy objective at the end of two years. The choice of these two indicators therefore enables the outputs and outcomes of the advocacy activities to be monitored throughout the project. The first enables the advocacy activity itself to be monitored to know whether the goal set is being attained (inclusion of Emergency Contraception on the list of essential drugs).

The second reveals the outcomes of a successful advocacy action to make emergency contraception available in healthcare facilities supported by MdM.

The data for calculating these indicators is available, as the first is calculated on the basis of MdM activity reports, minutes and reports of meetings and the second is based on supervision visit reports. Moreover, while these indicators enable the outputs and outcomes of advocacy activities to be monitored, they also provide an opportunity to convey the message about the availability of Emergency Contraception to health centres, the district health management team, the partner organisation AMPF and community leaders.

For monitoring result 5

Within 3 years, religious leaders in the 10 communities of Saapland district are made aware of the importance of family planning and encourage the use of FP services" – the chosen indicator is: the number of radio broadcasts involving religious leaders and conveying positive messages on birth spacing.

This indicator accurately measures the outcomes of activities undertaken with religious leaders, as it provides information about messages promoting birth spacing broadcast via community radio stations. It relies on data available in radio station written reports. The community radio stations agree to forward these reports on a quarterly basis to local project partner AMPF.

2 / DEFINING THE BASIS OF THE SYSTEM

"What", "How", "Where", "How much", "When", "Who by", "Why", "Who for", etc. are questions which, when systematically examined, make it possible to select the most relevant indicators for which data can feasibly be gathered. They also clarify the methods for collecting, analysing and sharing the data, and precisely determine who is responsible for doing what. Defining and explaining roles and responsibilities are tasks which must be done as a team.

This **systematic questioning** is expressed as an Indicator Summary which serves as a basis for team discussion and represents the first stage in drawing up the Monitool.

The information contained in the Indicator Summary is also essential for **ensuring the continuity of the data collection.** For two different individuals to be able to collect and analyse the same indicator, it is important to specify the frequency of the data collection ("when"), the method of data collection ("how"), the sources of data collection ("where"), the person responsible for data collection ("who by"), the reasons for data collection ("why") and who the analysis is aimed at ("who for").

FOCUS ON
WHAT IS THE MONITOOL?

The **Monitool** is a standardised, computerised tool and is, for MdM, the sole monitoring tool which comprises all indicators for monitoring a project's outputs and outcomes (even when derived from different

donor logical frameworks).
The Monitool and the logical framework are dynamic, complementary documents which evolve in parallel.
The Monitool includes:
→ **The Indicator Summary** which brings together the indicators and explains **when the data must be collected and analysed** and also **how, Where, who by, why and who for.**
→ **The monitoring plan** (table + graphs) which gathers together the data collected to facilitate its analysis.
→ Occasionally, formats for compiling the data (e.g. one tab per intervention site).

The paragraphs below explain each of the columns in the Indicator Summary.

What (heading)

This is the indicator heading.
The indicators are given as a gross value or a percentage. They may be grouped together depending on which objectives or results can be monitored using them.

For the reasons referred to above (comparability), it is useful to know whether the indicators correspond to:
→ Those indicators which are internationally determined as essential for monitoring a theme, for example the Millennium Development Goals (MDGs) or the Sustainable Development Goals (SDGs).
→ Those national indicators with data provided by a country's NHIS and routinely monitored by the country's health system and which facilitate national health policymaking.

How
(calculating the indicator)

Details should be given of the method of calculating the indicator. If it is a ratio between two numbers (for example, percentage of FP consultations given in line with national standards, or mortality ratio), it is important to know what is included in the numerator and in the denominator in particular. The terms used should also be clearly explained, especially if they can have differing interpretations (e.g. quality consultation, supervision visit, etc.).

Explaining the calculation method in detail is an essential stage: the NHIS and international calculation methods occasionally differ; moreover, this ensures continuity in the calculation methods, even where there are staff changes within the team.

Lastly, clearly defining the way in which the indicators are calculated facilitates the data collection since it makes known exactly which information is being sought.

FOCUS ON
POPULATION-BASED VS. SERVICE-BASED

Particular attention should be paid to the reference populations of the indicators, that is to say the populations on which the indicators have been calculated, especially those for the denominator when the calculation involves a ratio. These populations may be:
→ **Either based on total target population;**
→ **Or based on service-users.**

Indicators calculated on population-based data provide information on the health (including service coverage) of the target population,

whether or not the latter has used the health services. To calculate these indicators requires access to data concerning the whole of the population and notably access to reliable demographic data for the denominator. This is sometimes difficult in low- and middle-income countries and estimates of varying degrees of accuracy have to be used. Where these estimates are wrong, it is sometimes possible to find service coverage ratios in excess of 100%, which cannot be analysed except by studying trends.

The problem of obtaining reliable demographic data results in indicators being calculated on the basis of service users. This is a sub-group of the target population with specific characteristics, notably that of having access to these services. These indicators provide important information concerning the functioning and quality of the services but give biased information when it comes to evaluating the health status of the target population as a whole. The principal disadvantage of data derived from health services is the selection bias of the population using these services. A varying proportion of the target population does not use the services and often those people who do are, logically, those who have the least difficulty accessing care. Thus, the selection bias "favours" those who are the least remote, etc.

Example of maternal mortality:
→ Calculated on the basis of the general population, it provides information about the health of mothers as a whole group;

→ Calculated on the basis of health centre data, "institutional" maternal mortality principally reflects care of pregnant women and childbirth in these centres.

Where
(sources of verification)

To identify the sources of verification (elements of the data-collection toolkit), it is absolutely essential to be as precise as possible: on which form can the information be found? Here again, the importance of not duplicating the NHIS and/or creating parallel systems needs to be stressed *(see chapter on Programming).*

Where records, monitoring sheets and a computerised data-collection toolkit do not exist, they must be created, if necessary with partners, in so far as is possible before the activities are launched or, at the latest, right at the beginning. The elements of this toolkit must be carefully structured beforehand and must not be modified too often otherwise the information will not be comparable over time. This is even more necessary in situations where there is a high staff turnover and where each new arrival tends to want to bring his/her own individual touch to the data-collection toolkit.

How much
(baseline and target)

The baseline corresponds to the initial value of the indicator. The target is the value fixed as the objective to attain in a given time. An indicator may be combined with one or more intermediate or final targets.

The way a baseline and target(s) are determined must be adapted in line with the

existing situation in the area of intervention and with what the MdM intervention realistically hopes to achieve *(see chapter on programming)*.

When
(frequency of data collection)

This involves establishing the pace at which the data is collected. All indicators do not vary in the same way; therefore the frequency of the data collection must not automatically be the same for all indicators even though, generally speaking, it is monthly.

To establish how often the data will be collected, several more or less interdependent factors must be taken into account:
→ The **desired responsiveness in relation to the phenomenon** being monitored: the quicker one wants to respond, the more frequently the data must be gathered. For example, it is wise to closely monitor numbers of suspected cases of cholera in order to take appropriate measures in the event of an epidemic peak. Data would then be collected on a daily basis.

→ The **variability of the phenomenon measured by the indicator:** the more rapidly it evolves, the more regularly it needs to be monitored. If the indicator is not measured with sufficient frequency, there is the risk that what has happened between two measurements will not be known. For example, when monitoring supplies of essential drugs in a situation where there has been an influx of refugees, a low rate of stockouts is recorded over a month. But this low rate, spread over this period, may mask a much more significant stockout which occurred over a shorter period.

→ The **sensitivity of the indicator:** certain "sensitive" indicators can immediately reveal slight fluctuations

in the phenomenon; others become evident later and only when the changes are significant. If maternal mortality is used as an indicator of maternal health, it will only be possible to observe a drop in mortality after a delay relating to implementing the activities designed to improve the health of mothers. On the other hand, maternal health may improve in certain respects without any effect on mortality being observed. In this type of situation, gathering data every six months is generally sufficient.

→ The **resources required to collect and analyse the data:** an estimate of how frequently the data should be collected must also be based on the time and the human and material resources required for collecting and monitoring. For example, an indicator which is calculated by carrying out a one-off survey cannot be calculated monthly.

Who by
(individuals responsible for data collection and analysis)

The individual responsible for gathering the data and the individual responsible for analysing it should be identified **for each indicator;** generally speaking, this is not one and the same person. The individuals concerned do not need to be named but rather the role of the person in charge of data collection must be specified so that responsibility for the task can be easily transferred when there is a turnover in team staff (e.g. midwife, supervisor, etc.).

Why
(What am I going to do with the information obtained by calculating the indicator?)

The object here is to specify the information being provided by the indicator and the reasons why this information is being selected.

Each indicator is chosen in terms of its relevance for observing the evolution of a phenomenon. The issue here is to know the use that will be made of the evolution observed.

For example, the ratio of attended births, where calculated before and after reform, does indeed measure the effects of free provision of this care on service use. But what is gained from knowing that the ratio of attended births has increased, diminished or remained stable over time? The information can enable activities to be adjusted to meet the goals set, to promote this policy with the ministry of health or to feed into the results of operational research.

Project monitoring is a decision-making tool. The "Why" column offers an opportunity to reflect on the type of decisions which might emerge from analysing a specific indicator.

If the reasons for collecting the data for an indicator are not clearly identified, it is important to re-examine the relevance and usefulness of that indicator.

Who for
(Who is the recipient of the information?)

Who are we collecting this indicator for? Who will be informed of the evolution of this particular indicator?

Individuals/institutions are not all seeking the same information. Depending on the nature of the interlocutor, data must be presented in a different and appropriate manner. Asking who will receive the information may also reveal a mismatch between the type of information supplied by the indicator and the expectations of the recipient. In that case, further questions need to be asked about the indicator used.

For example, if one intends to demonstrate to the ministry of health the effects of free attended childbirth on the use of health services, the administration will be sensitive to the ratio of attended births. In contrast, politicians will pay more attention to economic measurements which prove that such a measure, overall, does not lead to a health system overspend.

Furthermore, it is essential to identify the individuals/institutions receiving the information in order to be able to inform them in a timely way of how an indicator is evolving. This communication is important for:
→ Taking decisions or informing the persons concerned of possible adjustments to the project linked to how an indicator is developing;
→ Complying with contractual obligations (e.g. donors and health authorities);
→ Providing information on the project's outputs/outcomes with a view to strengthening ownership in accordance with the principle of accountability. It is desirable to communicate regularly with our interlocutors about the project's progress.

Communicating the project's outputs/outcomes to different stakeholders and partners is an essential element. However, each stakeholder may be sensitive to different types of outputs and outcomes. It is important to determine which indicators are the most appropriate ones to highlight in our stakeholder communication strategy.

A global view must be taken of the monitoring system in order to respond to the information needs of MdM, its partners, donors, etc. But it is also essential to look closely at any indicator which would respond only to a donor's requirements. We need to ask whether there is not another indicator which would satisfy this donor's need for information and at the same time serve the operational needs of the project. The same

question could also be asked of an indicator which responds to MdM's own communication needs alone: an indicator might exist which would meet MdM's needs while being of interest to the country's health authorities.

> **NOTE /**
> Data which will not be analysed must not be either collected or computerised.

The Indicator Summary tab in the Monitool can be used to compile the answers to this series of questions for each indicator. See, for example, the tab for the project to tackle unwanted pregnancies in Libertalia for the Couple Year Protection indicator. *(See table on following pages)*

3 / PREPARING DATA COLLECTION

Different data-collection sources and methods exist for providing information about the indicators chosen, depending on the type of information sought:

1. Routine information systems:
National Health Information Systems (NHIS) and/or the Health Information System (HIS) of health establishments provide access to health service statistics and epidemiological, administrative and financial data for a precise administrative area: country, district and also community. Depending on the context, other routine information systems may exist. This data has the advantage of often being already entered and computerised. If data is missing from the NHIS/HIS, for example data relating to mental health, it can then be added.

2. One-off surveys:
These can be regularly carried out as part of supervision visits for example, to find out levels of patient satisfaction or skills among health professionals. Post-training tests or interviews can also be conducted with social workers. These surveys combine two different methods: observation of a sample of medical procedures or case studies, focus groups or interviews with healthcare workers, patients, social workers, etc.

3. Population surveys
or surveys of a representative sample of households (KAP-type survey[61]): these provide data which can be generally applied to the whole of the target population but require a lot of time, money, logistics and technical skills. It is therefore recommended that these are used sparingly and only if it is not possible to satisfy the need for information by other means. In contrast, the results of DHS or MICS-type population surveys, which are regularly carried out in the majority of intervention countries, should be obtained and used. These surveys comprise both national and regional data and may provide a considerable amount of useful information. Surveys carried out by other stakeholders may also be considered.

4. Longitudinal or "cohort" study of a group of individuals
is sometimes extremely useful, even if it involves investing a significant amount of time and energy. For example, it is justified in the case of a long-term treatment in a new context (e.g. Opioid Substitute Treatment), in order to assess

61. For more information, refer to the **MdM** guide "Data Collection, Quantitative Methods, the example of KAP surveys", 2011, available on the **MdM** website in French, English and Spanish.

participants' adherence as well as the determinants or the effectiveness of the treatment in this specific context.

Setting up a data-collection forms

Once the indicators have been determined, the conditions must be created to enable **quality** data to be collected which will then be **analysed** and **used** as part of project tracking. Indicators which are completed using ill-defined, partial or wrongly interpreted information will be of no use and could even lead to false conclusions.

**FOCUS ON
SERVICE COVERAGE AND USE**

> For all indicators relating to questions of service coverage and use, it is strongly recommended to refer to collections of data already existing in the intervention country and to limit the creation of new data-collection components. It is preferable to use (strengthen) existing systems, even if they are of average quality or are incomplete, rather than setting up parallel systems for collecting data. The aim here is to avoid increasing the workload of health staff. Moreover, this data is often already entered and computerised (usually at district level).
>
> Information must therefore be provided for the majority of indicators using existing ministry of health forms. Exceptions may be made in cases where MdM wishes to document specific aspects of health for which information is not routinely gathered by the NHIS: mental health, gender-based violence, etc., or when,

> in the wake of a conflict or natural disaster, there is no longer any national data-collection system.

> **NOTE /**
> It may be that health staff already have to complete more than fifteen different forms including information sheets and records of the ministry of health, the Global Fund to Fight Malaria and the national plan to fight AIDS; it is therefore more sensible to use existing forms, adding one or two relevant additional indicators if necessary rather than adding new MdM forms.

Thus it is important to take time to carefully devise forms or data-collection sheets and to train MdM or partner organisation staff doing the collecting.

Several questions must be asked when data-collecting tools are being drawn up and put in place:
→ Do the forms enable the **gathering/ collecting of all information/ data** required for the monitoring? (Above all, do not forget any breakdowns of data envisaged.)
→ In which language(s) must the tools be drawn up? Is the translation faithful to the original?
→ Etc.

MONITOOL INDICATOR SUMMARY TAB
PROJECT TO TACKLE UNWANTED PREGNANCIES IN LIBERTALIA

WHAT		HOW MUCH					WHEN				
Number	Indicator label	Min. Health Ind.	International Ind.	Baseline	Target		Frequency				
							Week	Month	Quarter	Year	Survey
Specific objective: To reduce the number of unwanted pregnancies in women of child-bearing age in the district of Saapland by increasing provision of and demand for FP.											
SO 1	Couple Year Protection	X		To determine at the start of the project	Year 1 : 50% Year 2 : 70% Year 3 : 100%				X		

HOW	WHERE	WHO BY			WHY	WHO FOR
Formula for calculating the indicator (Numerator/ Denominator)	Sources of verification (Form used during data collection)	Person in charge of data collection	Person in charge of data analysis		What is the purpose of this indicator?	Who are we calculating this indicator for (who is our target)?
Specific objective: To reduce the number of unwanted pregnancies in women of child-bearing age in the district of Saapland by increasing provision of and demand for FP.						
Couple Year Protection = Number of contraceptives distributed by type during one year x average duration of their effectiveness. For example (n cycles of oral contraceptives x 1/15) + (n condoms x 1/120) + (n Jadelle x 3.8 + etc.)	NHIS	Med. Coord.	Med. Coord.		This indicator provides a way of estimating the protection against pregnancy afforded by the family planning services over a period of one year, based on the quantity of all contraceptives sold or freely distributed to service users during that year. It tracks the use of contraceptives when the contraceptive prevalence rate is not available. On its own, this indicator gives an indication of the **outcomes of the project.** Analysing its trend in the light of the other indicators (1.1 - 1.2 - 2.1 - 4.1 - 5.1) identifies sticking **points or activities with the greatest influence** on protecting a population.	Project team Donor

NOTE /
The indicators must be broken down by sex and age group or according to other categories where appropriate and when possible (this may reveal inequalities between men and women, young and elderly people, displaced and non-displaced persons, refugees, etc.).

It is important to involve all individuals who are taking part in the data collection – MdM staff, health centres, data clerk, etc. – in the process of drawing up the tools and determining the collection methods. Care must be taken to define each person's role: who will be responsible for gathering the data; who will supervise the process; who will analyse the data; who will report on the information generated by the analysis?

Work relating to the quality of the collection tools and staff training must be carried out at the setting-up phase then, if necessary, improved during the implementation phase. The tools must be **tested** before being used, then **adjusted** when biases or gaps are observed in practice, or when improvements would be useful. However, care must be taken not to modify elements of the data-collection forms too often after the test period; there is the subsequent risk of incomparability of data which has been collected in different ways. Moreover, the person collecting the data has to adapt to each new format, thereby increasing the risk of mistakes and fatigue.

Data-collection training

It is essential to train staff who are collecting the data and reporting on it.

This means ensuring that these individuals have a good grasp of the expectations and aims of the data collecting and that

they know how to:
→ Handle the data-collection tools;
→ Identify inconsistencies;
→ Highlight problems;
→ Analyse the data;
→ Make recommendations, etc.

NOTE /
The individuals responsible for collecting the data are not necessarily those who analyse it. An inability to envisage the usefulness of the data may sometimes lead to certain aspects of its collection being overlooked. Ensuring the aims are properly understood is a significant factor in improving the quality of the data collected.

Whatever solution is chosen for entering the data, it is essential to set aside time for training which focuses on the way the database is presented and the manner in which the information must be entered.

NOTE /
A properly completed Monitool sets out data requirements, formulae for calculating indicators for tracking the project, data-collection formats, dataflow within the project and responsibilities of team members involved in the monitoring. This document may also be used to ensure continuity in the event of staff turnover.

4 / TESTING THE SYSTEM

Before any monitoring system is launched, it must be tested at pilot sites: this reveals

any potential inconsistencies or feasibility problems and ensures that the individuals in charge of data collection can still, at this point, voice their questions and difficulties. Likewise, at this stage, it is still possible to modify and adjust the system, something which will be much more difficult when it is up and running on a wider scale.

The following questions may provide a useful basis for testing the system:
→ Do the users understand the **aim** of the data-collection forms and do they know how to **use** them?
→ Are they fully aware of the type of data to be collected and do they know how to find it?
→ Do the members of staff feel they have the **skills required** for collecting the data? Or is there a need for specific training on interviewing techniques or compu-terised data-collection forms, for example?
→ Are the components of the data-collection forms **systematically, correctly** and **coherently** completed?

3.3C

DATA COLLECTION AND PROTECTING SENSITIVE DATA

> Care must be taken to protect project users by making personal data entrusted to us secure.

MdM considers that all personal data – or data which can identify an individual when cross-checked –, concerning an individual's state of health or life history, constitutes sensitive personal information.[62]

This data notably takes the form of:
→ Records of consultations and of individuals booked in and booked out;
→ Medical files: consultation reports, medical images, test results;
→ Medical certificates for acts of violence;
→ Life histories – gathered in writing or by audio, video or photographic recording.

Interviewing, filing and archiving of medical files and capturing sensitive data must be conducted in accordance with general or specific mechanisms which guarantee confidentiality and data protection.

62. To find out more, refer to the guide "For Ethics in the Field. Sensitive personal data management. (Health-life stories)", **MdM,** 2010.

3.3D

COMPILING AND PRESENTING DATA[63]

1/DATA ENTRY

It is the job of the field team to organise the data entry and, in doing so, they are answerable to the named individual responsible (general coordinator, medical coordinator, programme coordinator or monitoring officer).

The data-entry process demands rigour, patience and organisation. It must be viewed alongside the planned data analysis and feedback processes. An identified individual should preferably be responsible for structuring the monitoring system and a computer should be reserved for this purpose, along with a lockable cupboard to protect sensitive data. The individual responsible for the monitoring system must also organise the division of tasks and ensure that all data-collection, entry, analysis and feedback activities are carried out. Depending on the scale of the project, and thus the volume of data it generates, it is desirable for a dedicated member of staff to be responsible for the monitoring system (monitoring officer).

Ideally, the person in charge of data entry should begin entering data at the same time as it is being collected in the field. This enables possible errors to be spotted in the noting or filling out of information (for example, 300 syringes distributed to one individual during one visit instead of the normal 30) and to immediately inform the data-collection teams who can then rectify their mistakes. It also means inconsistencies between the format in which the data is collected and the tool used to enter it can be quickly identified.

In the majority of cases, all data may be entered in the Monitool by opening one tab per health facility and one tab for data accumulated for all health facilities. This solution offers the advantage of making all computerised data (raw data and indicators) available in the same document, thus minimising the risk of data-entry errors. In other situations, data may originate from other collection tools developed to respond to a specific need within the project (more complex databases for cohort studies for example).

Data is entered in accordance with the frequency of data collection specified in

63. This section draws on **Jean-Pierre d'Altilia, Jean-Pierre de Lamalle, Paul de Caluwé, Isaline Greindl, Frédérick Lecherlier** and **Alain Wodon,** "Health Information System, Editions", 2nd edition, L'Harmattan, 2011.

MONITORING PLAN

Country	
Project	
Advisor	
Start date	01/01/2012
End date	31/12/2012
Today's date	18/01/2013
Progress	105 %

Target 100% met	100 %
Target 50% met or more	50 %
Target less than 50% met	0 %

Number	List of indicators	Baseline	Target	Monthly progress												
				Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec
OS1	Number of couple year protection	1300	5500	1358	1254	2156	1374	1254	1323	1321	1658	1924	2241	2599	4012
1.1	% of FP delivered free	45 %	100 %	48 %	39 %	45 %	49 %	67 %	100 %	100 %	75 %	65 %	85 %	100 %	100 %
2.1	Rate of FP services disrupted	50 %	0 %	35 %	35 %	12 %	0 %	0 %	0 %	25 %	27 %	15 %	0%	0%	0%
2.2	% of FP consultations complying with standards	25 %	100 %	25 %	22 %	35 %	45 %	59 %	67 %	84 %	100 %	100 %	100 %	100 %	100 %
3.1	Number of meetings calling of EC		2	0	0	0	0	0	1	1	2	1	2	2	1
3.2	Number of centres offering EC		10	0	0	0	0	0	0	0	0	0	0	0	0
4.1	% of users who know 3 FP methods	5 %	75 %	5 %	7 %	8 %	17 %	15 %	17 %	38 %	41 %	39 %	75 %	72 %	77 %
5.1	Number of radio broadcasts promoting FP involving religious leaders	0	4	0	0	0	0	0	0	0	0	0	0	5	3

the "When" column of the Monitool Indicator Summary. Data entry (directly in the Monitool or via intermediate elements of the data-collection forms which feed into the Monitool) provides information for the monitoring plan, which means it is possible to see how the indicators are evolving. The colour of the cells (green, orange or red) shows whether an indicator is close to or a long way from its target.

The monitoring plan is constructed during the setting-up phase and includes indicators, baseline and targets.

The data entered may feed into **graphs** which are automatically synchronised with the monitoring plan. These graphs also set out the target value, thus enabling a simple and rapid visual analysis of how the indicator is evolving in relation to its target. Subsequent analysis provides an opportunity to complete the "Comments" box alongside the graph, which is where all the elements, required for understanding the indicator's evolution, must be included.

2 / DATA CLEANING

Verifying and validating the entered data represent important stages. This task

is the responsibility of the person in charge of the monitoring who must not be the same person as the one who entered the data. The person responsible for the monitoring is also in charge of cleaning the data and must be wholly familiar with the indicator calculation method, the sources of verification and their format. This same person reviews the data, identifies data-entry errors, verifies extreme data and checks any apparently aberrant data. Once verified and validated, the data is saved and set aside for analysis.

NOTE /
Careful attention must be paid throughout the data collection and entry process in order to obtain good quality data. Errors may arise at different points: errors in data collection (unsuitable data-collection toolkit, lack of staff training, data-entry errors, etc.) or entry (inconsistencies between data-collection format and data-entry tools for example). It is therefore essential to check the quality of the data during the different stages.

It is not always possible to notice errors but any values or discrepancies which are unexpected, aberrant or inconsistent must stand out.

EXAMPLES FROM THE FIELD

Erroneous data collected

Here are a few examples of erroneous, aberrant data:
→ Age given as 255 years
→ Abortion confirmed when, according to the data entered, the person has never been pregnant
→ An antenatal visit for a man

Examples of extreme data (surprising in terms of the situation and requiring verification):
→ Severe acute malnutrition rate of 90%
→ A person aged 85 years in a country where life expectancy is 45 years

3 / PRESENTING THE DATA

There are numerous ways of presenting information to make analysing it and communicating the results easier. Data may be presented in the form of a table (Monitool monitoring plan) or in the form of a graph (Monitool graphs). Different types of graphs respond to quite specific situations. Each graph has its own particular characteristics and it is important to know what these are in order to determine **which type of graph is most suitable for presenting which type of information**. The most appropriate form of graph will depend on the nature of the data and the indicators for which the

information is being provided. The tool chosen will be accompanied by a narrative description highlighting the most significant results.

Whatever the format chosen to represent the data, some simple principles must be applied so that readers can clearly interpret it:
→ Each representation must be able to be read independently from the accompanying text;
→ Representations must always carry an informative heading (population, place and period of study);
→ Acronyms must be expanded, either in a note or in the heading;
→ If percentages are given without the corresponding numbers, the total number used to calculate the percentages must be detailed in the heading;
→ Units of measurement must be systematically indicated alongside the name of the variable (e.g. years, months, %, etc.);
→ The use of a combination of **black / white / cross-hatching / dots** is always preferable to colours to avoid losing information when doing non-colour printing.

