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Program Design, Monitoring, and Evaluation (PDME) of Family Planning Programs

Facilitator's Guide

A Training Manual for Program Managers

CSTS+

Save the Children

September 2006 (updated in 2009)

This publication was produced for review by the United States Agency for International Development. It was prepared by Child Survival Technical Support Plus (CSTS+) of ORC Macro and Save the Children USA.

Program Design Monitoring and Evaluation (PDME) of Family Planning Programs

A Training Manual for Program Managers

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Westport, Connecticut, USA

September 2006 (revised 2009)

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Additional information about the Child Survival Technical Support Plus project may be obtained from CSTS+, ORC Macro, 11785 Beltsville Drive, Suite 300, Calverton, MD 20705 USA, Telephone: 301-572-0200, Fax: 301- 572-0983, E-mail: csts@orcmacro.com, Internet: www.flexfund.org and www.childsurvival.com.

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ACRONYMS

AMDD	Averting Maternal Death and Disability (Columbia University, Mailman School of Public Health)
CA	Cooperating agency
CBA	Childbearing age
CBD	Community-based distribution
CPR	Contraceptive prevalence rate
CSTS+	Child Survival Technical Support Plus Project
CYP	Couple years of protection
DHS	Demographic and Health Survey
DHO	District Health Office
FGC	Female genital cutting
FGD	Focus group discussion
FHI	Family Health International
FP	Family planning
HC	Health center
HFA	Health facility assessment
HIS	Health information system
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
HMIS	Health management information system
HSDA	Health service delivery assessment
IDI	In-depth interview
IEC	Information, education and communication
IMCI	Integrated management of childhood illness

IR	Intermediate result
IUD	Intrauterine device
JHU	Johns Hopkins University
JSI	John Snow International
KPC	Knowledge, practice and coverage
LAM	Lactational amenorrhea method
LMIS	Logistics management information system
LQAS	Lot quality assurance sampling
M&E	Monitoring and evaluation
MICS	Multiple Indictor Cluster Survey (UNICEF)
MOH	Ministry of Health
NGO	Non-governmental organization
ORT	Oral rehydration therapy
PDME	Program design, monitoring and evaluation
PLA	Participatory learning and action
PPT	PowerPoint
PRA	Participatory Rapid Appraisal
PVO	Private voluntary organization
QIQ	Quick investigation of quality
QMT	Quality measuring tool
QOC	Quality of care
RF	Results framework
RH	Reproductive health
SA	Situation analysis

SC	Save the Children
SDP	Service delivery point
SO	Strategic objective
STI	Sexually transmitted infection
TBA	Traditional birth attendant
UN	United Nations
UNFPA	United Nations Populations Fund
UNICEF	United Nations Children's Fund
URC	University Research Corporation
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization
WRA	Women of reproductive age

INTRODUCTION FOR PARTICIPANTS

Why Results Framework?

This course provides mid- and senior-level country managers with the skills to develop project designs using a results framework. When these skills are used in the design process, project activities are more reliably linked to desired outcomes, and the elements necessary for success are more likely to be addressed. Additionally, the monitoring and evaluation plan is more likely to reflect project accomplishments. When these skills are not used, project design tends to start with the development of a list of activities that may or may not contribute effectively to achieving the desired results.

There are many ways to present the key elements of a program design. We recommend the "results framework" in this course because of the advantages it has over other frameworks. Specifically, results frameworks help program managers focus on the key results required (i.e., that are necessary and sufficient) to achieve a larger goal, such as improved health status or reduced fertility. Results frameworks also require that we demonstrate the logical links between the goal, the strategic objective – the highest result that we are likely to influence, such as use of contraception – the intermediate results, and the lower-level strategies and activities that contribute to them. A good framework will show a chain of results that clearly identifies what a project is doing to bring about change in a specific population and toward what larger goal. Such a framework (or chain) links the strategic objective (results for ultimate beneficiaries) back to intermediate results at different levels, which in turn link to outputs, activities, and processes. This type of framework is usually called a "results framework."

Defining Terms

Before we go further in discussing how a results framework can be used in a project, it will be helpful to define key words as they are used in this and other USAID-funded projects.

