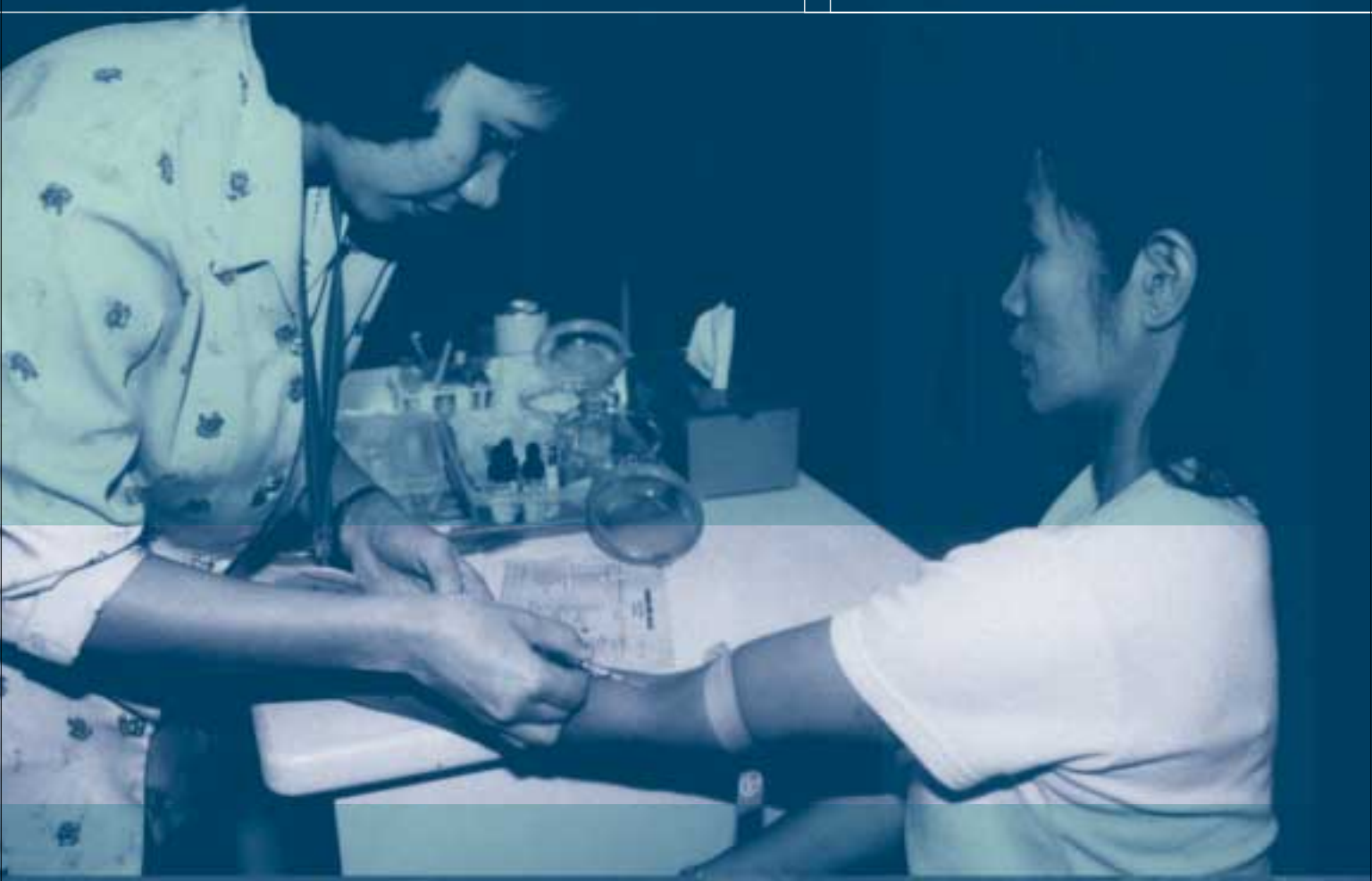
MONITORING SEXUAL AND REPRODUCTIVE HEALTH PROGRAMMES

Key concepts and issues



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The series on monitoring focuses primarily on Community Based Distribution and Social Marketing*