NOTE /
Despite being aesthetically pleasing, 3-D graphs must not be used, as they do not comply with statistical integrity rules (all sections of a graph cannot be viewed in the same manner and so visual bias is introduced).

Table

Use: The table is a means of presenting a summary of a large quantity of cross-tabulated data.

Appearance: A table consists of a collection of lines and columns.

Presentation rules: It is important to specify the column headings and the totals used to calculate percentages.

Line graph

Use: The line graph can be used to monitor developments and to compare the evolution of one or more indicators over time, but equally to compare the evolution of indicators with each other. It is basically used to monitor trends.

Appearance: The horizontal axis (X-axis) represents the variable "time" and the vertical axis (Y-axis) corresponds to the value of the indicators. It is also possible to present chosen targets. There are as many lines as there are indicators. A different form

of graphical representation – dashes, dots, squares, diamonds, etc. – (and not a different colour) is used for each line and must be detailed in the key.

Presentation rules:
→ Optional horizontal lines;
→ Limited number of indicators (3 or 4 maximum);
→ The same (vertical and horizontal) scales should be used so as to be able to compare several line graphs.

Common errors:
→ The graph contains too many or too few lines and so is not easy to read;
→ Too many variables are compared in the same graph which masks relevant information;

EVOLUTION OF INDICATORS OF FP PROVISION FOR 2012

- ···■··· Rate of family planning (FP) services disrupted
- –▲– % of FP consultations complying with standards
- ◆ % of FP delivered free
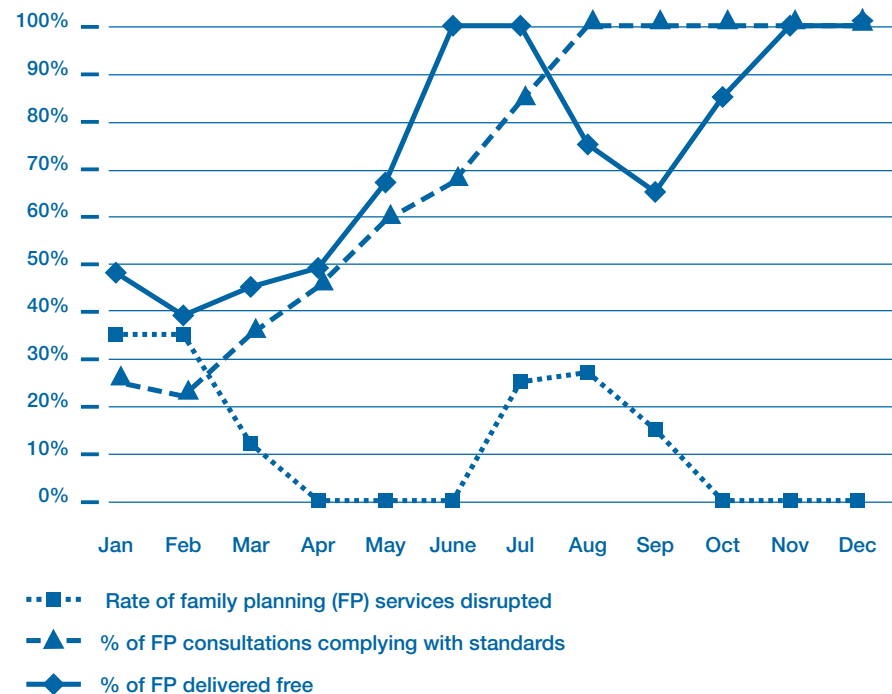
→ The graph contains a comparison of variables which cannot be compared (e.g. a 1000-bed hospital with a 2-bed health centre);

→ The scale is not suitable for the data being compared (e.g. if the indicators vary by 1% and do not exceed 20%, a scale of between 0% and 20% is more appropriate than one of between 0% and 100%.

Vertical line graph

Use: The vertical line graph is used to make geographical comparisons (districts, health centres, etc.) or to compare groups (sex, age group, etc.).

Appearance: The horizontal axis (X-axis) represents the geographical areas (districts, health centres, etc.) or the different groups (sex, age group, etc.) and the vertical axis (Y-axis) corresponds to the value of the indicators. Unlike the histogram, there is a space between the bars as each bar represents a different geographical area or group.

Presentation rules:
→ The bars may be vertical or horizontal;
→ The number of indicators must be limited (3 or 4 maximum).

Common errors:
→ Seeking to compare groups of significantly different sizes;
→ Seeking to compare too many areas or groups at the same time.
These 2 errors render the graph unreadable.

PERCENTAGE OF INDIVIDUALS ABLE TO NAME AT LEAST THREE MODERN METHODS OF FAMILY PLANNING

1088 people questioned using one-time exit surveys at two district health centres in the period January to December 2012
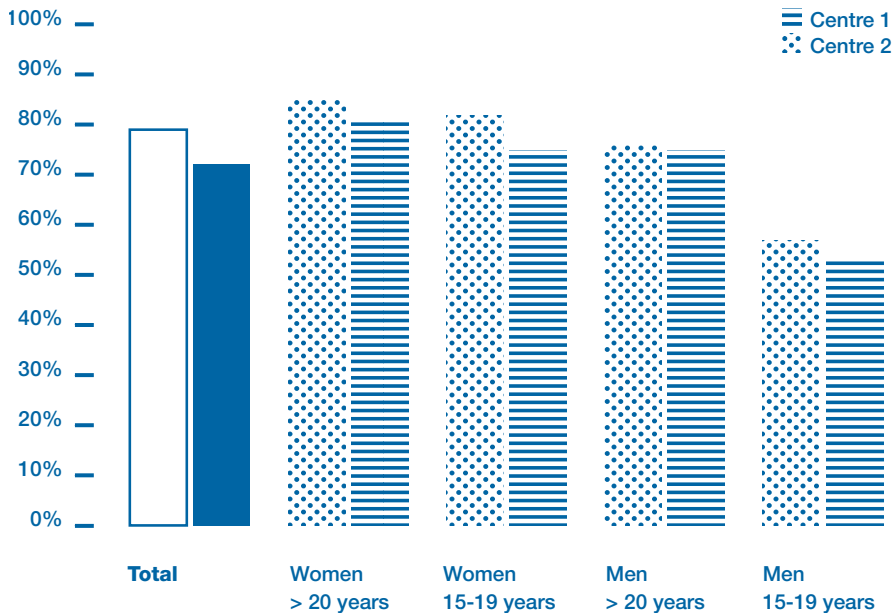
Sector or pie chart

Use: The sector or pie chart is a way of representing proportions, i.e. the weight/importance of the various elements which make up a whole. For example, the principle causes of mortality and the principal pathologies treated in health centres supported by MdM may be depicted using this method. To compare how the proportions change over time, several pie charts can be produced using the same colours to represent the same elements.

Appearance: Rather like a cake cut into portions, this graph looks like a circle divided into segments from the centre. Each segment represents a percentage of the whole and is generally identified using data markers (black/white/dots/cross-hatching, as colours disappear when printed). The segments are arranged in order of size from the right in clockwise fashion.

Presentation rules:
→ The convention is to begin at "12 o'clock";
→ If the classifications are determined by a continuous variable (e.g. age groups or period of time), the segments are ranged in a logical order of classification;

→ Otherwise, the convention is to classify the segments clockwise according to their decreasing order of importance. Where there is a classification "Other", this is placed last, whatever its importance.

→ The number of classifications must be limited (8 to 10 maximum).

→ Each classification must be clearly labelled, either alongside the segment or in a key.

→ Values are generally expressed as a percentage, placed inside or outside the segments. The total on which the percentages are calculated must always be specified.

Common error:
→ Several very narrow segments make the graph difficult to read; it is therefore better to regroup overly small segments into one.

CHILDBIRTH METHODS OF WOMEN IN THE DISTRICT

Data for 2758 women who gave birth in 2012
- Source: NHIS
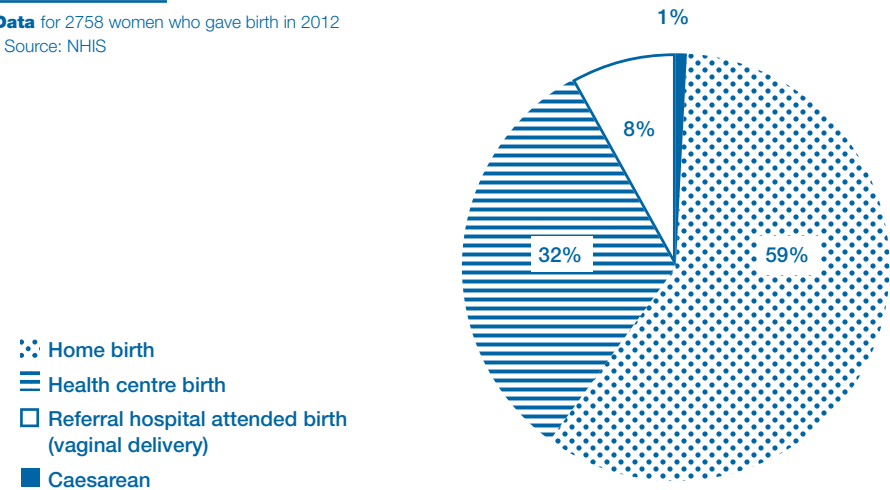
Spider or radar chart

Use: The spider chart provides a visual representation of the progress of several (between 5 and 8) indicators in relation to each other for groups of a maximum of three for a single criterion (three years, three health centres, three districts, etc.) on a scale of 1 to 4 or 5. For example, it provides a way of showing the constituent strands of community participation[64] or a health centre's performance, and of identifying which strands need strengthening.
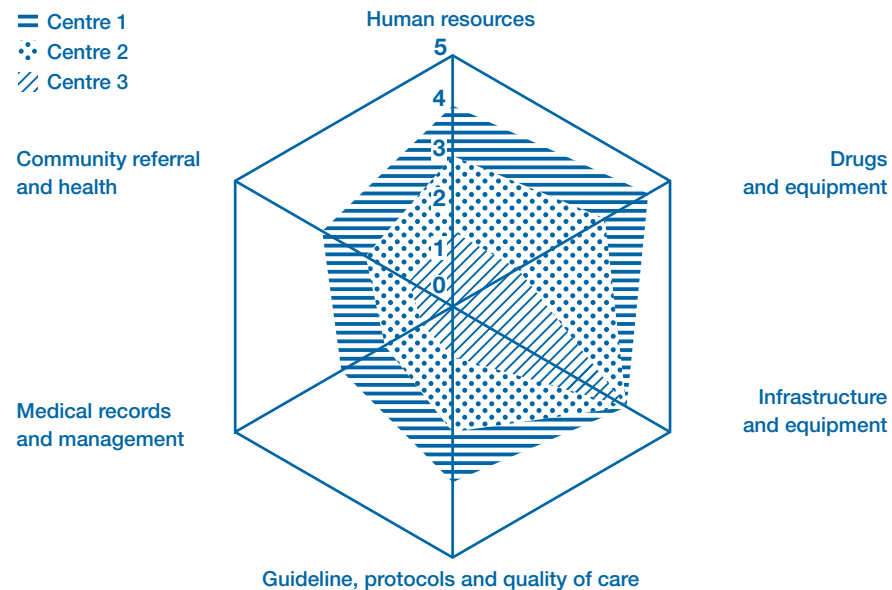
Appearance: In the spider chart, there are as many strands or axes as indicators. These axes all start from a central point. The values of the indicator, ranging from 1 to 4 or 5, are plotted on the axis. The values relating to the same group (a year, a centre, a district, etc.) are linked by a line to form an irregular polygon. If several groups are represented (up to a maximum of three), different shades of grey must be used as colours disappear when printed.

Presentation rules:
→ 5 to 8 indicators (= axes) maximum
→ 2 to 3 groups (= polygons) maximum.
→ Indicators must, in so far as is possible, be positioned in a logical way (e.g. indicators relating to curative care to the right and indicators relating to preventative care to the left).

Common errors:
→ The values of the superimposed groups are almost identical and therefore not always clearly visible.
→ The layout of the different axes may give very different results.

Legend:
— Centre 1
⋰ Centre 2
⫽ Centre 3

Human resources
5
4
3
2
1
0

Drugs and equipment

Community referral and health

Medical records and management

Infrastructure and equipment

Guideline, protocols and quality of care

64. Rifkin SB, "Primary Health Care: on measuring participation", Soc Sci Med, 1988, 26(9), p.931-940.

3.3E

ANALYSING AND INTERPRETING DATA

> The following section is illustrated by analysing part of the monitoring data for the project to tackle unwanted pregnancies in the district of Saapland in Libertalia. The data relates to a specific objective – "Reducing the number of unwanted pregnancies by improving the range of FP services offered and demand for these" – and the corresponding results *(see Indicator Summary)*.

> **NOTE /**
> Any data gathered must be analysed and all analysed information must lead to decision-making.

1/ BASIC PRINCIPLES

It too often happens that, despite the significant amounts of data collected and useful information compiled, little or no time has been scheduled for using and analysing it.

And yet, once processed into quantifiable information, the data represents a valuable tool for operational and strategic decision-making within projects. It highlights discrepancies regarding forecasts and objectives, the project's most effective elements and constraining factors requiring priority attention. In other words, monitoring enables enlightened decisions to be taken on the basis of lessons learned as the project progresses as effectively as possible towards attaining the goals set.

Time therefore needs to be scheduled for reflection and analysis, during which key assumptions can be examined, tested and validated. This analysis must be carried out as often as required (ideally at the same pace as the collecting) and must involve the whole team as much as possible.

Data analysis is wrongly viewed as a complicated process; in reality, it is a fairly

simple way of providing a large quantity of information, provided, however, that a few rules are followed:

→ **Formulate assumptions:**
What change is the project intended to bring about? What is it we want to know? What do we expect to observe, given how the project was constructed at the beginning, the activities which have actually been implemented, the elements linked to the context and the conclusions drawn from the latest analyses? Identifying discrepancies and exceptions presupposes having an idea of what it is we expect to observe.

→ **Carry out a systematic, descriptive analysis of the indicators.**
It would be a pity to overlook a crucial piece of information provided by the monitoring on the basis that it did not form part of the initial assumptions. Guidance in carrying out this analysis may be found in the section below dealing with its different stages.

→ **Share and use all information obtained for decision-making** (maintaining the same course if everything is progressing as planned, strengthening certain activities, prioritising action, etc.). The whole team must be involved as much as possible in interpreting the information extracted from the analysis and in seeking decision-making solutions.

GENERIC EXAMPLE
GROUNDWORK: CONTEXT, QUESTIONS AND ASSUMPTIONS FORMULATED FOR THESE ANALYSES

Summary of preceding analyses

The project began a year ago now and the first two quarters have enabled

health centre FP practices to be consolidated: availability of drugs, consultations complying with national standards, effective provision of free care (training of consultants, awareness-raising of issues of free care during the second quarter and increasing supervision). Three sessions to raise the awareness of women in the community have already taken place. The Couple Year Protection indicator remained stable during the first six months (except for a momentary increase in March when 120,000 migrants passed through) and gradually increased during the third quarter.

Bad weather, which began in June, rendered the main road impassable and thus resulted in problems with drug supplies. In some centres, these problems led to the resurgence in requests for payment for FP methods in particular and drugs in general. Consequently, supervisions have been increased.

Recent activities and events

The last quarter has been marked:
→ On the one hand by the end of the rainy season;
→ On the other hand by increased activities with religious leaders. The latter have been trained, as was initially scheduled, during June and July. However, the recording and transmitting of radio broadcasts initially scheduled for September have been postponed to October and November due to preparations for the festival of Libertalia.
→ The third session to raise women's awareness of family planning took place in the last week of September.

Seven of the ten communities have now benefited from this awareness-raising.

Assumptions made for the October to December quarter

→ Stockout problems are resolved along with those relating to free provision of FP methods.
→ The radio broadcasts have had a positive effect on contraception-related coverage.
→ Community knowledge of FP has been improved.
The other indicators have not deteriorated.

2 / PRECAUTIONS TO TAKE WHEN INTERPRETING DATA

For a host of reasons, an indicator's value and evolution do not always faithfully reflect reality. For example:

→ **Changes in the quality of data gathered** (deterioration or improvement) may lead to variations in the indicators which do not correspond to a variation in the result in question. Thus, the increase in the rate of child mortality due to malaria in a region may reflect:
1. Either more effective data-collecting: the problem is now considered a priority, extra funds have been allocated and, consequently, the gathering of information is now better organised and better reflects reality without, however, malaria-related child mortality actually having risen;

2. Or a real difference.
But before concluding there is a real difference between the two situations and beginning a more in-depth analysis of the causes, it is essential first of all to examine whether there have been any changes in the data gathering.

→ **Changes in the method of measuring the indicator** may simulate variations. This can happen when, for example, a new questionnaire is used to assess the population's knowledge or where rapid diagnostic tests are used at a particular moment instead of using clinical signs as the basis for identifying cases of malaria.

→ **Differences in the population in terms of size or characteristics** may equally lead to artificial fluctuations in the indicators. A sudden increase in the population, when for example there is an influx of refugees, may lead to an upsurge in the rate of antenatal consultations if the original population is retained as the denominator.

→ Lastly, **simple errors in transcribing and entering data** in the Excel sheet, etc. are not uncommon..

Note that biased data may be informative if its limitations are known and if these are taken into account in the interpretation.

This crucial stage requires communicating particularly effectively with those doing the data collecting, entering and cleaning.

3 / DESCRIPTIVE ANALYSIS OF MONITOOL GRAPHS

The descriptive analysis of graphs involves writing a short narrative for each, describing what can be observed: for example, a line which shows a marked peak, a pie chart containing five sections, two of which together account for 80% of the chart, etc.

Once the validity of the indicators is assured, the object of the descriptive analysis is to identify:
→ Discrepancies relating to the target, value or evolution that was expected for the given period;
→ Trends over time (shifts, peaks and periodicity);
→ Possible geographical disparities or disparities by sub-group of individuals.

Value of the indicator at a time *t*

The value of the indicator at a time *t* provides useful but incomplete information.

Indicator level in relation to baseline and target set and level expected for the period

A piece of information makes more sense if it can be compared with another as a point of reference. This means comparing the value of the indicator in relation to the initial situation (baseline), the value sought (target) and the frame of reference represented by benchmarks,

published and unpublished studies, prior and/or similar experiences. The colours displayed in the Monitool monitoring plan are extremely useful here for assessing at a glance the level of the indicator in relation to its target.

Evolution of the indicator over time

The data collected gives a "snapshot" of a situation at a given moment. It is important to consider the trends observed over time. As a minimum, one should try to identify trends, shifts in the line of a graph, stalling (sudden changes in the value of an indicator), peaks, periodicity (seasonal increase in an indicator for example), etc.

Examining how an indicator is evolving over time must be carried out:
→ In the short term (value in relation to the latest measurement: stable growth, sudden stalling, etc.),
→ In the medium term (evolution over the last three to six months: consequences of the activities and recent events),
→ And in the long term for the project as a whole (global trend beyond seasonal variations and one-off events).

Here, use can be made of the automatically created Monitool graphs which give the level of each indicator in relation to time.

Variations in the indicator in space

If data has been gathered for each centre, it is then useful to compare the indicators in space. The progress of the project can thus be reviewed in each area and potential disparities identified. An attempt must then

be made to understand these. In addition, such comparisons determine the priority areas for certain needs.
Comparisons in space are useful for identifying those areas experiencing greatest difficulty and those showing the best results. In particular, an analysis of spatial differences allows:
→ Resources available to be adapted to priority needs from one place to another;
→ Assumptions to be put forward which will be subsequently verified: are these differences due to problems with establishments, individuals, access, etc.?

GENERIC EXAMPLE
COUPLE YEAR PROTECTION INDICATOR (CYP)

As a reminder, this indicator, which tracks the specific objective of "reducing the number of unwanted pregnancies by increasing provision of and demand for FP", is calculated by multiplying the number of contraceptives distributed by type during one year by the duration of their effectiveness (e.g. 120 condoms are needed to protect a couple for a year, 15 packs of pills for a year, etc.).

Evolution of Couple Year Protection for 2012

List of indicators	Baseline	Target
Number of Couple Years Protection	1 300	5 500

J	F	M	A	M	J
1 358	1 254	2 156	1 374	1 254	1 323

J	A	S	O	N	D
1 321	1 658	1 924	2 241	2 599	4 012
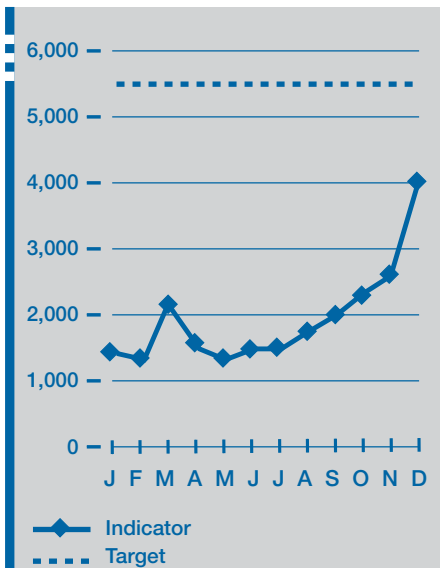
- Indicator
- Target

The following descriptive analysis may be given:
→ Value at time *t*: The CYP indicator was 4012 in December.
→ Level of the indicator in relation to its baseline/target: the CYP has increased in relation to its baseline and stands at 86% of the target set. According to the data of a survey conducted 6 months ago, the CYP reported for the population in the district is now the highest in the region. Its level is satisfactory given what was expected at this period in the project.
→ Evolution over time: After a period of stagnation from January to June (aside from the temporary increase in March), the CYP gradually increased between July and November (going from 1321 to 2599, showing a steady increase month on month), and rose more rapidly over the past month.

4 / INTERPRETA-TION: EXPLAINING THE LEVEL AND EVOLUTION OF INDICATORS

The objective here is to:
→ Interpret the discrepancies, evolutions and disparities identified by the descriptive analysis;
→ Understand why certain indicators progress and others do not with regard to activities, resources and elements of the context.

In particular, this enables the necessary corrective actions to be taken to attain the desired objectives and results. It involves determining how the evolution of different indicators is linked to all these elements.

Explaining the evolution of indicators by placing in context

Contextualising is what enables the data to be thus interpreted.
Here the emphasis is on the importance of quarterly or half-yearly project reviews: pooling information held by each team member enables the analysed data to be correctly interpreted.

For each indicator, the object now is to list the elements which could be the source of the level and trend observed.

These elements may be linked to:
→ Context,
→ Resources,

→ Activities implemented (which are also reflected in other indicators).

As regards the activities, do not hesitate to refer to the Gantt chart. Note that, if the project has been properly programmed, the logical framework correctly constructed and the indicators well chosen, it should be possible to observe an improvement in the results indicators once the corresponding activities have been implemented. Likewise, it should be possible to observe an improvement in the specific objective indicator once one or more corresponding results have been partly or wholly achieved.

Two points demand particular care and attention when reflecting on this. On the one hand, it must not be forgotten that the elements in question may have a more or less immediate effect on the evolution of the indicators. On the other hand, conclusions must not be drawn too hastily regarding the causal link between events, even if their sequence over time appears convincing. It is important to bear in mind that numerous factors can influence each of the indicators and that we do not know or control all of these elements.
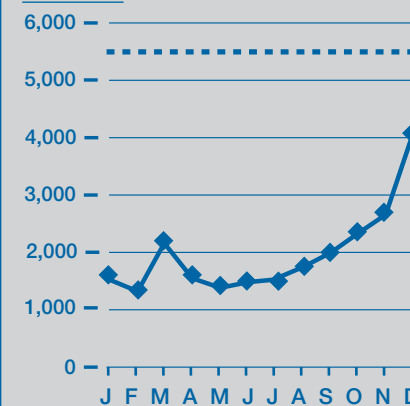
GENERIC EXAMPLE
INTERPRETING THE EVOLUTION OF THE COUPLE YEAR PROTECTION INDICATOR

Viewing all the graphs together here can be helpful.

Specific objective

→ Reducing the number of unwanted pregnancies by improving the range of FP services offered and demand for these

Number of Couple Year Protection

Result 1

→ **District health facilities offer quality FP services**

Rate of FP services disrupted
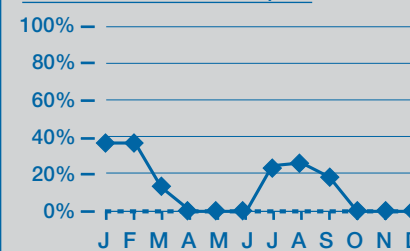
Percentage of consultations complying with national standards
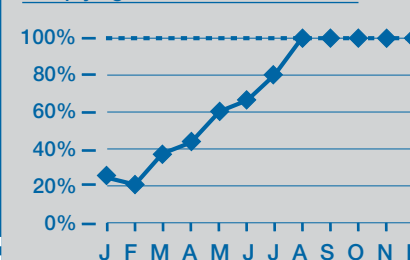
Result 2

→ **A control mechanism ensuring free access to FP services is put in place**

% of FP consultations delivered free
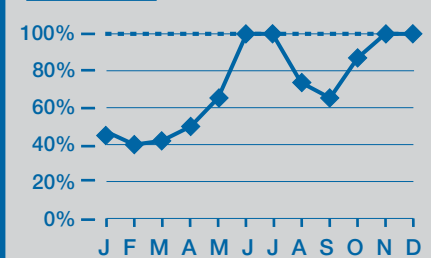
Result 3

→ **Population's FP-related knowledge and practices are increased**

% of users aware of 3 FP methods

Result 4

→ **Awareness of the importance of FP is raised among religious leaders and they encourage the use of FP services**

Number of radio broadcasts involving religious leaders and conveying positive messages on birth spacing

The descriptive analysis carried out in the previous stage is taken as the starting point:

→ **Period of stagnation from January to June:** The activities of the first two quarters were focused on improving the FP services offered (availability, training of healthcare staff, set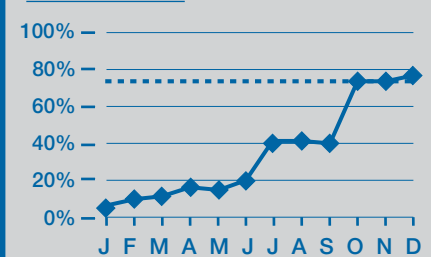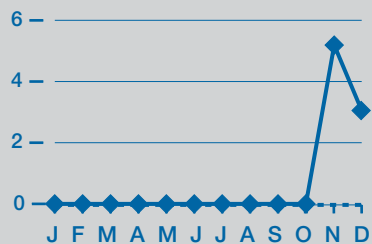ting up supervision, compliance with free healthcare policy, etc.) It is logical that no increase in CYP was observed during the setting up of these activities.