Goals: Big picture, long-term, ultimate ambitions to alter health status in a population. Goals are at the highest level and are usually not measured in the program context. For example, reducing morbidity and mortality in the general population are usually considered to be at the goal level. While the fulfillment of a goal may not be possible or verifiable during the lifetime of the project, the achievement of the project's more specific objectives should contribute to the realization of the goal.

Results Framework (RF): A results framework is the presentation of a coordinated view of a program including the highest goal or strategic objective, intermediate results, and other results while conveying the cause-and-effect linkages between the intermediate results and the strategic objective. It includes ideas about the things that have to be put in place to achieve success. A results framework is usually laid out in graphic format and supplemented by a narrative. A person looking at a results framework should be able to understand the premises underlying the strategy and see within the framework those intermediate results critical to achieving the strategic objective.[1]

Strategic Objective (SO): A statement of what the program plans to achieve during the lifetime of the project. A strategic objective is the highest level **result** that a program is likely to achieve given the time, host country environment, customers' perspectives and needs, and funding allocated. In other words, what can realistically be accomplished given the time frame and resources available. For example, "increased use of contraception," "reduced unmet need for family planning," and "increased utilization of antenatal services" are strategic objectives. Results are stated in terms of changes in the behavior of targeted beneficiaries or changes in the use of health services such as delivery with a skilled attendant or appropriate case management of common childhood illnesses.

[1] U.S. Agency for International Development (USAID). 2000. Building a Results Framework. TIPS No. 13.

Intermediate Results (IR): Intermediate results are a change in conditions that will lead to behavior change or a higher objective. For example, "increased access to contraceptive counseling and services," "improved quality of reproductive health (RH) services," and "increased motivation for use of family planning and selected RH information and services" could be a set of intermediate results necessary for achieving the desired higher **result** or strategic objective of "adequate child spacing practices." A change in conditions is necessary to ensure that people have access to sufficient and quality services.[2]

Other Results: Other results are short- and long-term impacts that affect beneficiaries (or customers). A key result at the strategic objective level might be adoption of healthy behaviors and practices by the beneficiaries. Another example might be "increased use of contraceptive methods by women of reproductive age." There are also lower-level results such as increased knowledge, improved quality of care by a health service provider at the community or health facility level, or changed attitudes of child caretakers. A provider dispensing health care according to standards is an example of a lower-level result.[3]

Who Is the Course Designed For?

This course targets mid- and senior-level managers and field staff who are responsible for developing proposals, designing programs, and implementing and monitoring programs. It is strongly recommended that participants have some experience with health programs so they are familiar with health terminology and basic health program tools. In the event that participants would like to do some preparation, they should be encouraged to review reference materials on topics such as Participatory Learning Appraisal (PLA), qualitative data collection methods, 30-Cluster household surveys, Lot Quality Assurance sampling (LQAS), health indicator selection and definitions, and health monitoring systems.

The training focus of this manual is the design of family planning programs. However, because the skills are broadly applicable, the content and exercises could easily be adapted for use by managers of other types of health programs.

PARTICIPANT PREPARATION

Participants should bring:

- Any documentation they have on their project area that can provide the basis or justification for the project design (secondary data, PLA or focus groups results, health facilities assessments, surveys, etc.)
- Project log frame or implementation plan
- List of project objectives and indicators
- Project M&E plan.

When Should Participants Take the Course?

Ideally, project design using a results framework takes place at the beginning of a project. This helps ensure that the essential elements for achieving the goals are addressed, and that a monitoring and evaluation plan is in place for tracking progress. However, it is possible to introduce a results framework to strengthen both project design and monitoring and evaluation at any point in the project implementation cycle. Annual reviews and/or midterm evaluations are alternative points for introducing a results framework during the project.

[2] Ibid.
[3] Ibid.