The terms appraisal, evaluation and monitoring are used loosely and interchangeably in development discourse. Working definitions are provided overleaf

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Appraisal, Evaluation and Monitoring defined

Appraisal

Refers to the project or programme preparation and design process[1], which includes needs assessments, feasibility studies and baseline studies – sometimes collectively known as *ex-ante* evaluation. Appraisal involves analysis of the situation, of past and likely future changes in the lives of the target population/community, and an assessment of the expected impact of any proposed intervention. During appraisal, baseline data and impact indicators are established against which progress can be assessed. Appraisal is thus anticipatory and prospective in its focus. Appraisal[2] involves analysing (chronologically):

- Which groups are most vulnerable to ill-health and the consequences of ill-health
- The behavioural determinants of that vulnerability, specifically the local social and economic contexts that determine health and shape health behaviour. Public health interventions often fail to address adequately the importance of social identity, vulnerability, marginalisation, and relations of power and control in shaping health status and influencing health behaviour
- Why specific population groups are excluded from information and services, and what are the sources of systemic institutional bias that make policies, systems and/or programmes unresponsive to the needs and realities of the poor and vulnerable (How for instance do social identity, gender, culture, ethnicity constrain access and shape institutional bias?)
- Whether and how the behavioural, service and institutional determinants of vulnerability and risk are amenable to interventions.

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1 Within funding agencies, appraisal often refers specifically to the critical examination of a proposed project or programme on the basis of agreed criteria, before approval to fund and proceed to implementation (see Rubin, 1995).

2 See Hawkins and Price (2000a) for a detailed guide to undertaking social appraisals for sexual and reproductive health programmes

Evaluation

Refers exclusively to the *ex-post* assessment of:

- programme impact in terms of health status changes
- programme cost effectiveness
- the validity of the programme's original objectives
- the lessons learned from the programme

Ex-post evaluation is also known as summative evaluation: the collection and analysis of data about a programme with the aim of deciding whether it should be continued or repeated. Summative evaluation assesses how effective projects or programmes have been in achieving results, and provides information, which can be used to compare the relative merits of different strategies.

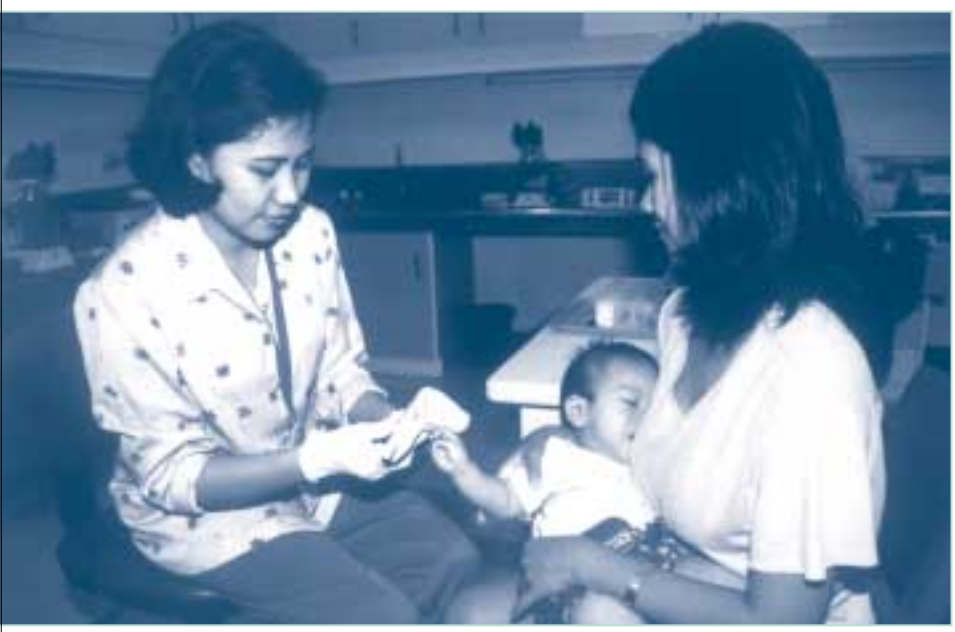
Ex-post evaluation is a technically complex and resource-costly activity, which is likely to be beyond the capacity of many civil society organisations.