→ **Temporary increase in March** is probably linked to a group of around 100,000 refugees passing through the district.

→ **Progressive increase in CYP between the months of July and November** is probably linked to activities implemented. The progress was, however, less rapid than expected which may be the result of stockouts and the unfavourable weather restricting movements between July and September.

→ **More rapid progress between November and December:** almost all the activities corresponding to this specific objective have been implemented and the preceding problems resolved, so this progress was expected.

Comparing different centres/ geographical areas

If the centres deal with different populations (in terms of size or type), if they have specific operational characteristics, or if they have progressively benefited from the project activities, comparing indicators between them provides vital information.

Analysis of spatial differences in particular provides:

→ An understanding of the overall evolution of the indicators (an average level overall may be due to high levels in a large number of centres and an extremely low indicator in others).

→ A basis for assumptions concerning the source of these differences (Are they due to problems with establishments, individuals or access?)

GENERIC EXAMPLE
COMPARING LOCATIONS OF HEALTH CENTRES

Comparisons are sought between health centres which are found in areas where women have already benefited from awareness-raising sessions and those found in areas where activities have not yet taken place.

The following indicators are examined:
→ Percentage of women attending the centre able to name at least three modern methods of FP,
→ Couple Year Protection (this latter relates to the number of women of child-bearing age for each area in order for a comparison to be made).

⫼ % of women service-users able to name at least 3 modern FP methods

▪ Number of Couple Year Protection in relation to the number of women of child-bearing age
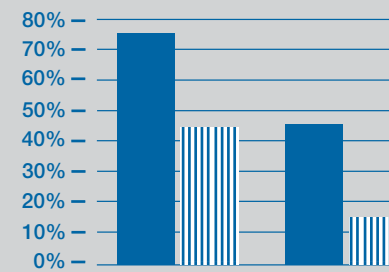
Centres in areas where women have already benefited from FP awareness-raising

Centres in areas where women have not yet benefited from FP awareness-raising

Here it can be seen that centres situated in areas which have benefited from raising women's awareness of FP have better-informed users and distribute more methods of contraception.

It may therefore be assumed that the awareness-raising activities were of good quality (the women have a better knowledge) and were effective at stimulating demand. Nonetheless, it must be verified that these observations are not linked

to other factors, for example better training of health centre staff or better geographical access to the centres.

Comparing different groups of individuals (age/sex)

If the data permits, comparing results by sub-groups can provide essential information. This approach follows the same logic as for geographical comparisons. As we know, health problems, knowledge, lifestyles and individuals' behaviour depend on a large number of criteria. Among these, age and sex are particularly important and are worth examining wherever possible.

GENERIC EXAMPLE
EXAMINING FP-RELATED KNOWLEDGE DEPENDING ON AGE AND SEX AMONG USERS AT ONE OF THE DISTRICT'S CENTRES

Percentage of individuals able to name at least three modern methods of family planning

Women >20 years | Women 15-19 years | Men >20 years | Men 15-19 years
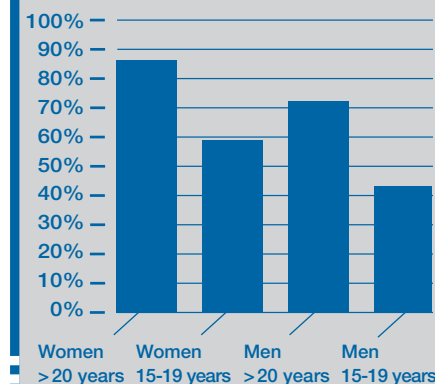
Firstly, adults over 20 years of age can be seen to demonstrate better FP-related knowledge than adolescents and, secondly, women are shown to be more knowledgeable than men on this subject.

A large number of assumptions can therefore be made as to the reasons for these differences and these will have to be examined in greater depth in the field:
→ Women initially had better knowledge of FP;
→ The project's awareness-raising activities have principally included adults and women in particular;
→ The project's awareness-raising activities are not suitable for all sections of the public; etc.

To conclude, it would seem worthwhile targeting men and adolescents in particular in the future, especially where they are taking FP-related decisions.

FOCUS ON
OUTCOMES GENERATED
BY A PROJECT

Once a health project has been implemented, **the outcomes** associated with the project itself and with MdM's presence as a new stakeholder gradually become apparent.

The outcomes are the consequences of the intervention on the collective health problem(s), the health situation in general and the social situation, as well as on the contextual factors.

These outcomes, which influence the population to varying degrees, may be linked to different elements:
→ Setting up the interventions: Environmental changes associated with the interventions, (changes in certain factors of the situation);
→ The presence of an institution: MdM embeds itself in a given social organisation and thus changes its dynamic: conflicts of interest, structure of social links, balances of power, etc.;
→ Additional phenomena: Presence of other intervening parties who interact with MdM.

There are therefore different aspects to the notion of "outcome". The outcomes generated by a health project must be identified, described, qualified, monitored and then evaluated. The outcomes are linked to implementing the project and are thus measured during monitoring and evaluation.

They may exceed expectations, that is to say the effects predicted at the moment the project was set up.

Outcomes may be expected or unexpected, positive or negative.

Expected outcomes are those which one can "predict" at the time of project programming.[65]
They may be:
→ **Positive:** they then represent the outcomes sought. These outcomes are directly linked to the objectives formulated during programming.

→ **Foreseeable but undesirable:** these are then referred to as expected negative outcomes. For example, it is known that in an emergency situation when free provision of care is introduced, a vital condition for facilitating access, the normal systems used by families to set aside money to meet health needs are undermined.

Unexpected outcomes (i.e. unforeseeable) at the time of project programming may equally be:
→ **Positive:** for example in the Disaster Risk Reduction project in Madagascar, the first phase of the project generated a huge momentum in the pilot communities to the extent that neighbouring communities, not included in the pilot phase, approached the pilot communities to ask for peer-to-peer transfer of experiences.
→ **Negative:** for example, the use of religious leaders to liaise in certain information/awareness-raising AIDS campaigns in some places destabilised existing power relationships to the leaders' advantage.

When the outcomes are analysed, it is therefore essential to **systematically examine the outcomes produced overall;** it would be simplistic to limit analysis to the expected outcomes.

The outcomes depend on the opportunities and constraints encountered and are interdependent. Unexpected positive outcomes offer **a lever for action** which can be used to strengthen the project.

Unexpected negative outcomes are, on the contrary, a form of **alarm signal** which must be heeded as soon as possible, thereby increasing our capacity to respond and anticipate. By systematically identifying these outcomes, we are able to predict situations which may, when discovered late, be difficult and even impossible to resolve.
It is essential to note here the importance of the processes for capitalising on experience. Analysing and documenting experiences make it possible to transform unexpected outcomes in an initial project into expected outcomes in those that follow.

The table shown below is a valuable visualisation tool which can serve as the basis for team discussions:

Unexpected positive outcomes	Expected positive outcomes
Unexpected negative outcomes	Expected negative outcomes

3.3F

FEEDING BACK INFORMATION AND SHARING DATA

> The conclusions or observations from data analysis must, without fail, be the subject of **feedback** both to data-collection teams and to stakeholders.

1/FEEDBACK TO THE TEAM

Feedback is a vital element in motivating data-collection teams. It may be conducted on a half-yearly or quarterly basis in the form of whole-team meetings and featuring the presentation of graphs and development trends and a reminder of the target to achieve. In emergency situations, this feedback is more usually monthly, or even weekly.

During meetings, this feedback serves as the basis for discussions:
→ To update the whole team on the progress of the project;
→ To gives everyone a chance to voice difficulties or satisfaction;
→ To provide an opportunity to complete the analysis and, in particular, to interpret the data together.

2/FEEDBACK TO STAKEHOLDERS

Feedback to stakeholders facilitates their ownership of the project's objectives and activities. This communication is essential in order to work with partners to adjust the project and influence the position of stakeholders.

Communication strategies must be adapted to the public targeted:
→ In the case of internal communication, the strategy adopted is one of classic reporting.
→ In the case of external communication aimed at political decision-makers, media, partners, population, etc, the most appropriate communication strategies need to be devised to convey messages and make them understood.

3.3G

USING DATA FOR DECISION-MAKING

Data analysis makes it possible to:
→ Verify initial assumptions: what **changes** did we wish to bring about by the project?
→ Review the overall progress of the project and of each objective towards the target set;
→ Identify geographical disparities or those between sub-groups in terms of progress (and thus the priorities which need to be defined);
→ Identify the elements positively or negatively influencing progress and to explain them in relation to the context.

These conclusions make it possible to identify and prioritise the elements on which to take corrective action and can lead to several types of decisions being taken. The object of corrective action is to **improve the outputs and outcomes** of the intervention.

1/MANAGING AND ADJUSTING ELEMENTS OF THE PROJECT

Inevitably, during the course of implementing a project, adjustments are required in the programming of activities in response to data collected or new elements encountered. Analysing the tracking and monitoring data makes it possible to understand discrepancies regarding the context, resources, etc. (i.e. all elements of project tracking), and to make adjustments to attain the planned objective.

Therefore, depending on which elements emerge from the analyses, adjustments must for example be carried out to:
→ Increase the resources and activities which have insufficiently developed/advanced in relation to what was planned in the Gantt chart;
→ Modify an activity set up but which is not producing the expected output;
→ Consolidate activities whose outputs are significant;
→ Reschedule the activities and objectives by scaling down the latter or, conversely, by increasing the resources to make additional means available.

GENERIC EXAMPLE
RESULTS OF THE ANALYSES

In the project to tackle unwanted pregnancies in Libertalia, the analyses have highlighted several elements. It seems, for example, that the FP awareness-raising sessions have a positive consequence on the effective use of FP methods but are not sufficiently directed towards adolescent girls. So while it is therefore desirable to increase these activities, they must in future target all sectors of the public concerned.

GENERIC EXAMPLE
FROM ANALYSES TO ADVOCACY

The analyses have enabled the effect of free provision of care on the use of FP services to be objectively presented. This message can therefore be conveyed to political decision-makers as substantive advocacy action material in support of free FP services.

2 / COMMUNICAT-ING AND ADVOCATING

The data provides information and reflects the results of action put in place. It may also be used to ensure accountability towards populations and communities. Therefore, in every case, it is essential to share the observations and conclusions with all MdM's partners (project team, institutional partners, partner organisations, donors, etc.). When adjustments are necessary, they must be clearly justified.

The data also constitutes the basis for any advocacy action. Our testimonies or advocacy directed at political decision-makers, media, partners, population, etc. must rely on solid and meaningful information.

3 / UNDERTAKING AN IN-DEPTH ANALYSIS

A "routine" analysis does not always provide an understanding of discrepancies or verify certain assumptions identified during the descriptive analysis. In such instances, an in-depth analysis is necessary, envisaging, for example, a specific one-off study to clarify certain points.

4 / COMMISSION-ING A PROJECT EVALUATION

Lastly, it may be the case that data analysis and interpretation actually raise questions about the very structure of the project and lead to an evaluation being commissioned to examine in greater depth the points in question and to suggest how the project may be reoriented.

SETTING-UP
Project launch

IMPLEMENTATION

DEFINING the system of
TRACKING/MONITORING

TRACKING/MONITORING

Adjustments
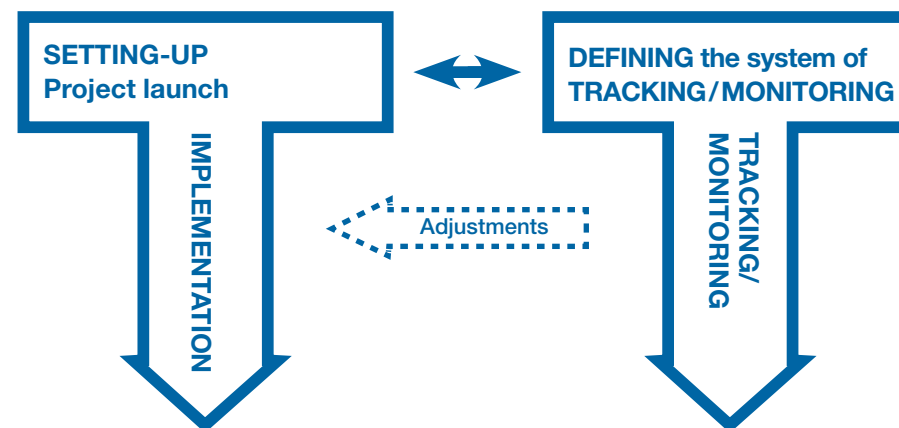
IN SUMMARY

KEY POINTS FOR PROJECT MONITORING

Monitoring is a **central element of the tracking system.**
It is based on indicators determined in advance and measures the project's progress and evolution towards achieving the expected outputs and outcomes. For MdM, the Monitool is an essential tool in the monitoring system.

The **person responsible** for defining and setting up the monitoring system must be **clearly identified** (general, medical or programme coordinator or monitoring officer, etc.).

→ **The principles for defining the monitoring system comprise:**
 – **Choosing the most appropriate indicators** to monitor the project's outputs and outcomes, taking account of the availability of data and possible comparability;
 – **Clarifying the basis of the system:** what, how, where, how much, when, who by, why and who for;
 – **Organising the data collection:** identifying existing elements of the data-collection forms, creating those elements which are lacking, carrying out data-collection training and testing the system;
 – **Protecting sensitive data:** Ensuring that sensitive data is being safeguarded.

→ **Compiling and presenting the data consist of:**
 – **Entering the data** using the forms provided for this purpose and prioritising existing data-collection elements;
 – **Verifying and validating the data entry:** identifying extreme or aberrant data;
 – **Choosing presentation formats** in relation to the type of information processed and respecting the rules of presentation.

→ **Analysing and interpreting the data involve:**
 – Formulating sound **assumptions;**
 – **Systematically analysing** all the indicators **to identify discrepancies, trends and possible geographical disparities** or disparities between groups of people;
 – Explaining the evolution of the indicators by **putting them in context** and systematically examining **all the outcomes produced** (and not only those expected).

→ **The data collected, organised and analysed must be shared and must be the subject of feedback to data-collection teams and stakeholders.**

→ **Lastly, this information must be used for decision-making aimed at:**
 – **Managing and adjusting** elements of the project;
 – **Communicating** and **advocating;**
 – Undertaking an **in-depth analysis;**
 – Commissioning or supporting a project **evaluation.**

IN SUMMARY

KEY POINTS FOR SETTING UP AND IMPLEMENTING THE PROJECT

→ **Setting up and implementing the project**
- **Setting up** a project is the stage at which its **adequacy** is established in relation to its context. This is an essential stage for ensuring any project is implemented in a secure and sustainable manner.
- **Setting up** a project provides an opportunity to refine the programming, establish a climate of trust, mobilise in support of and communicate about the project and put in place the support activities required to launch the project.
- **Implementing** a project involves developing the activities planned in line with the deadlines given and the resources available.

→ **Tracking system**
- **The objectives of a tracking system** are to ensure the project is aligned with its context; to know the extent to which a project has progressed at a precise moment (activities, resources, outputs and outcomes); to control and adjust the project and to provide the elements required for communication or putting together an advocacy action.
- **Tracking the context** corresponds to reviewing its factors (importance of factors linked to the health system, to sociocultural determinants and to risks for MdM staff, partners and users), stakeholders and community participation.
- **Tracking the activities** is done over time using the Gantt chart.
- **Tracking the resources** is carried out on various levels: administrative (permissions, contracts, etc.), human (recruitment, training, employment law, etc.), financial (annual reference budget and actual budget, financial plan), and logistical (supplies, inventoried items and equipment).

- **Tracking outputs and outcomes** operates using the monitoring system. **The tracking system** is put in place when the project is set up and continues to operate while the project is being implemented. It requires **regular exchanges** within the project team and between the team and other stakeholders and it must be **documented in writing** (minutes of team meetings, monthly coordination reports, etc.). Reporting enables different tracking information to be **centralised** and enables **knowledge which can be used for decision-making** to be drawn from it.

→ **Monitoring**
Monitoring is a **central element of the tracking system.** It is based on indicators determined in advance and measures the project's progress and evolution towards achieving the expected outputs and outcomes. For MdM, the Monitool is an essential tool in the monitoring system.

A **person responsible** for defining and setting up the monitoring system must be **clearly identified** (general, medical or programme coordinator or monitoring officer, etc.).

The principles for defining the monitoring system comprise:
- **Choosing the most appropriate** indicators to monitor the project's outputs and outcomes, taking account of the availability of data and possible comparability;
- **Clarifying the basis of the system:** what, how, where, how much, when, who by, why, who for;
- **Organising the data collection:** identifying existing data-collection elements, creating those elements which are lacking, carrying out data-collection training and testing the system;
- **Protecting sensitive data:** Ensuring that sensitive data is being safeguarded.

Compiling and presenting the data consist of:
- **Entering the data** using the forms provided for this purpose and prioritising existing data-collection elements;
- **Verifying and validating the data entry:** identifying extreme or aberrant data;
- **Choosing presentation formats** in relation to the type of information processed and respecting the rules of presentation.

Analysing and interpreting the data
involve:
– Formulating sound assumptions;
– Systematically analysing all the
  indicators to identify discrepancies
  in relation to the target and the value/
  evolution expected over the given
  period, trends over time and possible
  geographical disparities or disparities
  between groups of people;
– Explaining the evolution of the indicators
  by putting them in context
  and systematically examining all
  the outcomes produced, and not only
  those expected.

**The data collected, organised and
analysed must be shared and must
be the subject of feedback to data-
collection teams and stakeholders.**

**Lastly, the information obtained
in this way must be used
for decision-making aimed at:**
– Managing and adjusting elements
  of the project;
– Communicating and advocating;
– Undertaking an in-depth analysis;
– Commissioning or supporting
  a project evaluation.

**Tracking and monitoring enable
the project to be adjusted,
while evaluation may result in
its reorientation.**

**ANNEXES INCLUDED ON THE CD-ROM
– PART 3 – PROJECT TRACKING/MONITORING**

– **Programme opening checklist**
– **Reference document template**
– **Schedule/Gantt chart model**
– **Reference budget model**
– **Financial plan model**
– **Checklist for verifying proposals and reports**
– **Security plan template**
– **Risk analysis grid**
– **Base security rules grid**
– **Travel approval request form**
– **Security context analysis grid**
– **Security incident report template**
– **Security sitrep template**
– **Flowchart of responsibilities and communication between head office
  and field**
– **Monthly report template**
– **Budget follow-up model**
– **Flow chart of monitoring responsibilities**
– **Monitool: Indicator Summary and Monitoring Plan**
– **Medical dashboard**
– **Advocacy toolkit**
– **Accountability framework**
– **User satisfaction measurement**
– **Tracking community participation**
– **Stakeholder analysis**
– **Tracking partners**
– **Health staff supervision**
– **Health structure evaluation**
– **Health staff or partner capacity-building plan**
– **Terms of reference template for programme review/strategic workshop**
– **Programme review/strategic workshop report template**
– **Terms of reference template for study**
– **Handover or end-of-assignment report template**

4. EVALUATION

ANNEXES
INCLUDED
IN THE CD-ROM

This chapter draws on a few key works:

Guéneau, M.C., Beaudoux, E.
– *L'évaluation : un outil au service de l'action.* [Evaluation: a tool to assist action], **F3E, 1996.**

Fontaine, D., Beyragued, L. et **Miachon, C.**
– "Référentiel commun en évaluation des actions et programmes, santé et social", [Frame of reference for evaluating health and social action and programmes], **Lyon ERSP, 2004/05.**

Hallam, A. and **Bonino, F.**
– *Using Evaluation for a Change: Insights from Humanitarian Practitioners,* **ALNAP Study, ALNAP/ODI, London, 2013.**

Buchanan-Smith, M., Cosgrave, J.
– *Evaluation of Humanitarian Action, Pilot Guide,* **ALNAP Study, ALNAP/ODI, London, 2013.**

We would like to thank the authors for their permission to cite or reproduce passages from their work in this guide.

EVALUATION

> Evaluation is the final phase of the planning cycle.[66] It generally takes place during or at the end of a project with the aim of improving it or drawing lessons from the experience. It may also occur some while after the end of a project (ex-post evaluation).

The object of this chapter is not, unlike those preceding it, to provide a method or tools for conducting an evaluation but rather **to set out the principles and a methodological framework for requesting and managing an evaluation.** The evaluation methods are not therefore extensively developed in this chapter.[67]

An evaluation is rarely undertaken by the project team itself but is entrusted to in-house or external evaluation experts. However, the project team is extensively involved prior to, during and after the evaluation. Whether carried out at the request of a donor or the project team or another player from the organisation, an evaluation involves numerous players – the general, field or programme coordinator, desk officer, volunteer board delegate (RM), subject-based or medical advisers, etc. – in its preparation and execution, even in cases where it is entrusted to an external evaluation team. The object of this chapter is to give these different players the knowledge,

---

66. In this chapter, reference is made to evaluating projects underway. This therefore does not include either an ex-ante evaluation, which responds to different objectives and methodologies and which was dealt with in the Diagnosis chapter, nor a research or economic evaluation.

67. The interested reader will find it useful to refer to the excellent guide produced by ALNAP (**Buchanan-Smith, M.** and **Cosgrave, J.**, *Evaluation of Humanitarian Action*, Pilot Guide, ALNAP Study, ALNAP/ODI, London, 2013) as well as the website http://betterevaluation.org/, which brings together a vast array of resources linked to evaluation methods.

tools and elements required to prepare
and manage an evaluation, as well as
to ensure its recommendations are taken up
and followed up on.

NOTE /
Evaluation is often perceived
as an inspection process that carries
potential sanctions. This way
of looking at it restricts it in advance.
Continuing to think this way runs
counter to an approach that seeks
to improve project quality, which
is the principal aim of an evaluation.
How the evaluation is perceived is
closely linked to the way in which it
is thought about, realised and used.

4.1

EVALUATION OBJECTIVES AND ISSUES
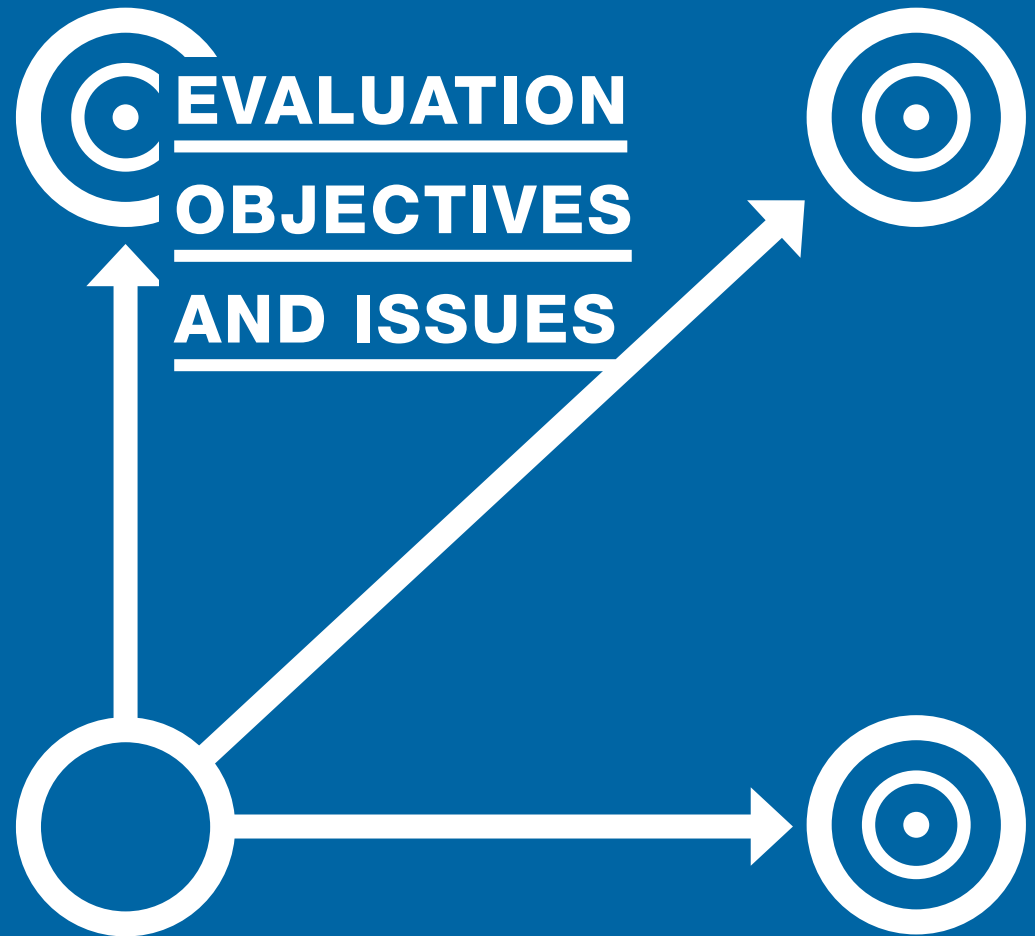
CHOOSE YOUR EVALUATOR WITH CARE

So... Would you say the project has altered your sexual practices?

4.1A

EVALUATION: ENHANCING QUALITY AND SUPPORTING CHANGE

> The Organisation for Economic Cooperation and Development (OECD) defines evaluation as "**the systematic and objective assessment of an on-going or completed project,** programme or policy, its design implementation and results. The aim is to determine the relevance and fulfilment of objectives, development efficiency, effectiveness, impact and sustainability. An evaluation should provide information that is credible and useful, enabling the incorporation of lessons learned into the decision-making process of both recipients and donors."