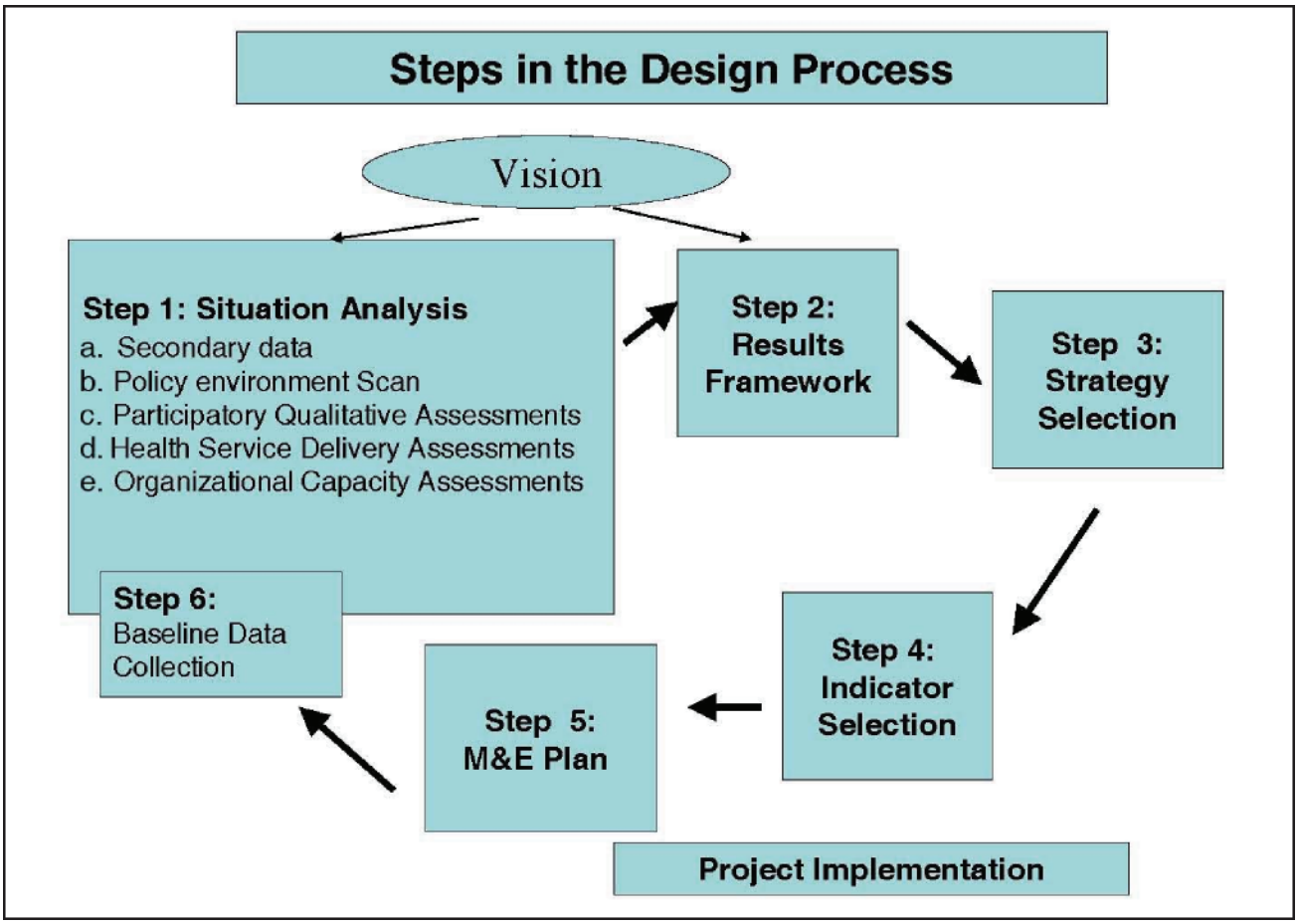
Through the use of case studies and self-critiques, this workshop accommodates projects that may be at different points in the project design and implementation cycle.

Course Structure

During this 6-day course, participants learn a six-step process for developing a project design using a results framework and a monitoring and evaluation plan linked to the project design. These activities are based on situation analysis and an organized process for extracting and analyzing information.