Monitoring

Routine monitoring is the regular assessment of programme performance using data that are routinely collected and analysed. Periodic monitoring (also known as reviews, and as process or formative evaluations) is diagnostic, using monitoring tools like operations research to investigate problems identified through routine monitoring. Monitoring, unlike evaluation, involves the collection of data while a programme is being implemented, in order to measure progress against objectives, and to keep programme management and other stakeholders informed about progress and any need for changes to programme design or strategy.

Monitoring systems

Approaches to monitoring, in terms of the nature and frequency of data collection and analysis vary significantly. However, there are basic principles in all monitoring systems. Effective monitoring systems should[3]:



- Test hypotheses using frameworks such as the Logical Framework or Results Framework, which structure monitoring by breaking down the developmental hypothesis into different levels of objectives (activities, outputs, purpose and goal), thereby facilitating identification of paths of influence, and ultimately causality.
- Draw on a number of data collection techniques to capture a wide range of information and choose the most cost-effective approaches. Quantitative data on numbers of new clients, acceptor and continuation rates etc need to be supplemented by periodic small-scale population -based or site-based surveys, qualitative investigation (informal interviewing, observation, group discussions etc), and operations research. However, there is no point in collecting rich, contextual, qualitative data only to subsequently reduce them to a narrow quantitative interpretation.

3 Much of this is derived from an unpublished document entitled "Effective Monitoring and Evaluation for AIDS Prevention" written by Population Services International (1998)

- Deliver information when it is needed. Managers need continuous feedback from programmes in order to adjust interventions and strategies. Rather than depend exclusively on large-scale surveys, programmes should use methods that allow rapid feedback, particularly qualitative methods, observation, and small-scale surveys.
- Not overwhelm managers with information that they do not need. One measure of the efficiency of a monitoring system is its ability to screen, analyse, and package data into usable and practical information.
- Be cost effective. It is important to manage the marginal costs and benefits of monitoring by regularly updating and revising the programme Logical Framework, streamlining data collection methods, and validating cost-effective proxy indicators. An efficient and cost-effective monitoring system is able to determine the degree of precision needed for specific indicators and to make creative use of all available data sources and collection methods.
- Recognise that monitoring is a learning process, through which programmes gain an improved understanding of their environment, the processes through which interventions are realised, and the effects of interaction between interventions and clients. In many programmes, supervisors focus on checking the accuracy and completeness of numerical data collected by field staff rather than processing data into information in a strategic effort to improve the programme. To facilitate the learning process, an effective monitoring system evolves from experience, and requires mechanisms for learning quickly of developments in choice of indicators and monitoring/research methods.
- Be professional. Given the complexity of information needs and sources, a monitoring system must have access to professional expertise. In-house research and monitoring specialists ensure the technical quality of monitoring systems, facilitate access to outside specialists, and ensure that research and monitoring become an integral part of programme management.

Focus of monitoring: Impact and effectiveness in reaching the poor and vulnerable

Monitoring systems measure progress in terms of **impact** and **effectiveness**. For those using the Logical Framework for programme monitoring, impact is broadly equated with *purpose*, and effectiveness with *outputs*.

Impact

Impact is the extent to which a programme is meeting the sexual and reproductive health needs of poor, marginal and vulnerable groups, measured through

- **Increased utilisation** of services and/or products promoted and distributed by the programme
- **Other behavioural changes** likely to benefit an individual's or the wider community's health status

A further dimension of impact is the extent to which a programme leads to 'beyond-health' improvements in the social and economic livelihoods of the target population and/or the wider community – sometimes including the programme's field staff.