Evaluation is an initiative or process leading to a critical assessment of a project by comparing observable situations with established norms, based on explicit criteria, with a view to furnishing information that is useful for decision-making. The notion of examining critically is implicitly linked to the need to make a judgment. There is no evaluation if there is no judgment. However, that judgment can and must serve as part of a constructive approach to improving the action taken.

Evaluation is an essential pillar of a quality assurance approach. The ongoing drive to improve quality is underpinned by the key principle of change. Quality is never attained and requires continuous adjustments in response to evolving needs and situations. Quality assurance is therefore a dynamic process and, from a learning perspective, evaluation leads to change that is on a par with the level of reflexivity within the organisation.

Evaluation is therefore an instrument of change. The main issue is to prepare for intentional and planned change: evaluation enables a project – and the organisation more broadly – to improve and adapt.

DIAGRAM: PROJECT CYCLE AND ONGOING IMPROVEMENT IN QUALITY

Quality

Learning

Learning

Learning

Ongoing improvement in quality

Prior experience serves to consolidate level attained

Timescale

Diagnosis

Programming

Implementing/Tracking-Monitoring

Evaluation

4.13
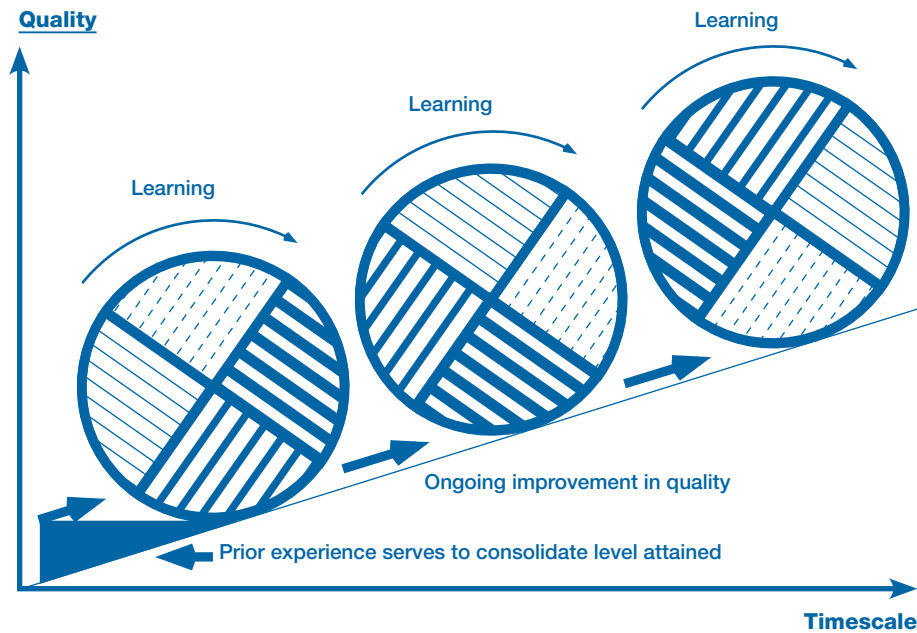
EVALUATION: BALANCING ACCOUNTABILITY AND LEARNING

> Evaluation is generally considered to be a process involving the twofold objective of accountability (focusing outwards) and learning (focusing inwards).

As regards accountability and responsibility:
→ As an organisation with a rights-based approach, accountability towards the populations with whom MdM works is of crucial importance. This means automatically involving project users in the process of defining and conducting projects, as well as passing on users' feedback via passive and active mechanisms;
→ Responsibility towards our private and institutional donors is also a priority, the aim of an evaluation therefore being to respond to the concern for a 'return on an investment'.

As regards learning:
→ Analysing what we have achieved and our mistakes offers the possibility of improving the quality of our projects, organisational strategies, processes and systems. It provides an opportunity to document and consolidate the meaning given to our actions;
→ Such a learning process implies that the lessons drawn from previous experiences, collected in evaluations and capitalisations and included in a valuable institutional memory, are used as a matter of course in decision-making, particularly where new projects or strategies are being designed.

NOTE /
The fact that an evaluation can simultaneously respond to accountability and learning needs is subject to debate. Numerous experts consider that there is tension between these two objectives. The need to present our work to and enhance its value in the eyes

of our interlocutors on occasion implies less than total transparency about our internal (dys)functioning, which de facto hinders learning.

As a recent ALNAP study[68] emphasised, "[…] real learning and performance

improvement requires frank and open discussion within an organisation, [and] an ability to share failures as well as successes, […]".[69]

In practice at MdM, where the aim is principally to learn from experience, the choice is made rather to conduct an evaluation while the project is underway or to conduct a capitalisation exercise.

DIAGRAM REPRODUCED IN HALLAM, A. AND BONINO, F., *USING EVALUATION FOR A CHANGE: INSIGHTS FROM HUMANITARIAN PRACTITIONERS*, ALNAP STUDY, ALNAP/ODI, LONDON, 2013.

Preconditions for effective evaluation follow-up and management response

Good Evaluation Planning

Identification of key stakeholders, definition of evaluation focus, TOR preparation, evaluation team selection, logistical arrangements for evaluation missions
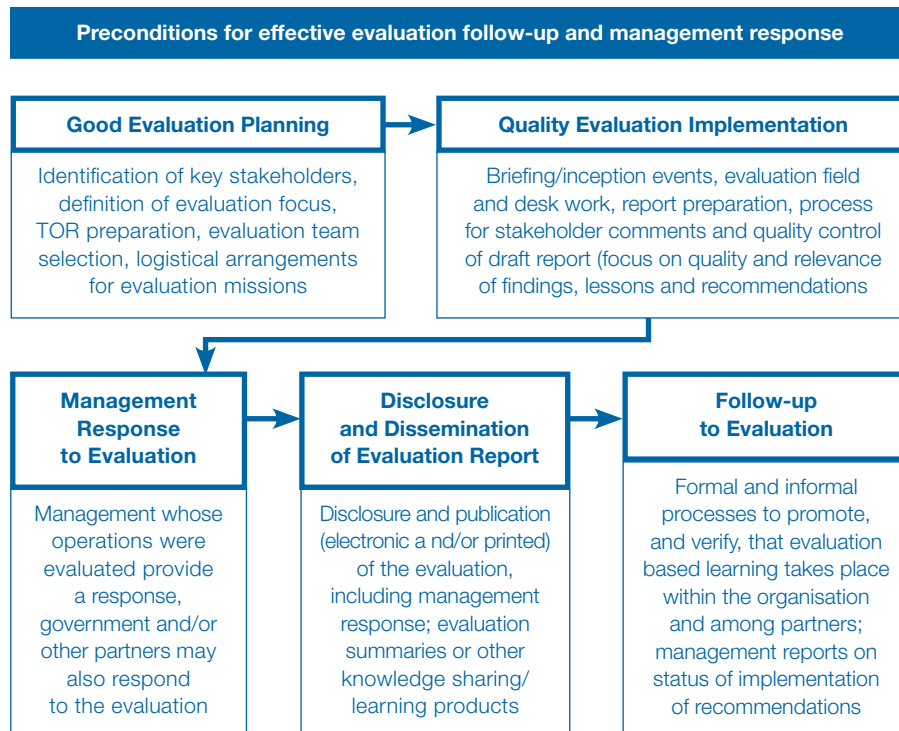
Quality Evaluation Implementation

Briefing/inception events, evaluation field and desk work, report preparation, process for stakeholder comments and quality control of draft report (focus on quality and relevance of findings, lessons and recommendations

Management Response to Evaluation

Management whose operations were evaluated provide a response, government and/or other partners may also respond to the evaluation

Disclosure and Dissemination of Evaluation Report

Disclosure and publication (electronic a nd/or printed) of the evaluation, including management response; evaluation summaries or other knowledge sharing/ learning products

Follow-up to Evaluation

Formal and informal processes to promote, and verify, that evaluation based learning takes place within the organisation and among partners; management reports on status of implementation of recommendations

Source : UNEG, 2013:3

68. ALNAP, the Active Learning Network for Accountability and Performance in Humanitarian Action, was created in 1997 as a way of providing the humanitarian sector with a forum to address issues of learning, accountability and performance,

which emerged following joint evaluation of emergency aid to Rwanda.

69. **Hallam, A.** and **Bonino, F.**, *Using Evaluation for a Change: Insights from Humanitarian Practitioners*, ALNAP Study, ALNAP/ODI, London, 2013.

4.1C

USING EVALUATIONS: A MAJOR ISSUE

> "Undertaking evaluation work and ensuring its quality are worthwhile if the activity leads to some use of the findings, and contributes to improving knowledge among those best placed to use it and bring about change and improvements in practice."[70]

1/ FACTORS INFLUENCING THE USE OF AN EVALUATION

Throughout the evaluation process, a certain number of factors influence the use that will be made or otherwise of the evaluation.

The first factor concerns the voicing of a request for an evaluation and **the original motivation,** expressed by at least one individual, to wish to obtain something from the evaluation (information, confirmation, new opportunities, visibility, etc.) and to wish to manage and lead the process. Without this initial motivation and energy,

there is little chance that the rest of the process, up to and including taking receipt of a quality product, will unfold in satisfactory conditions.

As well as the motivated individuals who are the driving force, the organisation as a whole must seize the initiative. In starting an evaluation process, the **organisation** must be ready to accept criticism, examine its practices and even call itself into question. An organisation that is not particularly given to learning from experience, or to analysing that experience as a basis for decision-making, has little chance of drawing conclusions and recommendations from an evaluation and of bringing about the change needed to enhance quality. What matters here, aside from the culture of the organisation, is whether decision-makers are willing or not to make use of evaluations.

An essential factor when taking account of evaluations, both at an individual and

70. **Hallam, A.** and **Bonino, F.**, *Using Evaluation for a Change: Insights from Humanitarian Practitioners*, ALNAP Study, ALNAP/ODI, London, 2013.

organisational level, is that of quality.
It is about the quality of the end product
(principally the evaluation report) as well
as the process as a whole – the rigo-
rousness of the preparation, application
of the methodology and analysis,
as well as the relationships between
evaluators and the Steering Committee.
All these elements create confidence
in the evaluation and give it credibility.

ALNAP identifies six groups
of factors contributing to the quality
of an evaluation:[71]
1. **Design** – The objectives
   of the evaluation must be clear
   and shared with anticipated users.
   The methodology must be chosen
   in relation to these objectives
   (for example, more participative
   for an evaluation oriented towards
   learning) and must provide
   answers to questions posed.
2. **Participation et appropriation** –
   A mechanism enabling key players
   to be involved throughout
   the process must be put in place
   (for example, via a Steering
   Committee).
3. **Planning** – The timing
   of the evaluation must be well
   thought out to enable the project
   team to be sufficiently involved
   in the evaluation process
   and to ensure that the findings
   of the evaluation do not arrive
   too late for the anticipated
   decision-making.

4. **Outputs** – The reports and
   other outputs must be accessible
   and easy to read and understand.
   The methodology must be rigorous
   and credible and must show
   a logical flow from the evidence
   to the findings, conclusions
   and lastly recommendations.
   The latter must be specific, realistic,
   targeted and ranked in order
   of importance.
5. **Follow-up mechanism** –
   A mechanism for following up
   on implementation of
   the recommendations must
   be put in place (for example via
   a Steering Committee).
6. **Evaluator credibility** –
   The skills, experience and reputation
   of evaluators must be credible.
   They must possess the necessary
   qualities in terms of interpersonal
   skills and must be capable
   of remaining balanced, impartial,
   objective and constructive.

2 / INVOLVING ANTICIPATED USERS OF AN EVALUATION

Each evaluation comprises different levels
of user: the project team of course and,
if applicable, the partners; but besides
these, there are also the decision-makers
from the various sections of the organisation.
The anticipated extent to which they will
use the evaluation largely determines
the degree of their involvement throughout
the evaluation process, such that key
players will take ownership of the evaluation

and thus of the recommendations arising
from it.[72]

NOTE /
It is important to identify, as soon
as possible, all the anticipated users
of an evaluation, so as to know
when and how to involve them prior
to receiving the conclusions and
recommendations.

Involving anticipated users can and must
be done at different moments in the evaluation
process:
→ At the point at which the decision
  is taken to evaluate in order to decide
  what is the priority objective
  of the evaluation;
→ At the point at which the Steering
  Committee is established;
→ At the point at which the Terms
  of Reference are drawn up;
→ At the point at which data is gathered,
  by involving anticipated users
  as key sources of information to allow
  them to express their views,
  and by communicating regularly
  on the progress of the work;
→ At the point at which the report is drafted,
  by allowing anticipated users to read
  and comment on the report before
  it is finalised;
→ At the point at which the findings are
  presented, to engage in discussion
  with the users who may have had little
  involvement in the preceding steps;
→ At the point at which the results
  are disseminated, to involve users in
  implementing the dissemination strategy;
→ At the point at which the
  recommendations are followed up on.

71. Buchanan-Smith, M. and Cosgrave, J.,
Evaluation of Humanitarian Action, Pilot Guide,
ALNAP Study, ALNAP/ODI, London, 2013.

72. The main difficulty lies in the fact that there is always
an element of the unknown in what will emerge from
the evaluation.

SUMMARY

KEY POINTS OF EVALUATION OBJECTIVES AND ISSUES

→ Evaluation is part of a **quality assurance approach** and an **instrument of change.**

→ An evaluation is part of the twofold **objective of accountability and learning.**

→ **The major issue for evaluations is that they should be used.**
Three principle factors influence usage: the requesting and managing of the evaluation by motivated players; the willingness of the organisation to use it as a basis for learning and decision-making; the quality of not only the final output but the process as a whole.

→ Anticipated **users should be identified and involved** throughout the process.

4.2

UNDERSTANDING WHAT AN EVALUATION IS

ASK SPECIFIC EVALUATIVE
QUESTIONS

So,
did it
go well?

Yeah...
Not
so bad...
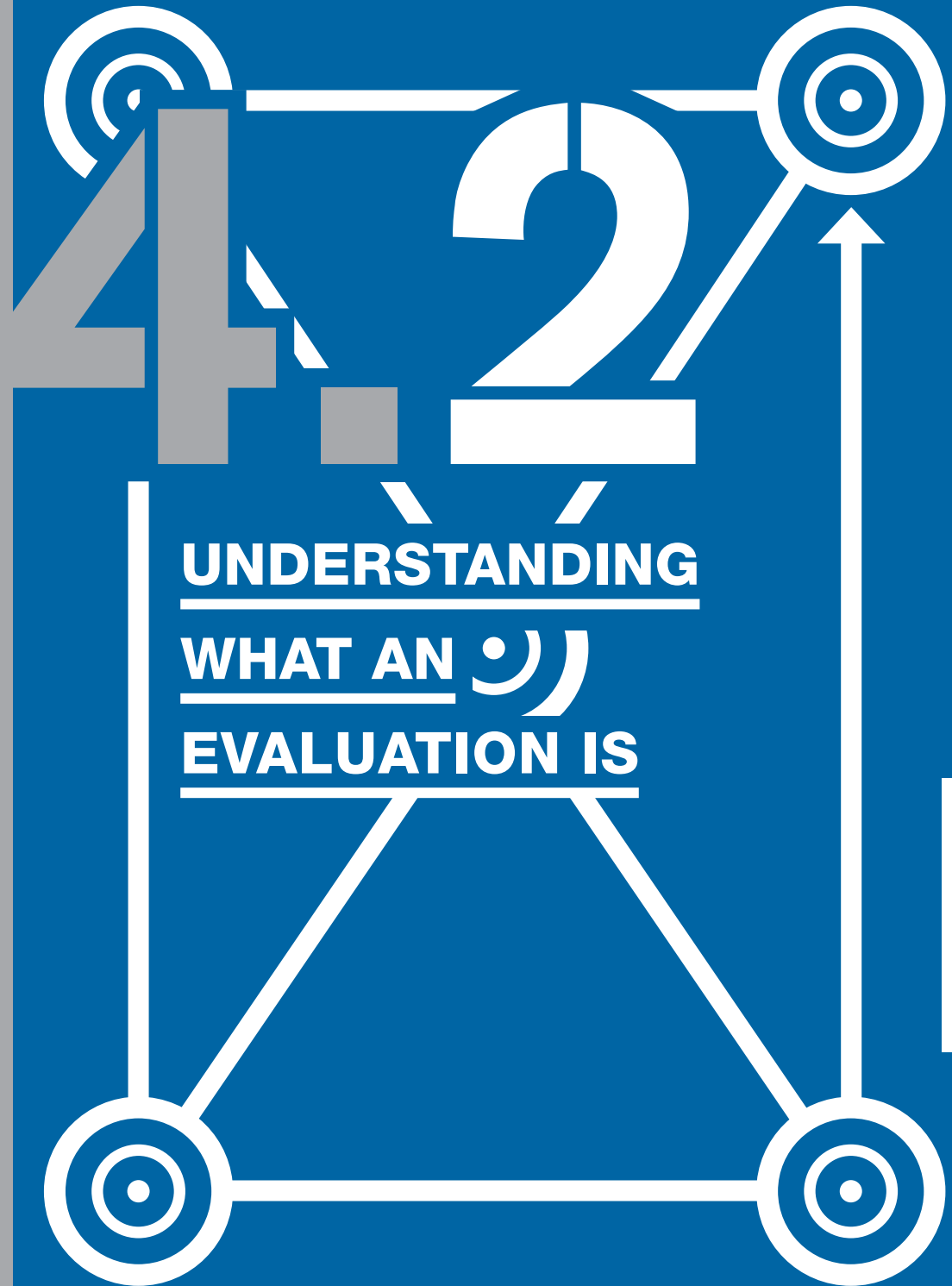
4.2A

DIFFERENT TYPES OF EVALUATION

> A host of different types of evaluation exists. Only the main groups are set out here, and these may, in their turn, be divided up into subgroups.

1/ FORMATIVE OR PROCESS EVALUATION: EVALUATING EFFORT [73]

Process evaluation – also referred to as **formative evaluation** – concentrates on the processes by which resources are converted into outputs. It consists of comparing the actual operational progress of the project with that envisaged: activities implemented, resources used, services produced, partner and community involvement, stakeholder satisfaction, etc. Normative evaluation is a subset of process evaluation: instead of comparing what

has been achieved with what was planned, it compares what has been achieved with norms and standards.

"Globally speaking [process evaluation] is interested in the project's internal dynamic and in factors both internal and external which influence its implementation." [74] It is interested in the 'how' and 'why' a project does or does not function and is aimed at improving performance. As a result, it is relevant to carry it out while the project is underway, which allows the project's functioning to adjusted for its further implementation. Formative evaluation is intended to consolidate the project team's knowledge, know-how and interpersonal skills and as a result uses more participative methods.

This type of evaluation is particularly recommended for documenting

73. **Fontaine, D.**, **Beyragued, L.** and **Miachon, C.**, "Référentiel commun en évaluation des actions et programmes, santé et social" [Frame of reference for evaluating health and social action and programmes], ERSP, Lyon, 2004-2005.

74. **Fontaine, D.**, **Beyragued, L.** and **Miachon, C.**, "Référentiel commun en évaluation des actions et programmes, santé et social" [Frame of reference for evaluating health and social action and programmes], ERSP, Lyon, 2004-2005.

the implementation of new types of project or replicating a project in other contexts. It is the precise description and analysis of all elements which have contributed to implementing the project. This enables levers and barriers to be pinpointed and the specifics of the local context identified (i.e. those which cannot therefore apply elsewhere). In this case, an overlap can be observed between formative evaluation and capitalisation.

> **NOTE /**
> "Process evaluations have the advantage that they can take place long before the results are clearly evident."[75]

2 / SUMMATIVE EVALUATION: EVALUATING OUTCOMES

Outcome or **summative evaluation** relates to a project's objectives and expected outcomes. Have the services delivered (output) led to the expected change (outcome)? Outcome evaluation involves comparing the outcomes arrived at with those fixed at the outset, using measurable, targeted indicators..

Summative evaluation measures an intervention's effectiveness. It responds to requirements for accountability. It is interested in 'which' and 'how many' outputs a project has achieved.

As a result, it is preferable to conduct a summative evaluation at the end of a project, when conclusive findings are available. The criteria traditionally applied in a summative evaluation are effectiveness, efficiency and relevance. The summative evaluation uses the quantitative methods needed to quantify the results and the qualitative methods needed to interpret them.

3 / IMPACT EVALUATION

Impact evaluation also belongs to the group of summative evaluations which evaluate the outcomes of an intervention. It is interested in the impact of all outcomes/consequences of an intervention on its environment in the broadest sense.[76] Impact evaluation implies value judgments regarding, for example, which types of changes are significant and for whom.[77]

Impact "simultaneously comprises:
→ The long-term dimension;
→ The population dimension, namely the impact on a broader population than that targeted;
→ The non-specific dimension, namely more far-reaching consequences than the project's specific objectives."[78]

As a result, an impact evaluation is generally carried out after the project

is completed as part of an ex-post evaluation.

In terms of methodology, the principal characteristic of an impact evaluation in relation to other forms of summative evaluations lies in the comparison with a counterfactual scenario or hypothesis: this is an estimate of what would have occurred in the absence of the intervention being evaluated. One of the principal approaches to constructing counterfactual scenarios consists of identifying a comparison group (control group) which resembles the group studied in every respect except for the fact that it has not been affected by the intervention. This type of evaluation presupposes complex and relatively costly methodologies (for example, comparative evaluations of the before/after or here/elsewhere type), and is rarely conducted by MdM.

4 / META-ANALYSIS OR THEMATIC EVALUATION

Meta-analysis is a summary of past evaluations. **Thematic evaluation** is an evaluation dealing with several projects sharing a common theme.

There are many advantages to conducting meta-analyses or thematic evaluations. They enable:
→ Other types of users than those normally targeted by project evaluations to be reached (notably the organisation's decision-makers and managers who require a more global perspective);
→ The cumulative weight of outcomes to be highlighted by collecting together the fruits of dozens of evaluations

or the evaluation of dozens of projects;
→ A form of triangulation to be established to validate important conclusions and recommendations, enhancing their credibility and therefore their use.

75. Buchanan-Smith, M. and Cosgrave, J., *Evaluation of Humanitarian Action,* Pilot Guide, ALNAP Study, ALNAP/ODI, London, 2013.

76. The current craze for impact evaluations in the humanitarian and development sector tends to obscure this broad definition to refocus evaluating on the question of the impact attributed to the intervention evaluated.

77. Buchanan-Smith, M. and Cosgrave, J., *Evaluation of Humanitarian Action,* Pilot Guide, ALNAP Study, ALNAP/ODI, London, 2013.

78. Fontaine, D., Beyragued, L. and Miachon, C., "Référentiel commun en évaluation des actions et programmes, santé et social" [Frame of reference for evaluating health and social action and programmes], ERSP, Lyon, 2004-2005.

4.2B

EVALUATION METHODS

> Evaluation methods divide into two main categories: quantitative[79] and qualitative.[80]

In general, evaluations use a combination of quantitative and qualitative methods, with qualitative methods being more commonly used.

Qualitative methods are sometimes viewed as less 'scientific' than quantitative methods. It should be noted that the scientific method refers to all steps necessary to obtain valid knowledge using reliable instruments. The aim of this method is to protect the researcher from subjectivity. Reproducibility is one of the major principles of the scientific method and refers to the capacity of a test or an experiment to be reproduced by any other individual. So, for example, two researchers working independently and rigorously in appropriately applying the focus group method should produce similar results.

Dozens of data-gathering methods exist, obtained through observation of individuals or groups, by using physical measurements or by examining existing files and data. Each of these methods responds to precise objectives and comprises advantages and disadvantages in comparison with other methods. It is the responsibility of the Steering Committee to examine the relevance of the methods put forward by the evaluation team and their feasibility in terms of budget and deadlines given. MdM generally recommends a method based on triangulating qualitative methods (principally observation, focus group and individual interview) and quantitative methods (relying in particular on the tracking/monitoring system).

FOCUS ON
METHODS FOR GATHERING OR COMPILING DATA LISTED BY BETTEREVALUATION[81]

Information from individuals:
1. Deliberative opinion polls
2. Diaries
3. Global assessment scales
4. Goal attainment scales
5. Interviews:
   → Convergent
   → Key informant
   → Semi-structured
   → Structured
   → Unstructured
6. Hierarchical card sorting
7. Keypad technology
8. Questionnaires (or surveys):
   → Email
   → Face-to-face
   → Internet
   → Mail
   → Telephone
9. Mobile data collection
10. Photolanguage
11. Photovoice Polling Booth
12. Postcards
13. Projective techniques
14. Seasonal calendars
15. Sketch mapping

Information from groups:
16. Stories
17. After action review
18. Brainstorming
19. Card visualization
20. Concept mapping
21. Delphi study

22. Dotmocracy
23. Fishbowl technique
24. Focus groups
25. Future search conference
26. Mural
27. ORID (Objective, Reflective, Interpretive, Decisional)
28. Q-methodology
29. SWOT analysis (Strengths, Weaknesses, Opportunities, Threats)
30. World cafe
31. Writeshop

Observation:
32. Field trips
33. Non-participant observation
34. Participant observation
35. Photography/video recording
36. Transect

Physical:
37. Biophysical
38. Geographical

Existing documents and data:
39. Big data
40. Logs and diaries
41. Official statistics
42. Previous evaluations and research
43. Project records
44. Reputational monitoring dashboard

79. The **MdM** guide "Data Collection, Quantitative Methods, the example of KAP surveys", 2011, available on the MdM website in French, English and Spanish, gives an example of applying the quantitative method.

80. To find out more, refer to the **MdM** guide, "Data Collection: Qualitative Methods", 2nd edition, 2012.

81. The collaborative website BetterEvaluation offers a number of extremely useful resources: the Rainbow Framework http://betterevaluation.org/plan, as well as a succinct introduction to the methods cited above http://betterevaluation.org/sites/default/files/Describe%20-%20Compact.pdf.

4.2C

EVALUATION CRITERIA AND EVALUATIVE QUESTIONS

> In 1991, the Development Assistance Committee of the Organisation of Economic Cooperation and Development (OECD/DAC) put forward five criteria for evaluating development projects: relevance, effectiveness, efficiency, sustainability and impact. A few years later, it adapted these criteria to emergency humanitarian action, adding the criteria of coverage, coherence, coordination and protection, and suggesting appropriateness as an alternative to relevance and connectedness as an alternative to sustainability.[82] These criteria are frequently used by the European Union, United Nations and international NGOs.