The training leads participants through the design process using a series of steps involving both theory and practice:

1. Carry out a situation analysis, including a policy scan by using data from four sources: (1) secondary data, (2) participatory qualitative research, (3) health service delivery assessments, (4) organizational capacity assessments.
2. Develop a results framework based on the situation analysis that includes definitions of a strategic objective and intermediate results.
3. Select strategies linked to the results framework that take into consideration the sustainability of the strategies and interventions.
4. Select indicators to measure the desired results.
5. Develop a monitoring and evaluation plan.
6. Select methods for baseline data collection.



At each step of the design process, instructional material is presented and participants are provided with exercises to practice the necessary skills.

PDME Modules

Module 1: Overview of the project design process and introduction to the results framework

Module 2: Use of secondary data and a policy environment scan for program design

Module 3: Using participatory qualitative assessments as part of the situation analysis

Module 4: Using health service delivery assessments and health facility assessments as part of the situation analysis

Module 5: Using organizational capacity assessments as part of the situation analysis

Module 6: Constructing the results framework and selecting strategies for impact and sustainability

Module 7: Selecting indicators and developing a monitoring and evaluation plan linked to the results framework

Module 8: Selecting methods for systematic collection of baseline data linked to the M&E plan

Module 9: Application of skills learned: Critique of real project designs using a results framework approach

Each module includes the following materials:

- A PowerPoint presentation of the instructional material
- Worksheet tools and other materials for use during the exercises
- Summary of session
- Suggested reference materials.

INTRODUCTION FOR FACILITATORS

Why This Course?

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This is a process course, which means it has an emphasis on participant practice and reflection rather than the linear presentation of informational material. At the same time, however, increasing the analytical and critical thinking skills of participants is an important part of the course. The effectiveness of the course depends to a considerable degree on group work that offers participants the opportunity to practice their skills. It also depends on the skills of the facilitator to respond with flexibility to issues and concerns as they arise. Project design is a circular, multidimensional process, and there is no single, correct way to implement it. The ability of the facilitator to include observations and remarks that are pertinent to the content being discussed – even if presented out of order relative to the course plan – enhances the relevance of the course to the experiences participants bring to discussions.

Adult Learning Methodology

Finally, the course depends on and uses adult learning principles. It emphasizes group work to give participants the opportunity to integrate and practice the use of results frameworks in designing projects – through both the case study and supervised review of participants' projects. Presentations by participants may offer experiential examples of the different steps in the design process and provide experience using the tools covered in the course, thereby improving understanding. The box below highlights the important principles and practices to remember during the facilitation of each activity. Remember that everyone learns from a workshop; the facilitator does not have all the answers, and serves only to facilitate the learning process.

Adaptation

This workshop will be most effective if it is carefully adapted to the local situation and needs. Participant skill levels, health program priorities, timing for project design cycles, and interaction between health and other sectors all influence workshop priorities.

The course is designed as a six-day workshop with time for small group work as well as presentations of instructional material. There are additional activities in some of the course modules that have not been budgeted for in this timeframe. There may be additional or substitute activities that are more relevant to specific participant skill levels and/or a country's health program. Through a review of the participant needs assessments, discussions with USAID Mission staff and senior country health staff, the facilitator should adapt both the course content and the course schedule to the time available and the training needs of the participants.

An example of a 6-day workshop schedule is included in the manual and is consistent with the proposed session times. It will be up to the facilitator to develop a course-specific schedule based on both local customs and the agreed-on priorities and program adjustments for the particular country. It is important to remember that even a well planned schedule needs to be flexible to accommodate participant needs as they arise.

Preparation

Participant selection is an important part of course preparation and depends on the needs and priorities identified for the particular country program. The course is easier to facilitate when participants have similar levels of experience with project design, implementation, and evaluation. Group work goes more smoothly and time management is less challenging if this is the case. On the other hand, the course content is such that less experienced participants will still be able to get a great deal out of the course. Also, having participants from a variety of different projects and experiences adds depth and interest to discussions.

The course content targets anyone involved with project design; it is particularly useful for project managers and field program supervisors and monitoring and evaluation officers. It enhances the synergy between these two roles (program management and monitoring and evaluation) because it links the project design, strategy, and monitoring and evaluation elements of the design cycle. Project managers are made aware of the role of monitoring and evaluation in their project designs, while monitoring and evaluation officers are made aware of their responsibility to provide information for analysis to the team for use in decision-making.