Effectiveness

Effectiveness may be measured in terms of improvements in

- **Access** to products, information or services defined in terms of affordability, convenience, and 'social' access
- **Knowledge and awareness** of relevant products and/or services and awareness about the benefits of using these products or services
- **Quality** of service and care with a particular emphasis on client-provider interaction
- **Cost-effectiveness** in terms of the cost of unit service delivered
- **Institutional capacity** of key implementing and policy-making organisations
- **Advocacy** in terms of policy changes and greater public awareness

Poverty, Vulnerability and Marginality

An emphasis on monitoring the impact of a programme upon the poor, marginal and vulnerable is central to an equity-based approach. The socially marginal are those individuals and groups on the "edge" of society – the socially excluded – and include ethnic minorities, adolescents, and unmarried adult women [including widows and divorcees in societies where marriage is universal].

Vulnerability specifically suggests defencelessness, insecurity, and exposure to risks, shocks and stress. The vulnerable are those who are least able to make and carry out informed decisions freely. Vulnerability is often linked to poverty and the poor are invariably more vulnerable than the less poor. They are more exposed to sickness from insanitary, polluted and disease-ridden environments both at work and at home and they are weaker with malnourishment and previous sickness tending to reduce their resistance to disease and to slow their recovery. The poor also have less access to prophylaxis or to timely and effective treatments.

This link between poverty and vulnerability is clear in relation to HIV, where poverty increases both vulnerability to the disease and vulnerability to the social and economic consequences and impact of the disease.

Like poverty, vulnerability is a relative concept, which is defined according to the specific setting of any given programme. Notwithstanding the need for a localised perspective, the key defining characteristics of vulnerability are likely to be gender, age, disability, livelihood and economic status, occupation, location of residence, ethnicity, and social status.

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The dominant measure of impact in Community Based Distribution (CBD) programmes has been contraceptive prevalence, or its widely used proxy, Couple Year of Protection (CYP), along with acceptance and continuation rates.

Monitoring community based distribution and social marketing programmes

The acceptor rate is widely used as an intermediate impact measure in CBD programmes because acceptor data are easy to obtain and because the most common short-term programme objective is expressed as an increase in acceptors. Acceptor data are, however, of limited use in programme monitoring. For instance, they underestimate impact because they do not reveal indirect effects such as couples who are stimulated to adopt family planning but who obtain their supplies from another source. Few if any CBD programmes collect acceptor data by socio-economic or vulnerability status of clients.

Continuation rates, which identify the proportion of acceptors who continue to use a commodity or service for a given period of time after first acceptance, have been less widely adopted as an outcome measure, largely due to the problems of calculation. Furthermore, the assumptions inherent in the application of continuation data are questionable. Continuation rates are conventionally used as a proxy measure of demand for, access to, and quality of services, with high continuation rates taken to indicate a strong motivation to regulate fertility/prevent sexually transmitted infections, high client satisfaction with services, and high contraceptive or condom use-effectiveness.

Like CBD programmes, social marketing programmes have (until recently) collected few data on client profiles, product use-effectiveness, or on method/source switching. Social marketing organisations and CBD agencies have been reluctant to collect or analyse data on social practices and health-seeking behaviour. In this respect these agencies continue a tradition, which has been ubiquitous in family planning programmes for some time where little credence is given to the idea that perceptions of family planning are influenced by traditional notions of health and illness. The cultural context in which health and illness is understood and given meaning is relegated to the domain of "misinformation" and "rumours" in family planning discourse.

Social marketing programmes are monitored predominantly from trends in sales, with sales data used to refine marketing, pricing and distribution strategies, and to produce CYP figures. The limitations of CYP as a proxy for prevalence, continuation and effectiveness are well known, and like acceptor rates, CYP data reveal nothing about quality of use, or whether methods are used consistently and correctly.

The approaches to monitoring which dominate CBD and social marketing programmes limit attempts to assess poverty impact, as well as impact against quality of care indicators such as whether providers are monitoring and responding to contra-indications, and have the time, expertise or interest to explain the correct use of or most appropriate type of contraceptive methods to customers.

Despite recent progress in the development of conceptual frameworks and indicators for monitoring sexual and reproductive health programmes, CBD and social marketing have been slow to apply these advances. The monitoring challenge is further complicated as CBD and particularly social marketing move into the prevention and treatment of HIV/AIDS and other sexually transmitted infections, voluntary HIV counselling and testing, and maternal and child health.

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Paper 2	Indicators
Paper 3	Data collection tools
Paper 4	References and key readings

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