82. Buchanan-Smith, M. and Cosgrave, J., *Evaluation of Humanitarian Action*, Pilot Guide, ALNAP Study, ALNAP/ODI, London, 2013.

FOCUS ON
WHY USE STANDARD EVALUATION CRITERIA?

There are certain advantages to using standard criteria rather than inventing new ones for each evaluation:[83]
→ They respond to the most important humanitarian action issues;
→ They level out particular differences inherent in the way each project is designed (notably as a result of formulating very specific objectives and results), in order to highlight common traits with a view to conducting a cross-wise or meta-analysis;
→ They make the task easier for evaluators who have to move from one project to the next with insufficient time to really get to know them.

Evaluation criteria are the perspectives chosen from which to assess action.[84] There is not necessarily any link between the criteria chosen and the type of evaluation. The choice of criteria is made in relation to what it is one wants to know: for example, for the evaluation during the course of the Harm Reduction project in Georgia, what was most important for the project team to know was whether the partnership with the self-support organisation was being correctly put in place: that being the case, the evaluation focused on the partnership aspect and user satisfaction rather than on effectiveness, which will be evaluated during the final evaluation.

83. Buchanan-Smith, M. and Cosgrave, J., *Evaluation of Humanitarian Action*, Pilot Guide, ALNAP Study, ALNAP/ODI, London, 2013.
84. Guéneau, M.C., Beaudoux, E., *L'évaluation : un outil au service de l'action* [Evaluation: a tool to assist action], F3E, 1996.

NOTE /
The criteria provide a way of structuring an evaluation, although the most important thing is to define in the form of questions what it is one wants to know and, only then, to classify these questions according to the different criteria. It is the questions which are most important and not the criteria.[85]

1 / PRINCIPAL OECD CRITERIA

Relevance/ Appropriateness

As has been seen in preceding chapters, a project is designed to respond to a problem identified and analysed during the diagnostic phase[86]: it is a matter of judging the relevance of the project's objectives in relation to the problems affecting the population in question. In other words, it is a question of assessing the balance between the project and the problems to be resolved.

Evaluating the relevance of a project therefore comes back to judging the quality of the initial diagnosis and, in particular, the involvement of communities in expressing their diverse needs. Consideration of sociocultural factors emerges as an issue here

85. Buchanan-Smith, M. and Cosgrave, J., *Evaluation of Humanitarian Action*, Pilot Guide, ALNAP Study, ALNAP/ODI, London, 2013.
86. For more information, see the Diagnosis chapter in this guide.

in analysing the problems and the chosen intervention strategy.[87]

As well as examining the project's objectives, relevance questions the operational choices made: several approaches and interventions are possible in response to a given problem and not all have the same degree of relevance. It is a matter, therefore, of examining the quality of the project programming: Are the interventions envisaged relevant in terms of the needs identified?

> **NOTE /**
> The question of relevance also involves asking whether the objectives, or design of the action, and the strategies selected are still appropriate, given developments in the context, i.e. whether the project has successfully adapted to a new diagnosis.

The appropriateness of a project measures whether a project's objectives correspond to users' expectations, the country's needs, global priorities, partners' and institutional donors' policies and also MdM's guidelines and strategies.

FOCUS ON
EXAMPLES OF EVALUATIVE QUESTIONS FOR RELEVANCE/APPROPRIATENESS

> → Does the project respond to identified needs?
> → Do the project's objectives and actions correspond to the target population's priorities and needs?

87. To find out more, refer to the **MdM** guide, "Sociocultural Determinants of Access to Healthcare", January 2012.

> → Is the project's design adapted to the social and cultural specificities of the potential users?
> → What is the nature and extent of the problem? How has the situation causing the problem developed (assumptions and external risks)?
> → Was the choice of intervention and target population likely to significantly improve the problem: in other words, was the intervention strategy well conceived?
> → To what extent are the project's objectives still valid?
> → Are the project's activities and results compatible with the general objective and with attaining the specific objectives?
> → Is there a plausible link between the project's activities and the expected outcomes?
> → Is the project sufficiently close to the populations to understand their situation and changes in their needs?
> → Would a different strategy have been preferable to that implemented, better able to respond to these needs and priorities and this context? If yes, why?
> → Has the project correctly identified the risks? Has the project implemented appropriate strategies for responding to these risks? Was the project overly cautious with regard to potential risks?

Effectiveness

The effectiveness of an intervention is the degree to which the objectives have been attained or are in the process of being attained. It involves evaluating the extent to which the activities

implemented have contributed to achieving the project's specific objective. The value lies in measuring the discrepancies between what was planned and what has been realised, and in being able to analyse them. To be able to do so, it is absolutely crucial to have established clear and precise objectives from the outset.

> **NOTE /**
> Evaluating a project's effectiveness means seeking to evaluate the results and not the activities.

Measuring effectiveness makes it possible to go beyond evaluating activities and to begin examining who is using and benefiting from the interventions. The data is broken down by, for example, sex, socioeconomic group and ethnic origin. Interviews with representatives of the population (those who have actively participated in the action, those who refuse to participate or who are excluded, etc.) are essential to understand what determines service use.

FOCUS ON
EXAMPLES OF EVALUATIVE QUESTIONS FOR EFFECTIVENESS

> → Was the timing of the intervention appropriate?
> → Is the project achieving the results specified in the reference document and the logframe? Is the project making satisfactory progress towards its objectives? To what extent has the project been carried out as planned in the reference document? If it has been modified, why was this done?

> → Is the intervention reaching its target population?
> → Were the project's activities appropriate for progress to be made towards the project's objectives?
> → Are the indicators, intended to gauge progress towards the expected results, of good quality?
> → What are the principal factors influencing whether or not the objectives are attained?
> → Has the quality of the health services increased? Are the services available? Are they accessible? Are they of good quality? Are they used?
> → Is the quality of the project in line with good practice and standards? In line with the populations' expectations? How can the effectiveness of the interventions be improved?
> → What has the project achieved? In the event that it has not obtained the results set out in the reference document, what caused the problems?

Sustainability[88]/ Connectedness

Evaluating the sustainability of an intervention means analysing the ongoing benefits resulting from an intervention after a project has ended, that is to say the probability of obtaining benefits over the long term. It deals with the technical sustainability of the project (human and material resources), institutional sustainability, the operational and financial

88. Notions of viability and of sustainability are sometimes used interchangeably in the literature.

sustainability of the institution which is conducting the project, during and after funding, and the economic sustainability of the project for the community.

In humanitarian contexts, where the question of sustainability is not at the heart of the intervention, reference is made to the notion of connectedness. This is about the need to ensure that short-term activities are carried out in a context which takes account of long-term and interconnected problems. Connectedness is linked to the idea of sustainability and to the notion that interventions must support longer-term objectives and, ultimately, must be managed without input from donors.

FOCUS ON
EXAMPLES OF EVALUATIVE QUESTIONS FOR SUSTAINABILITY/CONNECTEDNESS

→ Has an exit strategy been drawn up and implemented?
→ Are the partners hoping to continue the activities themselves? Are their financial and organisational capacities adequate to do so?
→ Are there sufficient and sustainable human resources to pursue the activities implemented? Is the system of supplying drugs sustainable without MdM support?
→ To what extent will the benefits and progress made continue once funding from institutional donors had ended? Has the project put processes in place that are likely to extend the impact of the project once its funding ceases?
→ What are the principal factors which influenced the attainment or otherwise of the project's sustainability?

→ How will the positive outcomes be maintained in the future at the end of the project at:
– Social/institutional level: Will the project be culturally accepted? How does it link up with local capacities and power structures?
– Economic level: How are recurrent costs and future expenses covered? What is the effect on other economic activities?
– Environmental level: What are the short and long-term environmental costs?

Efficiency

The efficiency of an intervention is the degree to which material, human and financial resources (funds, expertise, time, etc.) are converted into outputs. Efficiency is an economic evaluation which compares the outputs obtained and the resources mobilised.

This type of evaluation requires detailed cost analyses:
→ Total cost of the intervention broken down into type of intervention;
→ Input costs at local and international level;
→ Transport costs broken down into type of intervention and type of transport;
→ Staff costs broken down into local and expatriate staff;
→ Administrative costs as a percentage of intervention costs.[89]

Evaluating efficiency involves comparing the alternative options to see whether the most efficient has indeed been used.

89. ALNAP, *Evaluating humanitarian action using the OECD-DAC criteria*, 2006

NOTE /
'Generalist' evaluators do not necessarily have the skills required to analyse efficiency and it may be necessary to include someone with an economist or accountant profile in the evaluation team.

FOCUS ON
EXAMPLES OF EVALUATIVE QUESTIONS FOR EFFICIENCY

→ Have the results been achieved at an acceptable cost?
→ Has best use been made to achieve the results?
→ Is the level of inputs reasonable in relation to the quality of outputs?
→ Are the human resources appropriate to the job (number, skills and time)?
→ Did the way the budget was devised and applied facilitate attaining its objectives?
→ Is it possible to do more with the same budget? Is it possible to run the intervention at a lower cost?
→ What could be done otherwise to improve implementation in order to maximise impact at an acceptable cost (cost effectiveness)?

Impact

Analysing impact means reviewing all the effects of an intervention on its environment in the broadest sense – technical, economic, social, financial, etc.: **effects which are long term, positive** and **negative,**

expected and **unexpected,** primary and secondary, direct and indirect, intentional and unintentional.

NOTE /
Showing that the project has had a particular impact is particularly difficult, as numerous factors external to the project influence the results. This requires complex methodologies which are designed beforehand.

FOCUS ON
EXAMPLES OF EVALUATIVE QUESTIONS FOR IMPACT

→ What are the expected positive outcomes? Are there unexpected positive outcomes? What are the expected negative outcomes? Are there unexpected negative outcomes?
→ What long-term changes – positive or negative and expected or unexpected – have resulted? Can they be reasonably linked to the intervention?
→ What contribution to the change in the health of populations can be attributed to the project?
→ What real difference has the intervention made for users? Has the project had a tangible positive or negative effect on the project target users?
→ How many people have been affected?
→ Have unintentional and/or negative changes been produced?
→ Does the project have the opportunity to act as a catalyst for future change? How? Why?

While it is difficult and costly to carry out real impact evaluations, which are quite rare within MdM as a result, summative evaluations can pose the question regarding impact. Such evaluations cannot attribute impact to a project but can raise important questions leading to the project's possible reorientation.

The following table provides a way of organising the outcomes during the summative evaluation. It is also a table for tracking changes: negative outcomes must subsequently be mitigated by making adjustments or taking action and maximising the potential of positive outcomes. This table may be used as the basis for discussion with the project team and provides a way of drawing up a visual summary of the project's principal outcomes.

Unexpected positive outcomes	Expected positive outcomes
Unexpected negative outcomes	Expected negative outcomes

2 / ADDITIONAL USEFUL CRITERIA

Other complementary criteria, suggested by Alnap and the URD90 Group[90] in particular, may also be used.

90. Created in 1993, the Groupe URD is an independent institute which specialises in humanitarian and post-crisis practice and policy. Its role today is to help players improve the quality of their programmes by conducting evaluation, research, training and quality consultancy.

Partnership

Partnership is at the heart of MdM values. It is therefore imperative to include it when evaluating any MdM project and it should preferably be examined in isolation (rather than integrated into another criterion), with a view to improving practice and strategy.

The French national platform for coordinating international development NGOs, Coordination Sud, defines nine criteria by which to judge the quality of a partnership:[91]
1. Identical project goals;
2. Joint development of an implementation strategy;
3. Degree and type of involvement of each partner in the project;
4. Agreement on the distribution of roles, activities and resource provision;
5. Complementary competencies and means;
6. Reciprocity;
7. Long-term relationship;
8. Quality of the human relationships;
9. Transparency.

**FOCUS ON
EXAMPLES OF EVALUATIVE
QUESTIONS FOR PARTNERSHIP**

→ Do the partners share a vision of the project's objectives?
→ Do the partners have the same values in their approach to implementing the project?
→ How are the roles, activities and resources distributed between partners?

91. For more information, refer to the "Partnership Guide" by Coordination Sud, 2006, available at http://www.coordinationsud.org/wp-content/uploads/GuidePartenariatCSUDcompletGB.pdf

→ How do the skills and resources of each partner complement one another?

Coordination

Evaluating coordination involves assessing the extent to which the interventions by the different players are harmonised and act to complement rather than duplicate each other. Coordination is sometimes incorporated into the effectiveness criterion rather than being treated separately.

**FOCUS ON
EXAMPLES OF EVALUATIVE
QUESTIONS FOR COORDINATION**

→ Have all other players in the intervention zone been identified?
→ Is the coordination that has been put in place adequate?

Coverage and Equity

Evaluating coverage consists of assessing the extent to which the intervention is reaching the principal population groups affected. The criteria for coverage and equity are closely linked. Equity relates to the notion of need: is the humanitarian aid, or are the interventions in general, supplied in accordance with needs?

Equity means a form of equality or fair treatment. Two forms of equity are generally referred to in public health: horizontal equity and vertical equity.
→ **Horizontal equity** considers that an equal need must be matched by equal treatment. For example, horizontal equity relating to access to healthcare implies equitable access for all whatever the factors such as place, socioeconomic status or age.
→ **Vertical equity** is a form of positive discrimination and considers that individuals with different characteristics must be treated differently. It is according to this principal that the most vulnerable groups are prioritised as recipients of humanitarian aid. This principle also governs the systems for funding progressive healthcare in which those with the highest incomes contribute more than those on low incomes.

Evaluating equity in how needs are covered thus involves analysing data divided into the relevant socioeconomic categories, such as gender, socioeconomic status, ethnic origin, age, etc., as well as analysing data by geographical division.

**FOCUS ON
EXAMPLES OF EVALUATIVE
QUESTIONS FOR COVERAGE
AND EQUITY**

→ To what extent are the project activities having an effect on the target population?
→ Which factors are preventing access to the most vulnerable populations?
→ Is a particular group or are particular groups excluded from services?
→ Is there bias which prevents or limits the access by certain groups or minorities to the project's positive outputs and outcomes?

Innovation

The question of innovation, summarised in the 4P model[92] – product, process, position and paradigm innovation –, is at the heart of international debate, as it is viewed as a way of improving the effectiveness (and efficiency) of aid.

FOCUS ON
EXAMPLES OF EVALUATIVE
QUESTIONS FOR INNOVATION

→ Does the intervention demonstrate types of innovation:
  – In its approaches?
  – In its implementation methods?
  – In its technical package?
  – In the services offered?
→ If the project is seen as a pilot in terms of subject or intervention context, have the means for highlighting and disseminating the lessons learned from the project been considered?

The question more generally asked in the context of an evaluation is about **MdM added value** in the intervention being evaluated. This notion is extremely broad and is ultimately not very clearly defined. No attempt is made in this chapter to do so and, instead, it is suggested that it becomes a subject for discussion within the project team, then with the Steering Committee and the evaluation team, in order to define a common and specific scope for the project context that can be examined as part of the evaluation.

92. The website of the Humanitarian Innovation Fund offers interesting resources both for defining concepts and for practical tools for monitoring and evaluating innovation, http://www.humanitarianinnovation.org/innovation/types.

4.2D

EVALUATION VERSUS COMPLEMENTARY CONCEPTS AND METHODS

1/ EVALUATION VERSUS TRACKING/ MONITORING

Tracking/monitoring broadly refers to ongoing and continuous surveillance of a situation, person, process, etc. Transferred to the health-project context, this concept refers to the systematic and continuous examination of:
→ The project in context and its developments – contextual factors, notably risks to staff, users and partners as well as to the sustainability of the project –, and players/stakeholders.
→ Activities (including support activities);
→ Resources (financial, human and logistical);
→ Outputs and outcomes (health and services produced).

Thus, the tracking system as a whole provides information about the state of a situation and how it is developing, and a means of ensuring that the project implementation phase is progressing as planned and is in line with its context. It makes it possible, for example, to monitor whether the activities are running smoothly, what new opportunities there are for taking action, etc.

Tracking/monitoring	Evaluation
Frequency	
Ongoing process (frequency of information gathering varies: weekly, monthly, quarterly, etc.)	Limited (usually once or twice during the lifecycle of a humanitarian project).
Scope	
Determines whether the project's progress will enable the desired results to be achieved.	Reviews whether the strategies and objectives have been well chosen; whether the project's progress has enabled the desired outcomes to be attained.
Utility	
Used to monitor progress, draw attention to discrepancies and identify corrective action required for the project's results and objectives to be attained.	Used to establish a baseline at the start of the project; during and at the end of the project, used to judge the more or less long-term changes brought about by the intervention and to draw and consider the lessons learned from it.
Conducted by	
Players directly involved in project management.	Evaluation experts (internal or external/independent).
Users of findings	
Project teams responsible for implementation.	Project teams, decision-makers and donors involved in drawing up strategic and operational policies.

While it is important to make the distinction between evaluation and tracking/monitoring, it should be remembered that both feed into one another and that it is difficult to conduct a proper evaluation without a good project tracking/monitoring system. Th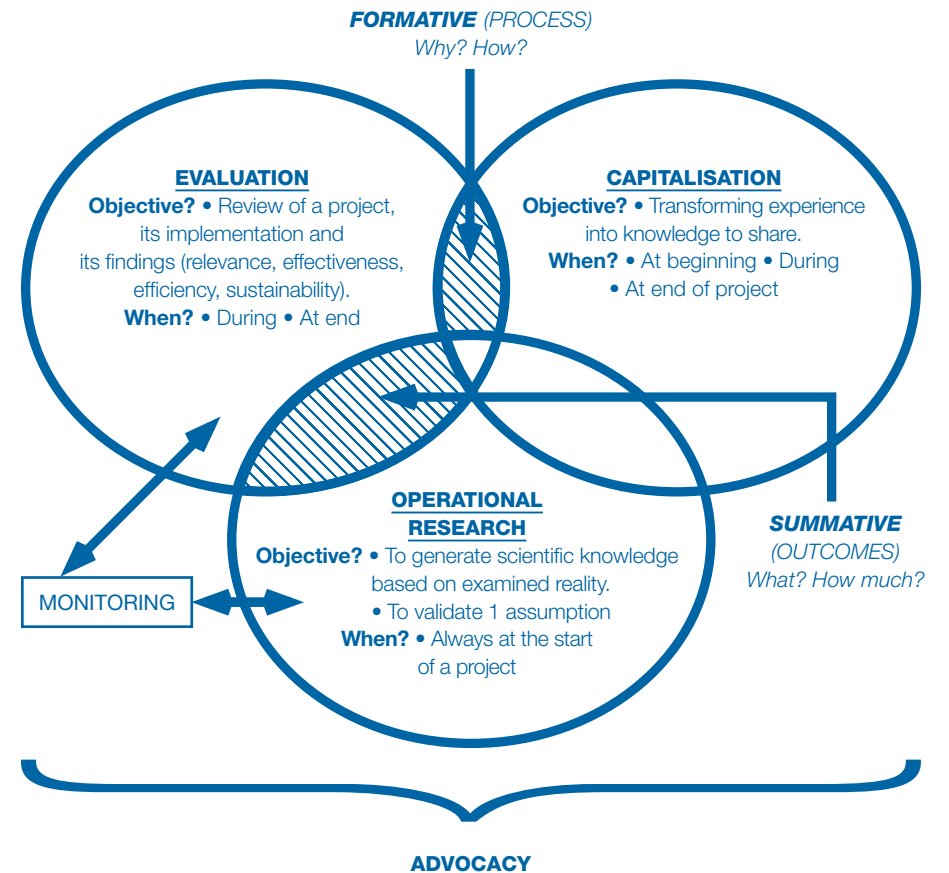e latter is indeed an essential element for feeding into the findings of an evaluation, even if it is not the only source of data. Conversely, it is on the basis of analysing the tracking/monitoring that the decision can be taken whether to commission an evaluation in order, for example, to examine certain points in greater detail.

2 / EVALUATION VERSUS CAPITALISATION AND OPERATIONAL RESEARCH

From this diagram, it can be seen that while evaluation, capitalisation and operational research overlap, each of these fields has its own particular space.

1. **Evaluation** seeks to establish a comparison between a desired and an observed situation by judging the value of the action. It is interested in the outcomes of the action. It has two main objectives: learning and accountability. It relies on a diverse range of methods, usually based on the OECD/DAC criteria: relevance, effectiveness, efficiency, sustainability and impact.

2. **Operational research** is the scientific analysis of a specific process or intervention, used for decision-making. It seeks to generate scientific knowledge based on examining an operational

FORMATIVE (PROCESS)
Why? How?

EVALUATION
Objective? • Review of a project, its implementation and its findings (relevance, effectiveness, efficiency, sustainability).
When? • During • At end

CAPITALISATION
Objective? • Transforming experience into knowledge to share.
When? • At beginning • During • At end of project

OPERATIONAL RESEARCH
Objective? • To generate scientific knowledge based on examined reality. • To validate 1 assumption
When? • Always at the start of a project

MONITORING

SUMMATIVE
(OUTCOMES)
What? How much?

ADVOCACY

reality. It is by its nature forward looking, subsequent analyses having the objective of verifying or refuting a research hypothesis. It is framed by a rigorous protocol and is validated from an ethical point of view by the competent authorities.

3. **Capitalisation** seeks to conceptualise practices with a view to improving them, and to reconstruct and reflect on an experience to draw lessons from it (the intentional and collective production of knowledge). This is the process of transforming "the experience into shareable knowledge". (Pierre De Zutter, 1994). In common with research, capitalisation is also a knowledge process. Capitalisation, while not strictly research, is a form of research which seeks to conceptualise practices.

> has learning as its principal aim. This is notably the case in Anglo-American literature, which does not distinguish capitalisation (or systematisation) as a separate discipline.

Despite the similarities which exist between operational research, capitalisation and evaluation – all three consist of an analysis of an experience which aims, in particular, to improve our practice – they differ both in terms of objective and also method. The three approaches are complementary and it may be entirely relevant to link them. But they are not interconnected and may be set up independently. Capitalisation work may be done without there automatically being an evaluation phase[93] and operational research doesnot necessarily require capitalisation, etc.

NOTE /
Capitalisation may be considered as the branch of evaluation which

FOCUS ON
LINKS BETWEEN CAPITALISATION, RESEARCH AND EVALUATION[94]

Capitalisation	Research	Evaluation
Object of study		
A social practice or an intervention experience in which a leading role has been played.	An aspect or dimension of social reality in relation to which the researcher places himself outside (fundamental research) or inside (operational research).	The outcomes and successes of a project from an external perspective.

Principal interest		
To describe the process, explain the manner of taking action and analyse the impact of the intervention on the population, the reports generated among the different players in the process and the factors which have played a role in the success or lack of it.	To verify or refute the hypothesis, clarify suppositions, analyse and describe facts and explain relationships of cause and effect.	To measure the results obtained, objectives attained, adequacy of the methods, efficient use of resources and impact generated/achieved.
Objective		
To learn from the experience so as to improve practice.	To generate scientific knowledge based on studying reality.	To recommend modifications and suggest improvements.

3 / EVALUATION VERSUS SUPERVISION

Supervision is concerned with individual skills in the context of professional practice and is addressed at people as individuals or collectively. It is aimed at maintaining or improving professional skills, with a view to providing good quality services.[95] There are two ways to view supervision: while 'traditional' supervision tends to place the emphasis on control and detecting poor practice, 'formative' supervision is aimed more at empowerment and ongoing support for individuals in their professional environment.[96]

Evaluation, as defined in this chapter, is not concerned with individuals but with projects. While human resources are included as an aspect of evaluation, this is not in order to examine individual skills but to evaluate certain collective dynamics. It is, for example, a matter of understanding which factors contribute to attaining an effective partnership; which relationships have been formed at the time of the project that have enabled it to be sustainable; etc.

4 / EVALUATION VERSUS CONTROL AND AUDIT

Control is about mastering (and not verifying) operational activities. The traditional function of financial management relates to all processes of budget forecasting, follow up

93. Villeval, P., *Evaluation & Capitalisation : deux démarches complémentaires pour renforcer la qualité de nos actions* [Evaluation & Capitalisation: two complementary approaches to enhancing the quality of our actions], Handicap International, May 2003.

94. "Guía Metodológica de Sistematización", Programa Especial para la Seguridad Alimentaria PESA en Centroamérica, FAO, http://www.pesacentroamerica.org.

95. Fontaine, D., Beyragued, L. and Miachon, C., "Référentiel commun en évaluation des actions et programmes, santé et social" [Frame of reference for evaluating health and social action and programmes], Lyon ERSP, 2004/05.

96. WHO, "Guidelines for Implementing Supportive Supervision", 2003.

and reporting. The aim of internal control is to identify and limit organisational risks (observing procedures, existence of documentation, etc.). Control is a tracking activity (budget follow up, observing procedures, etc.), which makes it possible to determine whether what has been planned (financial strategy, compliance with procedures, etc.) will be attained, to alert those concerned to any deviation and to identify the corrective action required.

Audit is a way of ensuring that information conveyed is reliable by on-site verification on an item-by-item basis. Usually it involves ensuring the compliance of financial information (financial audit), but an audit may also be concerned with other aspects such as operations (operational audit). The audit provides a way of qualifying the financial status or operational process and of judging the accuracy of the information.

Audit and evaluation are both one-off activities aimed at reaching a judgment. While an audit is concerned with the accuracy of information conveyed, evaluation examines a project's underlying logic.

SUMMARY

KEY POINTS FOR UNDERSTANDING WHAT AN EVALUATION IS

→ There are four principal types of evaluation:
  – **Formative or process evaluation** which compares the actual progress of a project with what was planned, analyses the overall dynamics of the project and responds to the questions why and how;
  – **Summative evaluation or evaluation of the outcomes** which measures the effectiveness of the intervention and responds to the questions why and how much;
  – **Impact evaluation** which is interested in all the effects/consequences of an intervention on its environment in the broadest sense;
  – **Meta-analysis or thematic evaluation** which undertakes cross-wise analyses of a greater number of projects.

→ **Standard evaluation criteria** devised by the OECD (relevance/appropriateness; effectiveness; efficiency; sustainability/connectedness; impact) are used to structure the evaluation and are formulated as contextualised evaluative questions.