The preliminary identification of project documents and secondary data that can be used for practical exercises during the workshop needs to be completed ahead of time.

Documents for Workshop

- Project documents: All participants should be asked to bring documents (results frameworks, log frames, M&E plans, lists of indicators, etc.) drawn from their existing or upcoming projects. They can review, develop, critique, and revise these documents during the last day (Module 9).
- Secondary data: The facilitator and support people need to identify local sources of secondary data that can be used during practical group work.

Instructions for CD-Rom

To access the PowerPoint presentations (including notes), open the CD-ROM by going to "My Computer," clicking on the CD drive (usually "D") and opening the folder called "powerpoint presentations including notes for the trainer".

Adult Learning Principles to Remember

- Create a safe learning environment.
- Give feedback to the participants and praise them for their efforts.
- Think about ways of making the topic useful to all the participants present.
- Let the participants know that you are a learner with them.
- Use small groups (as suggested in the session guide). Small groups help involve all participants, build a sense of teamwork, and create safety.
- Vary the setting and the energy level of the sessions. Encourage participants to move around for different activities.
- Show respect by valuing the participants' knowledge and experience with the subject.
- Be sure that throughout the session there is an opportunity for thinking, acting, and feeling.

(Freedom from Hunger, Jane Vellha)

Facilitating the Workshop

This workshop follows the six steps of the design process, including several modules reviewing different tools for situation analysis.

Daily activities include the following:

1. Introduction to the topic and brainstorming
2. PowerPoint presentation and explanation of the content
3. Practical exercises in small groups
4. Daily review sessions covering the preceding activities.

The last day is spent working in project-specific groups, giving participants an opportunity to develop and/or critique their own project design and M&E plans using the skills they have learned.

Organization of Group Work

While specific instructions for the group work are included in the activity plans, a few general comments are listed below:

- Participants appreciate working in small groups because in this environment they feel as though they are full participants. Groups of 5-6 participants are generally the ideal size.
- It is helpful to mix participants up as much as possible, particularly for the exercises on the case study, so they have an opportunity to interact with participants from different projects. An effort should be made to distribute strength and levels of experience more or less equally among the groups.
- A substantial amount of time in this course is focused on the different components of the situation analysis, giving participants experience through group work in compiling and using information from a situation analysis to inform project design. After the case study, they go through the process a second time with real projects. It is the responsibility of the facilitator to keep the group work moving along, and to continually put the individual activities in the context of the overall design process.

- For the final day, groups work on their own projects. If there are fewer than 4-5 people for each project, a balance needs to be made between the benefits of people working on their own project and the need for a critical mass in the group (both in terms of numbers and expertise). If the numbers for each project are small and/or expertise is not evenly distributed across groups, it may be useful to merge two or more groups into one. The newly formed group (or the facilitator) will then need to decide which project will be the focus of their work.

Time Management

The facilitators continually need to judge whether completion of group work activities is more important for the learning process than cutting groups off (or pushing them quickly) to keep the workshop on schedule and to maintain adequate time for group work on individual projects at the end. It should be noted that participants have often said that the group work on the last day was the most helpful part of the workshop.

Course Management

The activity plans offer guidance to the facilitator on how each module should be handled. Each activity is outlined with instructions for the facilitator and the suggested time allocation. There is also a list of needed supplies and tools for the activity. At the end of each module there is a list of useful resource materials for participants as well as a few optional activities. The following are additional aspects of course management that need to be addressed by the facilitator:

1. **Daily Schedule:** Breaks and lunch times are accommodated based on local custom, participant preference, and the flow of the curriculum. Each day should begin with some kind of exercise to review activities of the previous day.

2. **Review Sessions:** These tend to work best when participants are involved in leading them. Facilitators can ask for two volunteers per day. The volunteers will prepare an interesting group activity that will include a review of the key topics covered by the previous day's activities. The group activity might be some type of game. As part of organizational activities on the first day, it may be helpful to identify all the volunteers for the duration of the workshop, noting the names next to their day on a flip chart. Facilitators may need to work with the volunteers each night to help with synthesizing key points and/or to develop the activity.