→ **Additional criteria** can also be used: partnership, coordination and coverage/equity.

→ **Evaluation and tracking/monitoring** are distinct and complementary.

→ **Evaluation, capitalisation and operational research** all have a scope which sometimes overlaps but they are distinct in their objectives and their methods.

4.3

TEN STEPS
TO EVALUATION
MANAGEMENT

Step		Responsibility	
		Commissioner	Evaluator
1	Planning the evaluation	X	
2	Budgeting for the evaluation	X	
3	Setting up the Steering Committee	X	
4	Drawing up the ToR	X	
5	Selecting the evaluation team	X	
6	Preparation phase: reviewing the documents and writing the inception report		X
7	Fieldwork phase: collecting and analysing data	X	X
8	Writing phase: writing, commenting on and approving the provisional final report	X	X
9	Dissemination phase: presenting and disseminating the results and recommendations	X	
10	Ensuring follow-up to recommendations	X	

TEN STEPS TO EVALUATION MANAGEMENT

> The first part of this chapter has provided the elements needed to understand the issues linked to an evaluation and the principal conceptual and methodological bases underpinning an evaluation process. The second part of the chapter tackles the practical dimension and gives the elements required to manage and support an evaluation process.

The evaluation process is not limited to time spent by the evaluation team in the field. The project team – commissioner is extremely active prior to and following the fieldwork phase of the evaluation, as is summarised in the table below.

4.3A

STEP 1: PLANNING AN EVALUATION

1/ CLARIFYING ITS MAIN AIM: ACCOUNTABILITY OR LEARNING

While an external evaluation is most often at the initiative of the donor, evaluating a project may also be at the initiative of a (commissioning) project team.

The first step in planning an evaluation involves asking why one wishes to evaluate. Is there any real need to do so? What is one hoping to obtain from the evaluation?

If certain conditions are not simultaneously met then it is better not to evaluate:
→ If the main players are not particularly motivated and even reject the idea of an evaluation (high risk even before the start of the evaluation of the recommendations not being taken up or proposed changes to the project being rejected);
→ If the conditions for gaining access to the field and the population are such that the costs committed to evaluation exceed a reasonable proportion of those set aside for the project

(principle of proportionality);
→ If the project does not have the elements needed for conducting an evaluation – project documents, guidelines and tracking systems.

> **NOTE /**
> In the first instance, an assessment should be made as to whether the project earmarked for evaluation really can be evaluated.
> If the evaluation is contractual, it is a question of ensuring the conditions required for implementing an evaluation are put in place.

An evaluation is particularly important in the case of:[97]
→ Projects with high levels of funding and activities;
→ Technically highly complex projects or those involving an innovative approach;
→ Projects with the potential to be replicated or scaled up;
→ Projects involving developing a new strategy;
→ A request for evaluation from stakeholders, including agency donors.

97. For more details, refer to the **MdM** evaluation policy.

This first stage of clarifying consists particularly of deciding whether to place greater importance on the aim of accountability or learning: this has implications for the type of methods used, profile of the evaluators chosen and timing of the evaluation.

Whatever the principal aim chosen for the evaluation, it is important that the demand for an evaluation is shared by the key players. Indeed, an evaluation is of no use if there is no real need for knowledge relating to a project, or a desire to enhance it. Above all, it is a matter of ensuring that the project team is ready to question and examine its practices and conceptions – in other words, it is ready for change.

FOCUS ON PUTTING TOGETHER AN EVALUATION WITH THE PROJECT TEAM

> From the evaluation planning stage, it is important to construct the evaluation in a way that involves the project team.[98] To do so requires advance internal preparation: discussing as a team what it is one wants to obtain from the evaluation; responding to the team's questions and concerns; and updating the project documentation. Consideration must be given to the values, viewpoints, interests and expectations of team members at every stage of the evaluation process.[99] In view of the inevitable

98. Or with other stakeholders in the case of a strategic or cross-wise evaluation for example.
99. **Fontaine, D.**, **Beyragued, L.** and **Miachon, C.**, "Référentiel commun en évaluation des actions et programmes, santé et social" [Frame of reference for evaluating health and social action and programmes], Lyon ERSP, 2004/05.

> turnover of team members on projects, the evaluation process should be regularly re-discussed and shared.
>
> Expected users are more likely to implement the findings if they take ownership of the process and the evaluation results.[100] Regular communication throughout the evaluation can also help with this.
>
> The following should as a minimum be shared with the different players:
> → Objectives of the evaluation;
> → Evaluation criteria;
> → Evaluation methodology and process.

2/ CHOOSING THE TIMING OF AN EVALUATION

Once the general aim of the evaluation has been clarified, it is a matter of examining the lifecycle of the project to determine where the most appropriate point lies for meeting this aim. Each choice of timing offers advantages and disadvantages. The choice is usually between an evaluation during the term of the project and a final evaluation: carrying out the evaluation quite early on in the life of a project means that the necessary corrective measures can be implemented and intervention strategies adapted where applicable, but conducting it later means that the elements relating to the outcomes achieved during the project can be gathered.

100. **Buchanan-Smith, M.** and **Cosgrave, J.**, *Evaluation of Humanitarian Action*, Pilot Guide, ALNAP Study, ALNAP/ODI, London, 2013.

DIFFERENT POSSIBLE TIMINGS OF AN EVALUATION
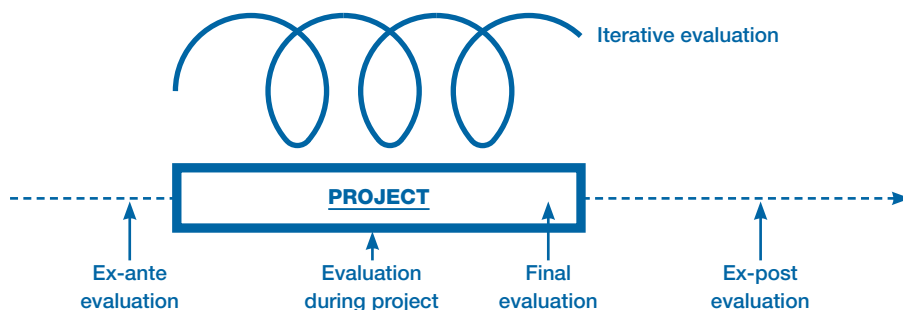
The evaluation timetable must be carefully thought out in a more detailed manner. In particular, this involves ensuring that, for example, the team is available for the evaluation and that it is not engaged in other strategic or time-consuming matters; that the fieldwork phase of the evaluation does not occur at the same time as a field visit by HQ, partners or journalists; that the evaluation takes place before a programme review or a workshop to redefine the project strategy, etc.

Ex-ante evaluation

Ex-ante evaluation consists of analysing a context before the start of a project (fact-finding mission and initial diagnosis). In addition, it enables a **baseline** to be established. It is developed in the Diagnosis chapter of this guide.

Evaluation during a project

Evaluation during a project is carried out when there are important changes, such as an alteration in the context or the emergence of new needs. It may also have been planned for – during the programming phase or at a donor's request – at a defined moment in the project to ensure that the latter remains consistent with its original objectives. It enables the project to be refocused and represents a pivotal step.

Iterative evaluation

Groupe URD defines iterative evaluation as being a dynamic evaluation and support process to improve practices in a changing context. An iterative evaluation comprises a series of evaluations conducted at pivotal moments in a project. Its aim is to increase the capacity of a project to adapt to developments in the context, capitalise on and use lessons learned more effectively, and ensure the good quality of the project. It is characterised by a participative approach which favours exchanging experience between project stakeholders and increasing their capacities.[101]

Final evaluation

As its name indicates, this evaluation is carried out at the end of a project and reveals not only the extent to which the project has attained its objectives but also whether the project is consistent with its underlying logic, the values it wishes to convey and the changes it wishes to bring about.

101. http://www.urd.org/Evaluation-iterative-du-Projet, last accessed on 30/11/2014.

> **NOTE /**
> It is preferable not to wait until a project is effectively terminated before undertaking the final evaluation: the evaluation team requires logistical support on the one hand and needs to be able to meet the different players on the other. This is more difficult if the project is finished.

Ex-post evaluation

This evaluation is carried out a few years after the end of the project to evaluate its impact and the sustainability of the changes it has brought about. It does not necessarily have to be conducted by external agents. As with the other types of evaluation, this type of evaluation must be planned from the project-design stage.

> **NOTE /**
> → Advance planning is essential to ensure the quality of the evaluations:
> – It enables sufficient financial resources to be provided;
> – It optimises the chances of the best evaluation team being available at the desired moment;
> → The evaluation must be devised and commissioned at least 6-12 months before its intended implementation.
> → The findings of the evaluation must be of use and therefore must not arrive too late for decision-making.

4.3B

STEP 2: BUDGETING FOR AN EVALUATION

> The costs of an evaluation are set in relation to the degree of complexity of the evaluation and the expertise required.

The total envisaged for an evaluation is calculated on the basis of the following elements:
→ Fees, insurance and per diem (if daily living expenses not met by MdM)
→ International and national travel
→ Accommodation (if not covered by MdM)
→ Interpreting services
→ Expenses for meetings and workshops (room hire)
→ Communication costs
→ Cost of producing the report (translation, layout, printing, etc.)
→ Other (specify)

One of the principal costs of an evaluation is the total number of external consultancy days.[102] The more complex the object of a consultancy is, the greater the need to allow for not only more days for the evaluation but also for one or more experienced evaluators.

102. The fees for international consultants are generally between €200/day for junior consultants and up to €1000/day for senior consultants. The MdM upper limit is fixed at €450/day.

Establishing an evaluation budget therefore principally comes down to calculating the number of consultancy days required.

**FOCUS ON
ESTIMATING DEADLINES**

0. Definition and selection phase
→ Allow a minimum of 3 to 4 weeks for the exchanges required to produce the ToR
→ Allow a minimum of 2 to 3 weeks between the issuing of a Call for Expressions of Interest (CEI) and receipt of applications
→ Allow a minimum of 1 to 2 weeks for scrutinising the applications
→ Allow a minimum of 3 to 4 weeks between sending the ToR and receiving the technical and financial proposals
→ Allow a minimum of 1 to 2 weeks for grading the proposals

The following points of reference may be used to calculate the number of consultancy days required:

1. Preparation phase (document review and briefings)
→ Allow 1 day's preparation for 3 days in the field (for example: 5 days' preparation for 15 days in the field; 8 days' preparation for 25 days in the field), spread over an average of 2 to 3 weeks.

2. Fieldwork phase (data-gathering and analysis)
→ Allow half a day to conduct a focus group, 2 hours for an interview; allow two to three times as much time to process the information resulting from focus groups and interviews. At MdM, the fieldwork phases of evaluations last an average of 2 to 4 weeks.

3. Provisional final report-writing phase
→ Allow 1 day for analysing/writing for every 2-3 days in the field (for example, 5-7 days' writing for 15 days in the field; 9-11 days' writing for 25 days in the field), spread over an average of 3 to 4 weeks.

4. Feedback and finalising phase
→ Allow a minimum of 3 to 4 weeks for reading over the provisional final report and collating comments from Steering Committee members.
→ Allow 4 to 8 days, spread over a minimum of 1 to 2 weeks, for the consultant(s) to incorporate the Steering Committee's comments.
→ Allow 1 to 2 weeks for the Steering Committee members to read over the definitive version of the final report.

→ Allow 1 to 5 days for reporting back and discussions – with the project team, teams at HQ, local, national and even international partners, and with donors. Reporting-back sessions can take different forms, including workshops bringing together all players and partners.

NOTE /
In estimating the time to allow for the fieldwork or data-collection phase, it is important not to overlook the time needed to travel from one location to another. Furthermore, it is important to set aside time to take stock, i.e. time for analysis between the series of interviews and focus groups. The evaluator must be able to take a step back from the information he has been able to gather in order to refine and add to it.

NOTE /
The time required as a whole between launching a consultation and receiving the definitive version of the final report varies between 22 and 24 weeks. If the time taken for discussion devoted to defining the principal aim of the evaluation and the time for reporting back following submission of the final report are taken into account, then the evaluation process lasts for between 6 and 12 months. The further ahead planning is done, the greater the likelihood of attracting experienced consultants whose schedule of work is filled at least 6 months in advance.

4.3C

STEP 3: SETTING UP THE STEERING COMMITTEE

> Once the decision to evaluate has been taken, a **Steering Committee** should be set up. This committee must comprise a minimum of several members of the project team (field and HQ), and one member of the technical team (medical and/or thematic adviser). It is important to carefully consider the composition of the Steering Committee in the light of how the evaluation conclusions and recommendations are to be disseminated.

1 / COMPOSITION

The committee should preferably comprise an odd number of members. One of the members of the Steering Committee – the head of the evaluation – is identified to coordinate the process and to serve as a focal point for the evaluators.[103] The recommended membership is:

→ 3 people for a small-scale evaluation involving no major issues (for example, the desk officer, general coordinator or project coordinator concerned and volunteer board delegate (RM) or medical adviser);

→ 5 people for a more complex evaluation or one which is intended to produce strategic recommendations for the project (for example, the desk officer, the general coordinator or project coordinator concerned, the volunteer board delegate (RM), the medical or thematic adviser, and the evaluation adviser);

→ 7 people or more for a large-scale evaluation or one which involves important issues for the organisation as a whole (here, in addition to the individuals listed above, it is a question of including

members of the Board of Directors and one or more of the directors). The key issue is to carefully plan the whole evaluation process so that Steering Committee members can be available for the predetermined deadlines.

NOTE /
Depending on the objectives of the evaluation, it may be relevant to include someone on the Steering Committee, who is working on a similar project in another context. This provides an additional, complementary view – which remains an external one – of the project being evaluated.

2 / ROLE

The Steering Committee has a very important role in guiding the evaluation. It must:

→ Validate the evaluation timetable, i.e. the major deadlines, including those for reporting back;
→ Validate the evaluation Terms of Reference (step 4);
→ Select the evaluation team (step 5);
→ Take part in the briefing/inception meeting with the evaluator (step 6);
→ Read and comment on the provisional final report (step 8) and then the definitive version of the final report;
→ Complete the 'Evaluation Feedback' form;
→ Play an active part in disseminating the evaluation deliverables and conclusions (phase 9);
→ Follow-up on implementing the recommendations (phase 10).[104]

103. This is the person responsible for implementing the procedure for providing intellectual services.

104. It is also possible at this stage to include other people in the Steering Committee and even to set up a specific committee to follow-up on the recommendations.

4.3D

STEP 4: DRAWING UP THE TERMS OF REFERENCE (TOR)

> The **Terms of Reference** are a key element of the evaluation: they are the tool which enables the different players involved to draw up a shared understanding of the objectives and aims of the evaluation.

The process of drawing up the ToR must also be as inclusive and participative as possible. At this stage, the evaluator does not intervene and has not yet been selected. But later on there is a *negotiating* stage for the Terms of Reference with the chosen evaluator.

In the first instance, the Steering Committee is responsible for defining the objectives and the reach or scope of the evaluation. Then it is a matter of determining exactly which evaluation criteria should be tackled, which questions the evaluation should pose, when the evaluation should take place, what the ideal evaluation team would be (external, internal, mixed, etc.), what budget can be earmarked for the evaluation, etc.

FOCUS ON
ESSENTIAL ELEMENTS OF AN EVALUATION'S TERMS OF REFERENCE

→ Setting out the context and the project;
→ Evaluation objectives (**Why** evaluate and **For whom**); scope and users;
→ Evaluation criteria (**What** will be evaluated);
→ Preferred methodologies (**How** the evaluation will be conducted);
→ Timetable (**When** the evaluation will be conducted);
→ Expected deliverables and presentations of findings, and format of these;

→ Budget available for the evaluation;
→ Skills required to conduct an evaluation (**Who** will do the evaluation?);
→ Application pack.

1/ SETTING OUT THE CONTEXT AND THE PROJECT

This involves detailing in a few paragraphs the general background to the project as well as the project's objectives and expected results, principal activities, budget and timescale.

NOTE /
Candidates prepare their proposal solely on the basis of the Terms of Reference. It is therefore important that there is enough information on the context and the project to enable them to prepare their evaluation questions and methodology as thoroughly as possible. With insufficient information, the proposals received risk being too vague and risk making selection of the evaluation team difficult.

2/ OBJECTIVES AND PURPOSES OF THE EVALUATION

Principal aim

This is a matter of clearly stating whether the principal aim of the evaluation is learning or accountability. This paragraph must briefly set out the considerations which led to the particular aim being chosen and must justify why it is believed that the evaluation is the best way to achieve the defined objectives. For example, where the aim is to learn lessons, why is it considered, in this specific instance, that an evaluation is more appropriate than a capitalisation exercise?

Evaluation scope

What is the range of the evaluation: what is its scope in terms of geography, timing and programming? (For example, does it cover certain sites or all of them, certain aspects or the whole of the project?)

Evaluation users

The origin of the evaluation request should be specified: who is requesting the evaluation and under which circumstances?

NOTE /
The evaluator must understand the reasons why the evaluation has been requested as this influences the methodologies chosen as well as how the work of the evaluation is organised.

Details must also be given as to how the results will be used and who will be using the evaluation. Will it be internal or external players, for example, national health authorities, national or international partners, the donor, HQ decision-makers or those involved in the project?

3 / EVALUATION CRITERIA AND EVALUATION QUESTIONS

It is important to be clear here about the different aspects one wants to evaluate and to provide questions that are precise and specific to the project. In order to be as thorough as possible and to bring together views and expectations, it is helpful to ask each member of the Steering Committee to list his or her own questions (which may then be reorganised according to the various criteria).

All criteria are not evaluated every time: on the contrary, it is advisable to carefully think about which ones should be prioritised and, if applicable, to explain this choice to the donor. Indeed the donor might have preferences in terms of evaluation criteria.

> **NOTE /**
> In the context of MdM projects, it is generally the criteria of relevance, effectiveness, sustainability and partnership that are chosen.

The importance of the evaluative questions, which guide all the evaluators' work, is not highlighted again here.

> **NOTE /**
> It is important to be sufficiently precise about the various aspects/criteria one wishes to evaluate and to submit precise and specific evaluative questions.
> The more general the questions put, the greater the risk that the evaluator's responses will be generalised.

4 / PREFERRED METHODOLOGIES

Quantitative/qualitative methods

This involves indicating which methodologies are preferred, i.e. the methods for data collecting or the combination of desired quantitative/qualitative methods (site visits, discussions with teams or partners, questionnaires, workshops, etc.). The evaluation candidates should then, in their technical proposal, set out the methodology that they wish to implement to respond to the evaluation questions.

> **NOTE /**
> It is recommended that the indications given regarding the methodologies should not be overly specific because, on the one hand, there could be a lack of familiarity with them which would give rise to errors and because, on the other hand, it is the candidates themselves who are expected to put forward

a methodology. It is on the quality of what they propose that their applications will be judged.

Key documents and individuals

Conversely, the Terms of Reference must specify which documentation to consult and the individuals and institutions to meet with during the evaluation process. By giving precise details of the number and type of documents and players, the evaluators can estimate their volume of work and quantify the number of consultancy days required.

> **NOTE /**
> Care should be taken not to swamp the evaluator with documentation to consult or individuals to meet. It is better to stick to the essentials and leave the evaluators to formulate additional requests during their assignment, should they feel it necessary.

5 / TIMETABLE

The ToR must specify the period during which the evaluation can and must be carried out: possible start date, latest date for submitting the final report, period during which the fieldwork phase can take place, depending on the availability of interlocutors (elections, annual leave or public holidays) and the accessibility of sites (rainy season or harvest), and dates envisaged for presenting the findings.

> **NOTE /**
> There must always be a margin for contingencies allowed for in the scheduling: unforeseen circumstances can arise not only for the evaluation team or among the field team but also for Steering Committee members.

6 / EXPECTED DELIVERABLES AND PRESENTATIONS OF FINDINGS

Deliverables

The ToR must specify the deliverables expected from the evaluation assignment. The principal deliverables usually expected from an evaluation are:
→ Inception report written by the evaluation team at the end of the preparatory phase;
→ Provisional final report written following the fieldwork phase. MdM then has a few weeks from receipt of the provisional final report in which to issue its comments and observations.
→ Definitive version of the final report which incorporates the comments and remarks resulting from exchanges and discussions.
→ PowerPoint presentation or any other illustrative material for presenting the findings.

There may also be intermediate documents (for example, reports of field visits or meetings).

Different versions of the same deliverable may also be desirable: for example, an external abridged version for wider distribution to stakeholders and an internal version designed to prompt discussion and debate within the organisation.

Lastly, rather more atypical formats may also be envisaged, such as video, photo montage, etc.

> **NOTE /**
> In every instance, the format of the expected deliverables must be specified: structure, length, annexes desired and even the house style, so as to avoid having to reformat the deliverables later on. Translations of the deliverables should also be envisaged, so that they can be disseminated to the players concerned. Lastly, attention must be paid to the fact that the more that is asked for in the way of deliverables, the greater the budget required in consequence.

Presentations of findings

Details are given here of whether or not the evaluator is expected to lead one or more sessions, conduct workshops, take part in one or more sessions to report back on the findings, etc. This entails giving some prior thought as to how the findings should be conveyed to the particular target audience.

Details should also be provided of the timetable for reporting back on the findings, some sessions taking place several weeks or months after the evaluation report has been submitted.

7 / ORGANISING THE EVALUATION MISSION

In this section of the ToR the following should be specified:
→ Logistical and administrative support potentially provided by the field team to the evaluation team (for example, arranging meetings, identifying interpreters, making hotel bookings, etc.);
→ Equipment and means of communication which can be made available (vehicle, printer, Thuraya phone, videoprojector and emergency aid kit);
→ Security rules and procedures which apply to the evaluation team (travel permissions, regular contacts, etc.);
→ Reporting back and any progress reports to the focal point of the evaluation in the field or to the Steering Committee.

> **NOTE /**
> Even when the evaluation team is made up of external consultants, they are still required to abide by the security rules and procedures, as it is not only their own security at stake in the case of non-compliance but the security of the whole project.

8 / BUDGET

A general idea of the size of the budget available is provided, but the ToR must be very clear about what is included in the budget. For example, it must be stated whether airline tickets, visas, travel in the field, accommodation, food and translation costs are covered by this budget or whether they are paid for by MdM.

9 / SKILLS REQUIRED TO LEAD THE EVALUATION PROCESS

The profile of the consultant(s) must be considered on the basis of each evaluation. For the profile, it is a matter of specifying whether it is preferable to have:
→ An individual consultant or a team of consultants (a team of consultants may provide a richer analysis but can be more complicated to manage as regards organising in the field and can make the process longer, notably during the report-writing phase);
→ An international evaluator (able to shed light on different contexts) or a national evaluator (able to bring an understanding of the local context and a mastery of the language);
→ A male or female evaluator (each with their own ease of access depending on the population groups);
→ Etc.

In terms of skills, the proper balance must be found between:
→ Experience of evaluation (expertise in methodologies and managing sensitive situations, for example relations with institutions or partners);
→ Technical expertise (in the field of health/public health for example);
→ Geopolitical expertise in a particular region;
→ Professional experience within an NGO (better understanding of the constraints in the field and greater credibility with the teams);
→ Proficiency in different languages (some key project documents may be written in one language but the principal interlocutors encountered may speak another);
→ Knowledge of the organisation;
→ Etc.

> **NOTE /**
> Clearly distinguish between the required criteria (for example, prior experience in evaluation) and those which are desirable (for example, knowledge of a local language).

10 / APPLICATION PACK

Finally, the ToR must list the information and documentation to be included in the application pack. An evaluation pack comprises two parts:

A technical proposal

A technical proposal including:
→ An understanding of the Terms of Reference (that is to say, a reformulating in the candidate's own words of how the project is understood, the objectives of the evaluation and the desired approach);
→ The evaluation methodology put forward by the evaluation team;
→ The composition of the team, distribution of responsibilities among its members, CVs submitted and availability of members;
→ The provisional timetable for the assignment as well as an estimate of the costs per person per day;
→ References from two similar previous assignments (if these evaluations have been made public, they will give an idea of the quality of the work carried out and will enable those who commissioned the work to be contacted for feedback

on how the evaluation assignment went);
→ A sworn statement as to the absence
of any conflict of interest.

A financial proposal

A financial proposal including:
→ The total budget including all tax and
incorporating a break-down of the budget –
fees, living costs, transport, interpreting, etc.

NOTE /
It is helpful to specify the number
of pages expected in the application
(some applications may run to one
hundred pages). An application of
10 to 15 pages provides a sufficiently
precise idea of the methodology
and approaches being proposed.

4.3E

STEP 5: SELECTING THE EVALUATION TEAM

1/ ADVANTAGES AND LIMITATIONS OF DIFFERENT TYPES OF EVALUATORS

The quality of an evaluation depends
largely on the capacity to identify the right
evaluator at the right time.

It is also important to be aware of the
advantages and limitations offered by each
evaluator profile, depending on whether
it is someone from within or totally outside
the organisation *(see next pages).*

2/ SELECTION PROCEDURES FOR EXTERNAL EVALUATORS

The transparency of the evaluation
team selection process is both
aresponsibility in terms of ethics
and accountability and a factor in giving
the evaluation credibility. "The acceptance
of the evaluator, by all parties, both
as regards his professional experience
and his personality, is fundamental
in guaranteeing his legitimacy."[105]

When selecting external consultants[106],
MdM chooses from two approaches
defined in accordance with internal
procurement thresholds and donors' rules:

---

105. Guéneau, M.C., Beaudoux, E., *L'évaluation :
un outil au service de l'action* [Evaluation : a tool
to assist action], F3E, 1996.
106. For more practical details, refer to the full procedure
for providing intellectual services.

TYPE OF EVALUATOR	ADVANTAGES
Self-evaluation team	In the case of a self-evaluation, those involved in the project evaluate their intervention themselves. The advantage of this method is that it builds up support from the project players for the conclusions of the evaluation and that it will therefore lead to the conclusions and recommendations being implemented
Internal evaluation team	An internal evaluation is carried out by someone who is external to the project but internal to the organisation. An internal evaluation team offers the advantage of: → Knowing the organisation, its culture and its projects well; → Being known internally and therefore perhaps better accepted during the evaluation process; → Keeping a form of distance and neutrality in relation to the project (as there is no direct involvement in the project in question); → Costing less; → Putting forward conclusions and recommendations that are more suited to the organisation; → Acting as a channel for disseminating and sharing knowledge; → Playing a role in constructing Institutional Memory.
External evaluation team	An external evaluation is carried out by someone who is completely outside the organisation. → Being completely familiar with evaluation methods and relying on its experience to analyse complicated situations; → Guaranteeing a degree of distance when evaluating a situation and the project team being in a position to remove themselves from everyday affairs; → Being positioned as mediators within the teams; → Being independent and less subject to the organisation's influences or pressures, notably as regards formulating sensitive conclusions or recommendations; → Giving the evaluation greater credibility, particularly in the case of evaluations contractually agreed on with the donor.
Mixed evaluation team	A mixed evaluation team is composed of both internal and external players. A mixed evaluation team offers the advantage of: → Knowing the organisation, its culture and its projects well; → Being completely familiar with evaluation methods and relying on its experience to analyse complicated situations; → Strengthening internal capacities relating to evaluation; → Putting forward conclusions and recommendations which are more appropriate to the organisation.

LIMITATIONS
Self-evaluations are principally limited by two factors: → A lack of method in how the evaluation is conducted, which may lead to → A lack of objectivity.
An internal evaluation team is principally limited by: → A lack of experience of and training in evaluation methods (which are based on pre-established criteria and triangulation analysis of methods and data); → Insufficient time to complete evaluations successfully; → Problems with stepping outside the organisation's workings to examine situations with a sufficiently distanced and critical eye; → Being subject to pressures or influences in how certain conclusions or recommendations are oriented; → Not enough credibility compared to external interlocutors.
An external evaluation team is principally limited by: → A lack of knowledge of the organisation, its culture and its constraints; → A tendency to put forward conclusions and recommendations which are not appropriate to the organisation; → Costing more; → Being self-censoring in certain observations and conclusions in order to be re-contacted later on.
A mixed evaluation team is principally limited by two principal factors: → It costs more; → Members do not all know each other and are not accustomed to working together.

Call for Expressions of Interest (CEI)

The Call for Expressions of Interest is a straightforward document which succinctly sets out the context, objectives and timetable of the evaluation as well as the applicant profile sought and the documents to include in the application.

The CEI is published on the internet and other public networks. Potential candidates (consultancy firms or individuals) submit a CV and a letter supporting their application explaining which requisite skills they believe they have for successfully conducting the evaluation. Consultancy firms submit their applications by forwarding the CV(s) of the consultant(s) who will conduct the evaluation: the application and the subsequent proposal are examined therefore on the basis of the CV(s) and not on the basis of the promotional literature or the reputation of the consultancy firm.

A short list of 3 to 6 candidates is drawn up based on skills, experience and availability. When examining the CVs for shortlisting an evaluator, consideration may be given to a consultant who has carried out several evaluation assignments for the same organisation and has given satisfaction in terms of the quality of his work, leading the organisation to approach him once more.

Shortlisted candidates are then invited to submit their technical and financial proposal on the basis of the Terms of Reference sent to them. It is possible to select candidates while expressing reservations: for example, asking a consultancy firm to propose a different candidate; or asking a candidate to combine his expertise with that of another consultant, etc.

A scoring grid, drawn up on the basis of the ToR and comprising two main sections

of equal value in terms of points (CVs and technical proposal), is used to rank the applications received. The Steering Committee meets and discusses the proposals received. This provides an opportunity to review the scores awarded to each candidate, collectively discuss each application and select a proposal. Personality and know-how are as important as experience and technical skills. It is therefore desirable to obtain information from other organisations which have called on the services of these evaluators.

NOTE /
The main disadvantage of the CEI process is the addition of another step of a few weeks to the selection process. There are many advantages: firstly, this process makes the shortlisting phase more efficient, as it focuses on a CV and letter of interest and not on a full and far lengthier proposal, and therefore enables a large number of applications to be dealt with much more quickly. Secondly, it increases the quality of the proposals received, as the candidates are more motivated to prepare a high quality proposal if they know they are competing with a handful of other candidates rather than competing with dozens of candidates, as is the case with a call for proposals.

Negotiated procedure

In the case of a negotiated procedure, a limited number of between 4 and 6 potential evaluators (either independent or belonging to consultancy firms or bureaus) is identified using the evaluators'

database, and those chosen are encouraged to submit proposals on the basis of the full ToR. This procedure is based on accurate and formal archiving of the whole selection process, which makes it possible to construct an institutional memory and to progressively identify evaluators whose skills and attitudes are in step with the organisation. Archiving is also important for the fact that it fulfils our requirements in terms of accountability, notably in the event of a donor audit.

Once the proposals have been received, the selection process continues on the basis of the scoring grid.

NOTE /
The main advantages of the negotiated procedure are that it shortens the selection process, as it begins directly with assigning a score to each proposal, and from the outset ensures that the services of a consultant, whose personal qualities and work have been appreciated in the past, are secured. The main disadvantage is that it is not always possible to identify enough candidates with the profile sought to guarantee that 3 proposals will be received.

4.3F

STEP 6: PREPARATION OR INCEPTION PHASE

1/ DOCUMENT REVIEW

Once the evaluation team has been selected and the contract signed, the evaluation team has access to the project documents and can thus begin studying the documentation and familiarising itself with the project to be evaluated.

The role of the Steering Committee is to select the most relevant documents to enable the evaluation team to become familiar with the organisation's strategies and policies relating to the subject under consideration, the context in which the project operates and the project itself.

For its part, the evaluation team supplements this basic documentation by researching other documents elsewhere to add to its understanding and analysis, for example evaluation reports for other, similar projects.

2/WRITING THE INCEPTION REPORT

The inception report is the finalised version of the technical proposal sent by the evaluation team following the review of key documents and discussion with the Steering Committee. A provisional version is submitted following an examination of the documents; it is discussed after the inception meeting and subsequently finalised. Depending on the scope of the evaluation, a period of between one and three days is required after the inception meeting with the Steering Committee in order to finalise the inception report.

The evaluation team must:
→ Review the ToR and put forward clarifications, changes or additions if necessary;
→ Prepare the evaluation matrix and add final elements to the methodology;
→ Create evaluation tools (e.g. interview guides, observation tables, questionnaires etc.);
→ Put forward a realistic plan of work with a definitive timetable (players to interview, documents to study, etc.) and a distribution of roles among evaluation team members.

FOCUS ON
EVALUATION MATRIX

The evaluation matrix generally comprises 4 columns containing the following elements:
1. Selected evaluation criteria;
2. Evaluative questions relating to each of the criteria (taken straight from the ToR);
3. Indicators or other tools for responding to the questions;
4. Methods and information sources envisaged.

The evaluation matrix enables the Steering Committee to judge the appropriateness of the methods chosen in responding to the evaluative questions and, at the same time, their feasibility in terms of the time and budget allocated.

The inception report acts as a guide for the evaluation team during their fieldwork. It must be approved by the Steering Committee before being implemented.

3/INCEPTION MEETING

Towards the end of the preparatory phase, an inception meeting is held between the Steering Committee and the evaluation team, often represented by the team leader. The discussion provides an opportunity to go over the objectives of the evaluation, the questions being asked, etc. The ToR are often, admittedly, far too ambitious in terms of allotted time and budget. The role of the evaluator is to suggest modifications to the ToR to ensure that they are achievable. Cette étape est très importante.

This is a very important stage: it is the point at which the Steering Committee and the evaluator(s) agree on the objectives and methodology of the evaluation:
→ For the Steering Committee, it is an opportunity to verify that the evaluation team has clearly understood what is expected and that its approach to tackling the issues is in line with that of the organisation – for example, regarding the role of the user in validating the quality of the project;
→ For the evaluation team, it is an opportunity to highlight any ambiguities or even contradictions in what is expected, and to clarify what the priority requirements are.

NOTE /
Any proposal to modify the Terms of Reference (relating to objectives, scope, evaluative questions, preferred methodologies, etc.) must be validated in writing by the Steering Committee. In the event of a major modification, a new version of the Terms of Reference must be produced.

TEST OUT CONCLUSIONS
IN REPORT-BACK SESSIONS

BUT THAT'S NOT IT AT ALL!

Good.

That's everyone agreed then.

4.3G

STEP 7: FIELDWORK OR DATA-COLLECTION PHASE

1/ INTRODUCING THE EVALUATION

If the evaluation has been properly prepared, it should already have been introduced to the players concerned during the meetings to clarify the objectives and methods.

This does not, however, mean that the evaluators should not be expected to organise a meeting with the field teams and partners on their arrival in the field. Such a meeting provides an opportunity to introduce the various members of the evaluation team, go over the objectives and questions of the evaluation and set out the timetable for intended travel and meetings.

2/ DATA COLLECTING

Data is collected according to the different methods used in the diagnostic phase:

Document review

The document review involves analysing reports, project documents, project proposals submitted to donors and strategic plans, and reviewing the literature directly linked to the project and the intervention context.

However, one of the pitfalls is losing one's way in all this documentation. The responsibility of the Steering Committee is therefore to see to it that the number of documents examined by the evaluator remains within reasonable limits. Experienced evaluators know to ask for additional, specific information emerging from interviews or observations during the course of the evaluation.

Quantitative methods

An essential task within an evaluation is analysing epidemiological data or the project indicators from a monitoring system (an ongoing process).

Less commonly and depending on the scope and objectives of the evaluation,

a specific survey may be put in place.[107] For example, a questionnaire survey to gauge user satisfaction.

Qualitative methods

Qualitative methods are widely used in evaluations. They make it possible, for example, to obtain an appraisal of the project from the different stakeholders, including users. These methods are not developed here and have been the subject of a separate guide dealing with issues linked to working with interpreters in particular.[108]

Observation plays a very important role in an evaluation, as it provides an opportunity to note group dynamics, agreements and disagreements, forms of leadership, etc. This is why it is important to leave the evaluator sufficient time for field visits.

Individual interviews provide the means to gather the opinions and impressions of the different stakeholders, who should preferably be questioned individually to enable them to speak freely.

It is important to have the means to gather user opinions: therefore, individual or group interviews (i.e. focus groups) should, in so far as is possible, be held in the language of those taking part.

3 / DATA ANALYSIS

The data collected is analysed as follows:
→ Continuously throughout the evaluation;

→ Once the evaluation is finished and all the information is collected, the data emerging from the different methods and/or techniques used must be compared and examined. During this process of **triangulation**, the emphasis is on looking for differences and similarities, including those relating to perception.

The analysis must be approached from multiple angles and must compare and contrast points of view and sources of information in order to understand the reasoning of those involved. The Steering Committee, when reviewing the provisional and then the definitive report, must ensure that the analysis adopts a triangulation approach by studying, for example, the annexes produced by the evaluation team.

FOCUS ON
RELIABILITY AND VALIDITY
OF A MEASUREMENT

A measurement is said to be reliable if it produces similar results when repeatedly applied. In other words, several measurements done by different observers or at different points in time must give the same result. Reliability is an essential condition but is in itself not enough to ensure validity.[109]

A measurement is said to be valid if it actually measures what it is supposed to. In other words, a valid measurement actually represents

the subject of the research. When a measurement is not valid, it is said to be biased. Bias is a systematic measurement error relating to actual values.

The annexes may include an analysis of statistical data or a content analysis, which generally takes the form of classifying the documents on the basis of theme.[110]

Triangulation reinforces validity. It involves comparing and contrasting data, sources or methods on the same question examined. There are three possible forms of triangulation:

→ **Data triangulation:** This involves comparing one set of data with another, whether or not the sources and methods of collection are the same – for example, comparing changes of attitude described by users with the objectives attained by those intervening in a similar project; or comparing and contrasting the satisfaction of participants with the knowledge they have acquired.[111]

→ **Data-source triangulation:** This involves comparing information obtained from different sources using the same method – for example, comparing an assessment of the quality of healthcare by users and healthcare workers, as perceived by each in a focus group.

→ **Data-collection method triangulation:** This involves comparing information

obtained using different methods – for example, analysing the degree of user satisfaction by observation, questionnaire and focus group.

Exploiting and analysing the data represents a tricky stage. It involves sorting through a considerable amount of information and extracting the items which are most relevant and those which have been confirmed during the process of triangulation. It is essential to avoid the pitfall of drawing conclusions on the basis of the opinions expressed by a single interlocutor. In contrast, it is useful to highlight conflicting opinions. The Steering Committee must leave enough time for this analysis phase.

In practice, often rapid and even rough work is initially carried out in the field and is not completed and refined until afterwards during the writing-up of the evaluation report.

4 / TESTING INITIAL CONCLUSIONS

A discussion between the evaluation team and the project team takes place 'on the spot', in the field, based on a rapid analysis of the initial findings. Ideally, this discussion happens on the basis of the provisional version of the report, but this is not always possible. In such cases, discussion takes place around an oral presentation of the principal conclusions and recommendations, illustrated, for example, using PowerPoint.

Time must be set aside for reporting back on the findings. This is an extremely important stage involving discussions and exchanges of views about the results among the various project players. It is the occasion for everyone to make their voice heard, to provide complementary information

107. For more information, refer to the **MdM** guide "Data Collection, Quantitative Methods, The KAP Survey Model", 2011, available on the MdM website in English, French and Spanish.
108. To find out more, refer to the **MdM** guide "Data Collection: Qualitative Methods", 2nd edition, 2012, available on the MdM website in English, French and Spanish.

109. Fontaine, D., Beyragued, L. and Miachon, C., "Référentiel commun en évaluation des actions et programmes, santé et social" [Frame of reference for evaluating health and social action and programmes], ERSP, Lyon, 2004-2005.

110. To find out more, refer to the **MdM** guide "Data Collection: Qualitative Methods", 2nd edition, 2012, available on the MdM website in English, French and Spanish.
111. Fontaine, D., Beyragued, L. and Miachon, C., "Référentiel commun en évaluation des actions et programmes, santé et social" [Frame of reference for evaluating health and social action and programmes], ERSP, Lyon, 2004-2005.

and to set out their view of the situation. The role of the member(s) of the Steering Committee representing the field is very important here: it is up to them to establish the best possible conditions for facilitating the reporting back and for encouraging rich and productive discussions.

For the evaluator, reporting back is a valuable process for three reasons:
1. For gathering complementary information;
2. For verifying the conclusions reached in order to refine them where necessary;
3. For testing assumptions in the recommendations.

It is desirable to organise various sessions to present the findings depending on the different types of players involved in the project. The information fed back to the project team will not produce the same exchanges as that conveyed to local players or the authorities. It may be that, following the reporting-back sessions, the evaluators will wish to review all or part of their arguments and conclusions.

NOTE /
Interaction between the evaluation team and interlocutors in the field during interviews, workshops, etc. plays a major role in the process of taking ownership of the evaluation conclusions and is consequently more likely than written reports to lead to lessons being learned.[112] It is therefore advisable to draw up a timetable of visits and interviews which is not so tight as to leave insufficient time for such interaction.

112. Buchanan-Smith, M. and Cosgrave, J., *Evaluation of Humanitarian Action,* Pilot Guide, ALNAP Study, ALNAP/ODI, London, 2013.

4.3H

STEP 8: WRITING-UP PHASE

> The following paragraphs attempt to give a brief idea of the importance of each section of the report in order to provide the Steering Committee with all the elements it requires to critically examine the report. The quality of the final report is the responsibility of the Steering Committee and it is up to that committee to have as many exchanges as necessary with the evaluation team to obtain a product which meets all the quality requirements as detailed below.

1/ WRITING THE PROVISIONAL EVALUATION REPORT

The evaluation report remains a crucial element, whatever the steps envisaged to ensure optimum dissemination and ownership of the evaluation.

To facilitate sharing, an evaluation report must be concise (forty pages excluding annexes). Conversely, the report must not be too short, so that it can set out the confirmed findings.

It is customary for the evaluation team to write an initial version of the evaluation report (a provisional report). This consists of an initial assessment, which will be confirmed during reporting-back and feedback sessions by the project teams, then clarified by more refined analysis of the data later on. The advantage of a provisional version is that it allows the reactions of the different players involved in the evaluation to be taken into account and their remarks then incorporated into the definitive report by the evaluator.[113]

113. Guéneau, M.C., Beaudoux, E., L'évaluation : un outil au service de l'action [Evaluation: a tool to assist action], F3E, 1996.
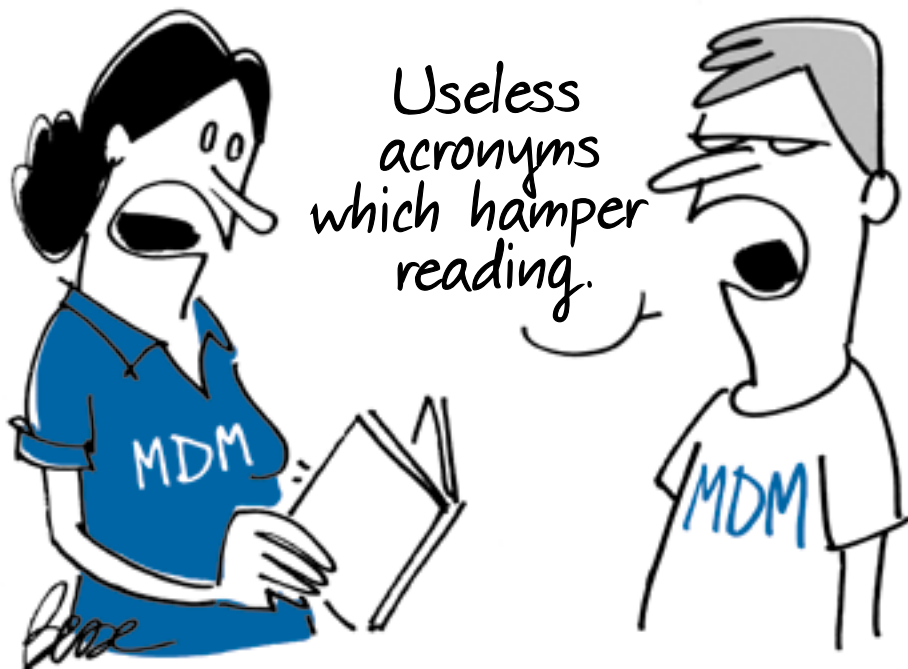
NOTE /
It is essential not to confuse the provisional evaluation report with a draft version. The provisional version of the report is a complete and fully edited version (with the exception of the executive summary) of the evaluation report. It gives all the elements required – including the annexes – for a critical reading on the part of the players concerned.

(arranged according to evaluation criteria)
– Completed Recommendations Follow-up Sheet
→ **Annexes:** ToR, list of individuals met and timetable, evaluation instruments used – questionnaires, interview guides, observation tables, etc. –, results of the statistical data and content analysis, etc.

FOCUS ON
EVALUATION REPORT
TEMPLATE AND FORMAT

The main body of the evaluation report running to forty pages (excluding annexes)[114] must be submitted in Word and must include the following sections:
→ Title page
→ Executive summary
→ Paginated table of contents
→ List of acronyms
→ **Section I:** Introduction
   – Context and brief description of the project
   – Objectives and scope of the evaluation
   – Methodology and limitations
→ **Section II:** Principal results and analysis
   – Presentation by evaluation criteria
→ **Section III:** Conclusions and recommendations

Preliminary pages and Introduction

The preliminary pages set out the general framework for an understanding of the findings and conclusions of the evaluation work.

→ The **executive summary** must be written to respond to the needs of decision-makers who will not have time to read the full report. It must be between 2 and 5 pages long. It must be meticulously written, as a greater number of people will read the executive summary than read the report in full: sufficient time must therefore be set aside for writing it. It makes sense not to write the executive summary until the Steering Committee's comments on the provisional report have been received. This enables the evaluator to fully grasp which elements to prioritise in the executive summary. The first paragraph is crucial for capturing and retaining the readers' attention: it should therefore include what is new or interesting in the report. It should then be followed by the principal elements relating to context, findings, conclusions and recommendations. **The executive summary must not contain new elements not contained in the main body of the text.**

114. The Médecins du Monde house style specifies the fonts which may be used as well as recommends page layout.

NOTE /
The executive summary must not be included in the first versions of the report to avoid comments being made on the summary rather than on the whole report.[115]

→ A paginated **table of contents** must not be overlooked: it enables readers with different needs to quickly identify the sections most relevant to them.

→ **Acronyms** must be avoided as much as possible, as they hamper reading and thus comprehension. They are therefore limited, as far as is possible, to those which are extremely common and so easily recognisable. Likewise, the use of terms which are highly specific to the local context must be avoided, and these should be replaced or placed alongside more generic expressions. For example, use health centre rather than CSB[116], feeding centre rather than CRENI or CRENA[117].

→ The pages concerning **context and description of the project** deal with the principal elements which enable readers to grasp the key contextual issues. They also provide a reminder of when work first started in the country and of the principal data concerning the project – intervention areas, number and type of beneficiaries, budget, funding and objectives.

→ The pages concerning the **objectives of the evaluation and the criteria**

selected provide a reminder of the objectives and scope, as negotiated at the end of the inception phase, the criteria selected and the reformulated versions of the evaluative questions.

→ The pages concerning **methodology and limitations** describe the methods used and any difficulties encountered in applying them. (The principal elements are included here and, where necessary, a more detailed description is given in an annex.)

Results and Analysis

This section responds more particularly to the needs of the project team and must be written with this group in mind.

This section is expected to introduce the responses to the questions posed by the evaluation, as they emerged from implementing the quantitative and qualitative methods. According to ALNAP, "the most common criticism of evaluations is that the recommendations are not based on the conclusions, the conclusions are not based on the findings and the findings are not based on the evidence."[118] The diagram below illustrates the ideal mechanism for producing conclusions and recommendations.

Here, data collected from observations, interviews, documents, etc., leading to the findings and then the conclusions, is triangulated. The way the results and analysis are presented must enable the reader to understand how the evaluator has reached the conclusions he has. "Objectivity is verified by the fact that the reasoning may be reconstructed by those other than the authors of the evaluation, who must be able

115. Buchanan-Smith, M. and Cosgrave, J., *Evaluation of Humanitarian Action*, Pilot Guide, ALNAP Study, ALNAP/ODI, London, 2013.
116. Centre de santé de Base – Basic Health Centre
117. Centre de Réhabilitation et Education Nutritionnelle Intensif – Centre for Intensive Nutritional Rehabilitation and Education; Centre de Renutrition et d'Éducation Nutritionnelle Ambulatoire – Walk-in Centre for Renutrition and Nutritional Education.
118. Buchanan-Smith, M. and Cosgrave, J., *Evaluation of Humanitarian Action*, Pilot Guide, ALNAP Study, ALNAP/ODI, London, 2013.

DIAGRAM: IDEALISED CHAIN OF EVIDENCE
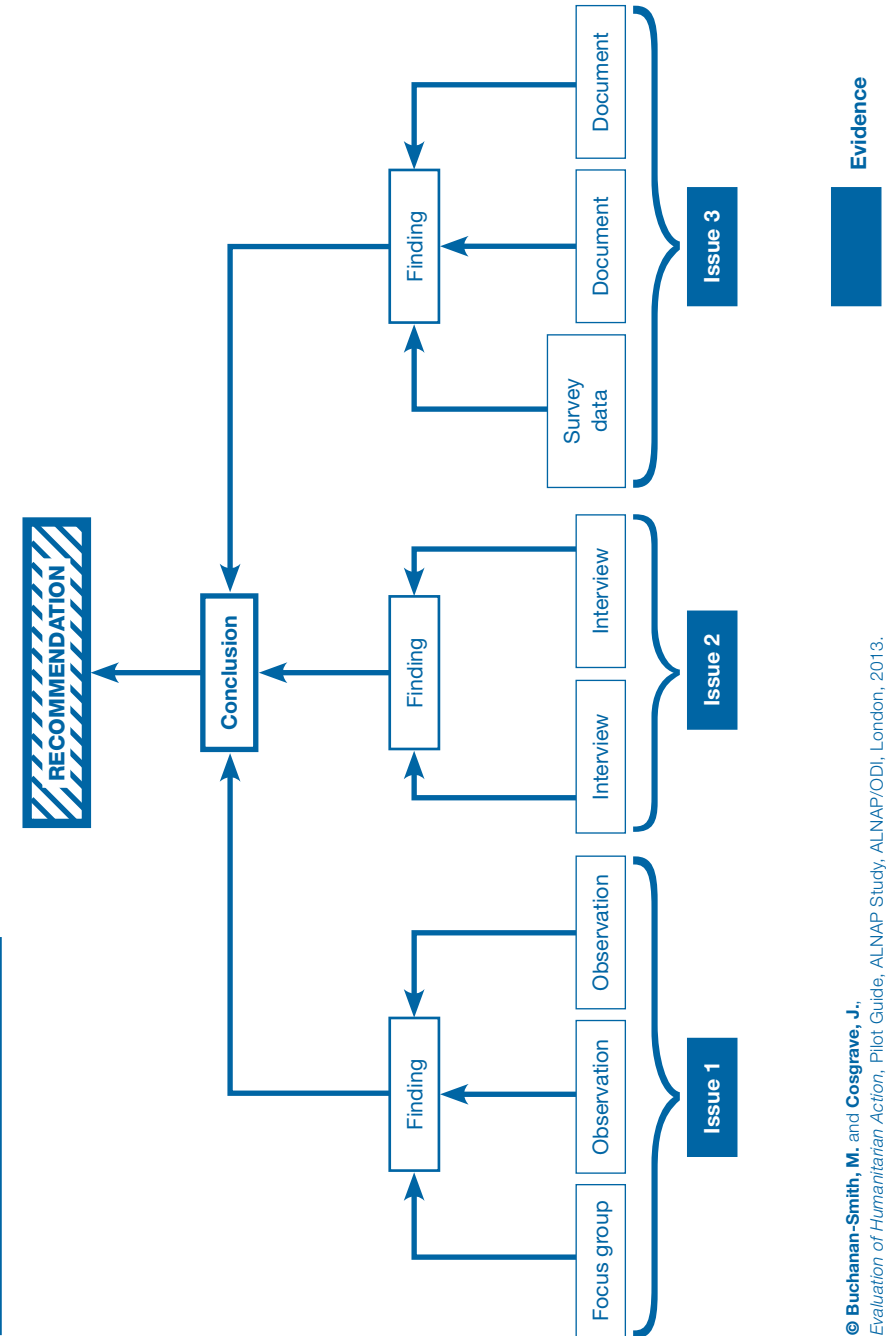
© **Buchanan-Smith, M.** and **Cosgrave, J.,** *Evaluation of Humanitarian Action,* Pilot Guide, ALNAP Study, ALNAP/ODI, London, 2013.

to reach the same conclusions."[119]
Any assumption underlying the analysis must be explicitly stated.