3. **Participant Presentations:** Early in the workshop, facilitators need to consider which participants might have experience or presentations to contribute to the learning objectives of the workshop. It is useful to draw on the participants who have the most experience or have experience with specific aspects of the course content. In the past, participants have done presentations on appreciative inquiry, PLA, organizational capacity assessment, and LQAS. Regardless of the topic, participants should be encouraged to focus on the process, or "how they did their activity," rather than the results or findings from the activity. In this way, the rest of the group benefits from the experiences of the participants.

4. **Outlines:** The facilitator should be involved to maximize the focus and usefulness of the presentations. It may be helpful to give presenters a simple outline:

    - Question or topic to be addressed by the assessment
    - Type of assessment methodology
    - Benefit
    - Biggest challenges
    - How they overcame challenges, and lessons learned.

5. **Energizers:** Similar to the review sessions, these sessions are most useful if participants lead them. They should be used when group energy seems to be lagging; however, course interruption should be kept to a minimum. It may be helpful to suggest that each project team have an energizer in mind with an identified facilitator for when they are needed.

6. **Parking Lot:** This is a tool for time management. When issues come up in discussion that are not planned or may detract too much from the focus of the session, they can be put in the "parking lot." This may take the form of a flip chart on the wall where the facilitator can note issues to come back to at a later time. It is then the responsibility of the facilitator to work with the participants to:
    - Schedule a special time to cover the issue if there is interest
    - Agree that it has been covered elsewhere, or
    - Agree that they don't need to come back to it.

Follow-up

Follow-up on the workshop skills depends on the country situation. However, it is important to recognize that participants will likely need additional technical assistance and support as they try to incorporate what they have learned into subsequent projects and M&E design efforts. The more supervisors and program support people that can be involved with the workshop and encouraged to provide follow-up, the more likely it is that the participants will be able to apply what they have learned.

Suggestions for Energizers and Review Sessions

Energizers offer a fun, high-energy way for participants to review what they learned the previous day. A variety of games can be used to "select" individual participants who are then called on to identify something they learned. Other participants are invited to help if the selected person has difficulty. By the time 5 or 6 participants have been selected, the key points from the previous day will have been covered.

Examples include:

- Musical chairs – A selection game set up with one less chair than the number of participants. Music is then played or sung while participants walk around the chairs. When the music stops, everyone scrambles for a chair. The one left standing is called on to answer a question or to name something they learned the previous day.

- Circle game – Everyone holds hands in a circle except one person who is in the middle. The middle person calls out a characteristic (such as wearing something blue). All those with that characteristic are then required to switch places with others. The center person tries to take one of the places, leaving another person stuck in the middle. The middle person is then called on to answer a question or to name something they learned the previous day.

- People in life boats – Have all participants "saunter around as if on a cruise ship" until a caller states there are lifeboats that will hold "x" people (a number divisible by the number of participants with a remainder of 1 or 2 or 3). Everyone then needs to form groups that will fit in the lifeboats, leaving one person or some people out. They will be asked to respond to a question or to name something they learned the previous day.

- Ball game - Make a tight ball out of recycled flip chart paper; ask all participants to stand in a circle. As the ball is thrown from one participant to the next, the participant that catches the ball must answer a review question or state a key learning from the day's sessions.

Change of Situation and Scene

Even if content needs to be presented and the groups have work to do, varying the scene and mode of presentation provides diversion. Alternatives to the passive learning associated with the use of PowerPoint slides need to be actively developed. Have participants stand around a flip chart and brainstorm a list of ideas, encourage people to post flip charts on the wall with participants moving around to read and discuss them, encourage small groups to work in different or more relaxed settings, and encourage people to change places within the room.

SAMPLE SCHEDULE
PDME Workshop

	8:30–10:30	10:30–10:45	10:45–12:30	12:30–13:30	13:30–15:30	15:30–15:45	15:45 –
Day 1	Opening and Introductions **Module 1** Overview Presentation	Break	Vision for Improved FP Introduction to the Results Framework Overview of the Design Process	Lunch	Overview of the Design Process (continued)	Break	**Module 2** Use of Secondary Data and Policy Environment Scan for Program Design
Day 2	Daily Review Group work: Case Study **Module 3** Qualitative Methods	Break	Qualitative Methods (continued) Group work: Case Study	Lunch	Group work: Case Case Study (cont.) Practice Focus Group PLA & PD	Break	**Module 4** Using Health Service Delivery Assessments– Introduction
Day 3	Daily Review HSDA Presentation Group work: Using data from HSDA	Break	**Module 5** Organizational Capacity Assessment Intro & Presentation Exercise	Lunch	Exercise (cont.) Synthesis of Situation Analysis **Module 6** Completing the RF & Selecting Strategies	Break	Group work Results Framework
Day 4	Daily Review Group work (continued) Presentation of group work	Break	Group work & Discussion (cont.) **Module 7** Choosing indicators & developing a M&E plan Exercise: Match Indicators& Results Presentation	Lunch	Presentation (cont.) Group work: case study	Break	Presentation of group work and discussion

	8:30–10:30	10:30–10:45	10:45–12:30	12:30–13:30	13:30–15:30	15:30–15:45	15:45 –
Day 5	Daily Review **Module 8** Baseline data collection methods Methodology exercise: LQAS and 30 cluster	Break	Methodology Exercise (cont.) Presentation & Discussion	Lunch	**Module 9** Project Design Critique Results Framework & Sustainability Triangle	Break	M & E Plan
Day 6	Daily Review Discussion	Break	Discussion (cont.) Closing	Closing (cont.)	Lunch		

MODULE 1

Overview of the Project Design Process and Introduction to the Results Framework

Purpose

The purpose of this module is to present the course and to give participants a basic understanding of the steps in the PDME process using a results framework.

Achievement-based Objectives

By the end of this module, participants will have:

1. Reviewed the purpose and flow of the workshop
2. Shared their expectations
3. Developed a vision for an improved family planning situation and discussed how such a vision feeds into the design process
4. Identified the necessary and sufficient conditions for a successful health or family planning program
5. Described the steps of the design process
6. Listed the components of a results framework and a sustainability plan
7. Identified the components of a monitoring and evaluation plan and discussed how this is developed from the results framework

Activities *(approximately 5.5 hours)*

Activity 1 – Opening presentations and ice breakers (1 hr., 45 min.)

Activity 2 – Vision for improved family planning (30 min.)

Activity 3 – Introduction to results framework (45 min.)

Activity 4 – Overview of Design Process (2 hrs., 45 min.)

Supplies and Handouts for Participants

- Flip chart posters for the steps of the design process and for a blank results framework. These should be posted after doing the exercise in Activity 1 and referred to throughout the workshop
- Flip chart with "ideal family" in the middle as inspiration for vision exercises
- Completed participant needs assessment forms or compilation of responses
- PowerPoint – Module 1 (printouts for participants)
- Flip chart to list participant expectations
- 6 cards – each with one step of the design process written on it
- Post-it papers or index cards for vision exercise
- Flip chart with blank results framework (goal, strategic objective (SO), 4 intermediate results (IRs)
- Handouts – participant needs assessment form, steps in the design process, Tool for Synthesizing Situation Analysis, Project Summary Results Framework , Monitoring & Evaluation Planning Matrix

(Note: Participants should bring examples of original research and/or project design documents (log frames, M&E plans, etc.) that they have for their current projects. The facilitator should collect copies of these now since they will give a baseline idea of participant capacity, as well as orientation for planning the final workshop day where they will be working on their own projects using the results framework tools.)

Activity 1 – Introductions and Ice Breaker *(1 hour, 45 min.)*

1. Invite the appropriate person/people to give welcoming remarks and introduce the facilitators *(5 minutes)*

2. Group introductions/Ice breaker *(45 minutes)*

Depending on how people sat down, ask people to move around so they are sitting with people they don't know very well. Then divide people into groups of 3-5 and have them introduce themselves, their country of origin, and their experience with Program Design, Monitoring and Evaluation (PDME). They should then select one person in the group to "sell" the group and their expertise to the larger group. *("we have 30 years of collective experience managing health programs ....")*

For people with other favorite introduction exercises, they can be substituted for this. However, it is preferable for the exercise to have some relationship to the PDME.