Setting the objective of learning lessons from an evaluation naturally tends to focus attention on analysing those elements where improvements could be made. However, to ensure that the report's conclusions have a greater chance of being heard, it is important that the strengths and successes of the project are also highlighted. The Steering Committee should be attentive to this point.

To capture the reader's attention, the Results and Analysis section should combine tables, graphs, diagrams, quotes, anecdotes, photographs, etc,; but all these elements must be accompanied by a narrative and provide an understanding and explanation of the results.

119. Fontaine, D., Beyragued, L. and Miachon, C., "Référentiel commun en évaluation des actions et programmes, santé et social" [Frame of reference for evaluating health and social action and programmes], ERSP, Lyon, 2004-2005.

Conclusions and Recommendations

The report must clearly distinguish observation of reality on the one hand (for example, what was said in an interview as presented in the form of a quote) and the formulation of a judgment on the other (how what was been said has been interpreted by the evaluator in the light of other pieces of information available).

Thus, the conclusions review the findings again, incorporating into these the evaluator's own analysis based on his methodological skills and rigour, and on his experience.

For the recommendations to be effective – i.e. for them to be taken into account and implemented – they must include certain features, and it is up to the Steering Committee to ensure they do. They must be:

→ **Specific:** this requires a succinct form of wording beginning with with a verb in the infinitive;
→ **Realistic:** they must take account of the context, capacities and resources of the organisation and/or its partners in putting the recommendations into practice;
→ **Targeted:** they must be directed at the person responsible for implementing them by a given deadline;[120]
→ **Prioritised:** the evaluator must be able to distinguish between those recommendations it is essential to implement and those it is desirable to implement, i.e. those which must be implemented before others which may be implemented (the evaluator must indicate a level of priority on the Recommendations Follow-up Sheet).

120. At this stage, this is proposed by the evaluation team and may be revised by the Steering Committee.

It is important to include the Recommendations Follow-up Sheet in the main part of the report and not in the annexes.

Annexes

The annexes are important as they provide a way of detailing certain points which cannot be developed in the body of the text; they also increase the credibility of the evaluation by shedding light on the 'behind-the-scenes' process of the methodology.

The annexes generally comprise the following elements:

→ The **Terms of Reference:** it is customary for this to be the first annex of an evaluation report;
→ The **list of people encountered:** the variety and number of players interviewed gives an indication of the reliability of the findings;
→ The **timetable for the process** : this shows in particular whether the team has been able to take the time needed for analysis during data collection and exchanges with the teams;
→ The **detailed maps** of the intervention areas, which help with understanding the context or project;
→ The **evaluation instruments:** interview guides, questionnaires, etc. presented give an idea of the quality of the data collection and of any potential gaps. In addition, these instruments may be useful to other teams which will not then have to devise everything from scratch;
→ The raw results from statistical data or content analyses;[121]
→ The **bibliography:** complementary research carried out by the evaluation team may be of considerable interest to the project teams or to other players concerned;
→ The evaluators' **biographical profiles:** presented in one or two paragraphs at the most, these profiles enable readers who are not part of the Steering Committee (and who therefore have not taken part in selecting the evaluators) to understand the evaluators' specific skills and experiences and to clarify any potential bias;
→ Any other important item which might be useful to the project team or the organisation and which it would be a pity if the evaluator(s) did not share.

121. If these do not have to be automatically forwarded to the Steering Committee, it is important to make clear to the evaluators that transcriptions of interviews should be kept until the final approval of the report, as it may be necessary to return to them in the event of any misunderstanding or even contesting of certain conclusions.

depending on the chosen scope
of the distribution.

2 / COMMENTING ON THE PROVISIONAL EVALUATION REPORT

All members of the Steering Committee must comment on the final version of the provisional report. Each member of the Steering Committee, with the agreement of the latter, is responsible for circulating this version to others where necessary and for compiling the resulting comments. If the evaluation comprises elements relating to learning or recommendations with institutional ramifications, it is advisable to have the provisional version reviewed by directors or members of the Board.

Circulating the report in its provisional version offers two types of immediate benefit:
→ In terms of **content,** sharing the document enables inaccuracies in the findings or in the analysis and interpretation made of these to be highlighted.
→ In terms of **process,** it provides a starting point for disseminating the conclusions and recommendations in what is not a definitive and is therefore a less sensitive format, thereby making it easier for the various players to gradually take ownership of them.

NOTE /
The more the report is shared outside the Steering Committee,

the more time must be earmarked for revising and compiling the comments before it is sent to the evaluation team. When distribution is limited to the members of the Steering Committee, a minimum of 2 to 3 weeks must be allowed. When more widely circulated, the time set aside will depend on the number and role of those contacted.

FOCUS ON
STRUCTURING THE REVISING OF THE FINAL VERSION OF THE PROVISIONAL REPORT

It is appropriate and helpful to ask those reading the provisional report to structure their examination on the basis of the following criteria:

→ **Content:** consistency with the ToR; quality of the information provided; correct presentation and interpretation of the findings; adequate response to the evaluation criteria; clear and specific recommendations.
→ **Structure:** consistency with the desired structure; clear internal logic; balance between sections; absence of duplication.
→ **Style:** level of language/expression (easy to read); correct use of tables/diagrams; concision.
→ **Format/Layout:** consistency with the stipulated format; number of pages; table of contents; headings/subheadings.

It is imperative that the comments received from each individual are discussed within the Steering Committee. This discussion makes it possible to:
→ Filter out certain comments outside the remit of the evaluation;
→ Bring out points of consensus and points of disagreement;
→ Reach agreement in the event of conflicting comments;
→ Organise the comments (group and rank them).

The comments therefore need to be compiled and it is the job of the Steering Committee coordinator or the person leading the evaluation to do this. If few reviewers are involved, it is possible to make the comments directly on the provisional report. Conversely, if too many reviewers are involved, the comments should, preferably, be compiled in a separate document, for example in the form of a table with the first column listing the comments (detailing the paragraph and page number concerned) and the second column being left blank for the evaluation team to put forward additional comments and modifications.

3 / APPROVING AND FINALISING THE EVALUATION REPORT

Once this first series of comments has been incorporated by the evaluation team, the members of the Steering Committee are contacted to review the document once more, this time more rapidly; on the one hand this is to ensure that the comments have been satisfactorily taken into account; on the other hand

it is to move to a critical review of the executive summary.

Following these exchanges, disagreement may persist between the Steering Committee and the evaluation team regarding certain conclusions or recommendations. The Steering Committee (or other players) cannot require the evaluation team to withdraw or radically alter certain conclusions or recommendations, as this would be contrary to the principles of an external evaluation. Several solutions are suggested by ALNAP[122]:
→ Present just one of the interpretations;
→ Include both interpretations in the report;
→ Include just one interpretation but mention that the interpretation was not shared unanimously.
If the members of the evaluation team are not satisfied with how the problem has been resolved, they have the right to demand that their name be removed from the report.

At this stage the Steering Committee must also fill out the evaluation appraisal form which preserves evidence of this evaluation experience, both in terms of process and content. This enables other project teams to approach evaluation teams as part of a negotiated procedure on the basis of the strengths demonstrated by previous evaluations.

122. Buchanan-Smith, M. and Cosgrave, J., *Evaluation of Humanitarian Action*, Pilot Guide, ALNAP Study, ALNAP/ODI, London, 2013.

TRY BLUE-SKY THINKING FOR REPORTING BACK

Evaluation Report:

ANNEX: 1
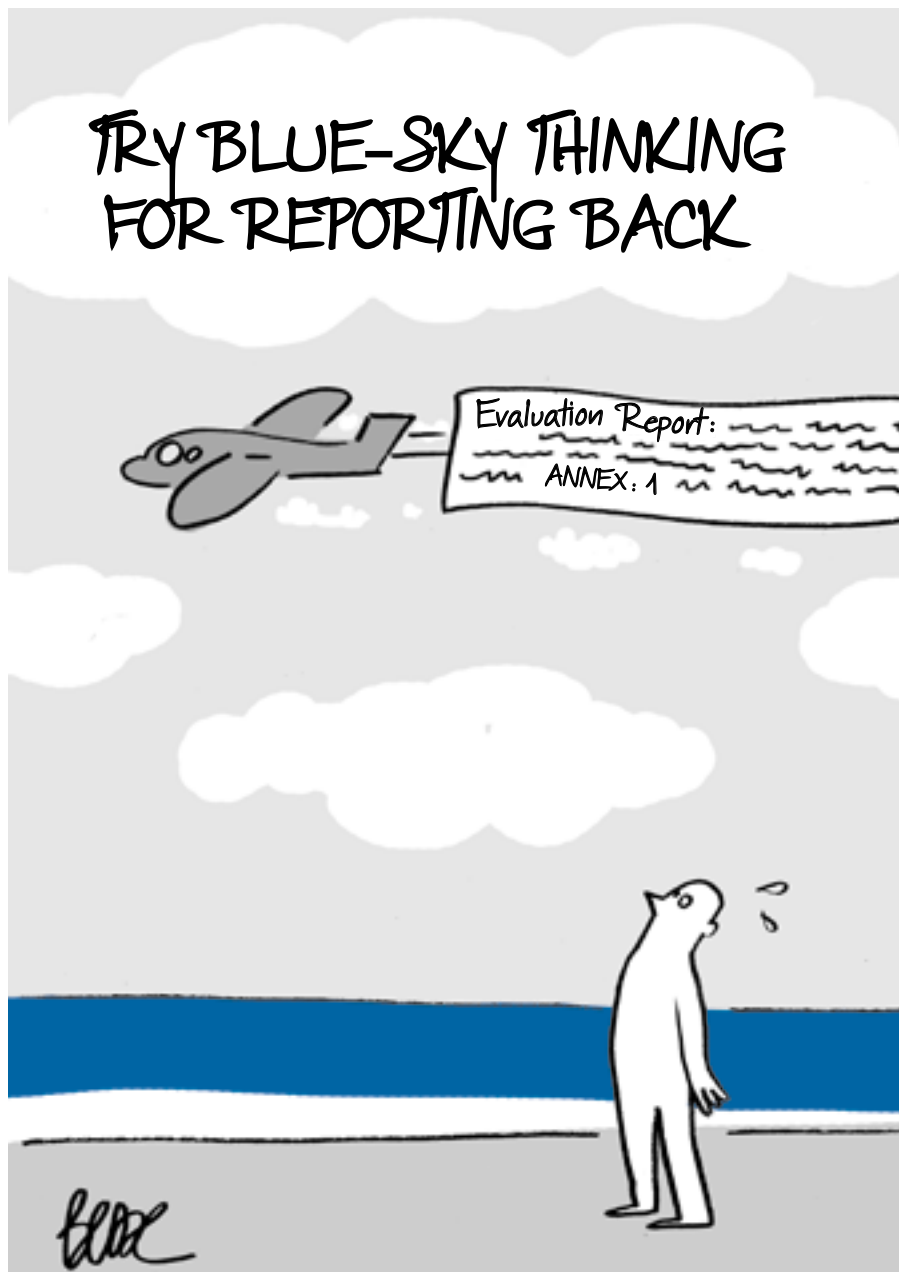
4.31

STEP 9: DISSEMINATION PHASE

The dissemination phase is an integral part of the evaluation process. It is essential to think about and plan the different methods of disseminating the report from the moment the evaluation is designed. This has implications for:
→ Budget;
→ Skills expected of the evaluation team (for example, should some consultancy days be included for a videographer?);
→ Type of data to be collected;
→ Availability of evaluation team members who might be consulted up to several months after the final evaluation report is submitted.

As ALNAP emphasises, **"delivery is not the end of the evaluation report, it is simply the beginning of the dissemination phase."**[123]

1/ PRESENTING THE RESULTS

As has been seen, the provisional report is completed with additions based on points clarified during the different reporting-back sessions, principally those held in

the field at this point. Once the comments have been incorporated by the Steering Committee, the report is then finalised.

A second series of reporting-back sessions is held, most often at HQ, this time on the basis of the definitive report. These sessions provide an opportunity to discuss the recommendations and their implementation, and represent the starting point for the dissemination phase proper. At this point, the opportunity is taken to distribute copies of the report, launch it on the intranet, view the videos or reportage photos, etc.

> **NOTE /**
> It is important, from a strategic point of view, to plan dates for presenting the findings that relate to the internal timetable for strategic decision-making. This maximises the chances of the evaluation results being taken into account in the decision-making process.

123. Buchanan-Smith, M. and Cosgrave, J., *Evaluation of Humanitarian Action*, Pilot Guide, ALNAP Study, ALNAP/ODI, London, 2013.

2 / DISSEMINATING THE RESULTS

The Steering Committee coordinator, or person in charge of the evaluation, is responsible for sharing the evaluation conclusions and recommendations with the individuals concerned, both within and beyond the organisation, using the means which are most readily understood by and most useful to the different players – teams, populations, partners, donors, etc.

The dissemination strategy must therefore clearly detail:
→ Who the target audiences are,
→ What forms of disseminating the report are most suitable for each audience targeted,
→ Who is in charge of disseminating each of the formats chosen.

It is not enough to simply distribute the evaluation report. As many interactive (rather than passive) methods as possible should be adopted. Disseminating the results can and should take diverse forms:
→ An email with the main findings, conclusions and recommendations;
→ The executive summary attractively presented and translated into the appropriate languages and/or a learning sheet based on the report;
→ A collective presentation open to different categories of staff and partners, which may be filmed and uploaded to the intranet/internet to be accessed later by those not present;
→ A targeted presentation or tailored reporting-back session for decision-makers;
→ A series of tweets setting out the main findings, conclusions and recommendations;

→ A seminar or workshop bringing together the key players;
→ A series of blog posts;
→ A photo reportage or video covering the main findings, conclusions and recommendations;
→ A podcast;
→ A paper presented at a conference;
→ A publication for the general public or, conversely, for a specialised readership;
→ Etc.

NOTE /
Language is the principal barrier to dissemination: translating the materials must therefore be allowed for both in terms of budget and deadlines.

4.3J

STEP 10: IMPLEMENTING THE EVALUATION RECOMMENDATIONS

> The point of any evaluation is to have its recommendations taken into account. This is the moment at which it is finally possible to judge the usefulness of the evaluation.[124] "An evaluation is meaningless unless it brings about change by bringing about knowledge."[125]

As has been seen in the previous pages, whether the recommendations of an evaluation are taken up depends in large part on the steps which come before. In particular, it is essential that:
→ The objectives, uses and users of the evaluation have been properly identified (Step 1);
→ The right people have been involved in the Steering Committee (Step 3); or a special committee has been set up to implement and follow up the recommendations, involving, where necessary, directors and members of the Board;
→ The evaluators have been well chosen to ensure their credibility (Step 5);
→ The decision-makers are regularly informed of the findings and conclusions which are emerging (Step 7);
→ The decision-makers are involved in reviewing the provisional report (Step 8);
→ The findings are disseminated in an appropriate form (Step 9).

A key tool for ensuring that recommendations are followed up on is the Recommendations Follow-up Sheet: it enables users/decision-makers to explain which recommendations will be taken into account and the extent to which they will be prioritised, and to approve or modify the proposals in terms of the individual who will be responsible for them and the timetable for implementing them.

124. **Fontaine, D.**, **Beyragued, L.** and **Miachon, C.**, "Référentiel commun en évaluation des actions et programmes, santé et social" [Frame of reference for evaluating health and social action and programmes], ERSP, Lyon, 2004-2005.
125. **Fontaine, D.**, **Beyragued, L.** and **Miachon, C.**, "Référentiel commun en évaluation des actions et programmes, santé et social" [Frame of reference for evaluating health and social action and programmes], ERSP, Lyon, 2004-2005.

As was seen at the beginning of this chapter, the factors influencing the use made of an evaluation, in other words how the changes proposed via the recommendations are implemented, comprise:

→ The initial motivation of those requesting the evaluation;

→ The willingness of the organisation via its decision-makers to seize on evaluations as a tool for learning and change;

→ The quality of the evaluation: its credibility, methodology and the trust placed in the process and the evaluators;

→ The accessibility of the evaluation: the ease with which it may be obtained (is it easy to find?), understood (has it been translated?) and taken ownership of (is it realistic in terms of organisational and contextual constraints?).

The challenge for an evaluation is to incorporate following up on recommendations into programming a new phase of the project and even, cross-wise, into defining a new project.

SUMMARY

KEY POINTS FOR GUARANTEEING THE SUCCESS OF AN EVALUATION

→ The evaluation must be **planned** well in advance – 6 to 12 months.

→ Its objectives must be clear and **shared with stakeholders.**

→ The **Steering Committee** has an extremely important quality-assurance role to play throughout the process, relating to informing and involving key stakeholders and ensuring the implementing of and following up on recommendations.

→ The **Terms of Reference** are a key element of the evaluation, as they enable the different actors involved to produce a shared understanding of the objectives and results of the evaluation. They must be drawn up in a participative way.

→ The quality of the evaluation depends largely on a capacity to identify and recruit a good **evaluation team** in a timely and transparent fashion.

→ The **inception phase** is important in ensuring that the Steering Committee and evaluation team have the same understanding of the evaluation's objectives and the approaches proposed.

→ The **credibility of the evaluation** rests in large part on how rigorously the data-collection methods are applied and on the validity of the analyses, underpinned by triangulation.

→ The time allocated to **reporting back** must be planned and must be sufficient to be able to involve all project players and to discuss the conclusions of the evaluation internally.

ANNEXES INCLUDED IN THE CD-ROM – PART 4 – EVALUATION

– **Evaluation Terms of Reference Template**
– **Example of Evaluation Matrix**
– **Capitalisation Terms of Reference Template**
– **Consultancy Budget Template**
– **Consultancy Model Schedule**
– **Recommendations Follow-up Sheet**

→ The **dissemination phase** is an integral part of the evaluation process. The different evaluation deliverables and their method of dissemination must be considered in terms of the target public.

→ **Take-up of the recommendations** is the aim of any evaluation process. The Recommendations Follow-up Sheet is a key tool in ensuring that use is made of the evaluation.

SELECTIVE BIBLIOGRAPHY

SELECTIVE BIBLIOGRAPHY

Bonino F. with **Jean I.** and **Knox Clarke P.,**
– *Closing the loop: Practitioner guidance on effective feedback mechanisms in humanitarian contexts,* **Alnap-CDA Guidance, London: ALNAP/ODI, 2014, www.alnap.org/resource/10676**

Bonino F. with **Jean I.** and **Knox Clarke P.,**
– *Humanitarian feedback mechanisms: research, evidence and guidance,* **Alnap Study, London: Alnap/ODI, 2014, www.alnap.org/resource/9944**

Coffman J.,
– *Monitoring and evaluating advocacy,* **Unicef, 2012, www.unicef.org/evaluation/ files/Advocacy_Toolkit_Companion.pdf**

Dearden P., Jones S., Sartorius R.,
– *Tools for Development. A handbook for those engaged in development activity,* **Department for International Development, UK, 2003, www.k4health.org/toolkits/leadershipmgmt/ tools-development-handbook-those- engaged-development-activity**

Environment in Humanitarian Action Reference Group,
– *Environment and Humanitarian Action: Increasing effectiveness, sustainability, and accountability,* **Unep/Ocha, 2014, http://www.urd.org/IMG/ pdf/EHA_Study_web_FINAL.pdf**

Espace régional de santé publique Rhône-Alpes (ERSP),
– *L'évaluation en 9 étapes. Document pratique pour l'évaluation des actions santé et social,* [Evaluation in 9 steps. Practical document for evaluating health and social action], **2008 (2e édition), http://www.pepsal.org/wp-content/ uploads/2014/01/eval_9_etapes_08.pdf**

Espace régional de santé publique Rhône-Alpes (ERSP),
– *Référentiel commun en évaluation des actions et programmes santé et social,* [Common standard for evaluating health and social action and programmes], **2004, http://education-sante-ra.org/prc/ evaluation/elearning/bibliographie.asp**

De Reviers B. and **Hadjaj-Castro H.,**
– *Agir pour le changement. Guide méthodologique pour accompagner des processus de changement « complexe » : analyser, planifier, suivre et évaluer,* [Acting for change. Methodological guide to support processes of 'complex' change: analysing, planning, monitoring and evaluating], **F3E-COTA, 2014, http://f3e.asso.fr/media/transfer/doc/ guide_chgmt_f3e_cota.pdf**

Totté M., Duroyaume P. and **Feuvrier MV.,**
– *Agir en pluri-acteurs pour une éducation de qualité. Penser les enjeux et Construire sa démarche,* [Multiplayer action for quality education. Examining the issues and constructing an approach], **Inter-Mondes Belgique-F3E, 2014, http://f3e.asso.fr/media/transfer/doc/ guide_education_reperes_sur.pdf**

International Federation of Red Cross and Crescent Societies,
– *Project/programme monitoring and evaluation (M&E),* **Geneva, 2011, http://www.ifrc.org/Global/Publications/ monitoring/IFRC-ME-Guide-8-2011.pdf**

Groupe URD,
– *Quality COMPAS Companion Book,* **2004, www.compasqualite.org/en/ images/V9.06-EN_Quality_COMPAS_ companion_book.pdf**

Groupe URD,
– *Participation Handbook for humanitarian field workers,* **Groupe URD, 2010, http://urd.org/Participation-Handbook**

Hallam A. and **Bonino F.,**
– *Using Evaluation for a Change: Insights from humanitarian practitioners,* **ALNAP Study, London: ALNAP/ODI, 2013, www.alnap.org/resource/8980**

Herrero S.,
– *Integrated Monitoring: a Practical Manual for Organisations That Want to Achieve Results,* **inProgress, 2012, http://www.hapinternational.org/pool/files/ demystifying-the-monitoring-process.pdf**

Hummelbrunner R. and **Jones H.,**
– *A guide for planning and strategy development in the face of complexity,* **Overseas Development Institute, 2013, www.odi.org/sites/odi.org.uk/files/odi- assets/publications-opinion-files/8287.pdf**

Hummelbrunner R. and **Jones H.,**
– *A guide to managing in the face of complexity,* **Overseas Development Institute, 2013, www.odi.org/sites/odi.org.uk/files/ odi-assets/publications-opinion-files/ 8662.pdf**

Jones L., Ludi E., Carabine E., Grist N.,
– *Planning for an uncertain future,* **Overseas Development Institute, 2014, www.odi.org/sites/odi.org.uk/files/ odi-assets/publications-opinion-files/ 8851.pdf**

Milton N.,
– *The Lessons Learned Handbook: Practical Approaches to Learning from Experience,* **Chandos Publishing, 2010.**

O'Flynn M.,
– *Tracking Progress in Advocacy: Why and How to Monitor and Evaluate Advocacy Projects and Programmes,* **Intrac, 2009, www.intrac.org/data/files/ resources/672/Tracking-Progress -in-Advocacy-Why-and-How-to-Monitor -and-Evaluate-Advocacy-Projects-and -Programmes.pdf**

Ramalingam B.,
– *Tools for Knowledge and Learning: A Guide for Development and Humanitarian Organisations,* **Overseas Development Institute, 2006, www.odi.org/sites/odi.org.uk/files/odi- assets/publications-opinion-files/188.pdf**

Simister N., with **Smith R.,**
– *Monitoring and Evaluating Capacity Building: Is it really that difficult?* **Praxis Paper 23: Intrac, 2010, http:// www.intrac.org/data/files/resources/ 677/Praxis-Paper-23-Monitoring -and-Evaluating-Capacity-Building-is -it-really-that-difficult.pdf**

Sterne R., Heaney R. and **Britton B.,**
– *The Partnership Toolbox,* **WWF, 2009,**
  http://assets.wwf.org.uk/downloads/
  wwf_parthershiptoolboxartweb.pdf?_
  ga=1.263303820.1237681719.1418835855

Tsui J., Hearn S., and **Young J.,**
– *Monitoring and evaluating policy*
  influence and advocacy,
  Overseas Development Institute, 2014,
  www.odi.org.uk/sites/odi.org.uk/files/
  odi-assets/publications-opinion-files/
  8928.pdf

LIST OF COLLECTION TITLES

Bouchon M.,
– *Data Collection - Qualitative Methods*,
   MdM, 2009, 2nd edition 2012 – ISBN 9782918362166. **DVD included**

Bouchon M.,
– *Violence Against Women - Gender, Cultures and Societies,* **MdM, 2009.**

Branchat J., Duplessy C.,
– *Gender-Based Violence Prevention & Response - A Methodological Guide,* **MdM, 2010.**

Gueguen J. et al.,
– *Health Education - A Practical Guide for Health Care Projects,* **MdM, 2010.**

Dromer C. et al.,
– *For Ethics in the field - Sensitive Personal Data Management*, **MdM, 2010**
  (electronic version only).

Gumucio S. et al.,
– *Data collection - Quantitative Methods - The KAP Survey Model (Knowledge,
   Attitude & Practices),* **MdM, 2011, ISBN 9782918362159.** **DVD included**

Bouchon M.,
– *Les déterminants socioculturels de l'accès aux soins,* **MdM, janvier 2012,
   ISBN 9782918362180.** **DVD included**

Bouchon M.,
– *Sociocultural Determinants of Access to Healthcare,* **MdM, 2012, ISBN 9782918362180.**
   DVD included

Lesieur E., Simon S.,
– *Sexual and Reproductive Health Guideline,* **MdM, 2013, ISBN 9782918362654.**
   DVD included

Collective,
– *The history & principles of Harm Reduction. Between public health and social change,*
   MdM, 2013, ISBN 9782918362616.

Gumucio S. et al.,
– *Health project planning. Health promotion and Humanitarian Action,*
   MdM, 2015, ISBN 9782918362777. **DVD included**