3. Participant listing of expectations *(20 minutes)*

Before beginning the workshop, give participants the opportunity to share their expectations. This can be done in a brainstorming format with the facilitator writing these on a flip chart. The group can then refer to this list at the end of training (and as monitoring throughout) to be sure the training indeed meets expectations. It also allows for correction of expectations if there are things the training will not cover and/or scheduling of special sessions to meet needs not covered in the training.

(Note: Save the flip chart of Participants' Expectations for reference at the end of the training.)

4. Developing group norms *(10 minutes)*

In a participatory way, the group can agree upon how the workshop will be managed. In particular, the group needs to agree on the following:

- The schedule – With approximately 7 hours of content, they need to decide when they want to start, stop, and take breaks and lunch.
- Behaviors such as smoking, management of cell phones, etc.

This is also an opportunity to make sure accommodation arrangements are adequate and to explain any details regarding per diem and/or management of expenses.

Basic operational procedures for the workshop should also be set up at this time:

- Identify volunteers to lead revision sessions each morning.
- Ask participants to think of warm-up activities they can lead as needed.
- Explain the term "parking lot" (for questions that need to be put aside until a later time)
- Identify the participants who have or have not brought in documents on their projects.

5. Workshop overview, outline of first day PPT slides # 1-6 *(15 minutes)*

6. Participant needs assessment *(10 minutes)*

(Note: Briefly summarize the cumulative results of Part 2B. of the Self Assessments, (received prior to the workshop) regarding participants' level of interest, knowledge, and willingness to share examples relevant to each of the topics. For participants who did not complete the form prior to coming to the workshop, ask these participants to fill out the form in their participant binder and hand it in.)

Activity 2 – Visioning Exercise to Improve Family Planning *(30 min.)*

Show a flip chart with a picture of an ideal family as an inspiration for their vision. Explain that before planning a program, it is important to "dream" about the ideal a family planning program might achieve. What would it take for everyone who would like to limit the size of their family or space their children to use family planning? How might people be encouraged to use family planning? What kinds of services are needed to meet their needs? Who needs services that aren't currently getting them?

1. Distribute 3-5 post-it papers or index cards to each participant. Have people take 5-10 minutes to write down the vision or their hopes for a family planning program in their country. They should write one idea on each card (or post it) so the different ideas can be sorted into categories a little later.
2. Ask participants to hold on to the cards or post-its they have written for a few minutes.

Activity 3 – Presentation of Results Framework and Sustainability Framework *(45 min.)*

1. Presentation - PPT slides # 7-18

Explain the elements of the results framework and sustainability framework and how they relate to each other. Allow time for questions. Emphasize that we are teaching a thinking process, and we do not need to focus on details at this point.

Activity 2 (continued) – Classification of Vision Post-its

Posting the flip chart with a blank health results framework, briefly explain the 4 IRs and the SO for community-based family planning programs funded by the USAID Office of PRH Flexible Fund to PVOs and NGOs. Have people read their vision ideas and identify which level or element of the results framework they pertain to. Cards should then be moved to the results framework flip chart according to their respective categories, graphically showing how the common vision can be organized into the different results and/or the objective.

Allow some discussion on where different ideas belong, as this allows people to begin to internalize the scope and content of the different results levels. However, it is important to remember that this is not a science and there is no real right answer. Do not let the discussion get lost in determining which category a particular element belongs in, since this is not the point of the exercise; for example, it does not matter whether the availability of drugs goes under quality or access.

(Note: Depending on the format, trainers can save this to refer to at the end of the training)

Increased Family Planning Use and Improved Family Planning and Reproductive Health Practices			
Increased Knowledge/Interest	Improved Quality of Family Planning Services	Increased Access to Family Planning Services	Improved Social and Policy Environment for Family Planning

Activity 4 – Presentation of Steps to the Design Process *(2 hours 45 minutes)*

1. Introductory exercise *(10 minutes)*

Ask for 6 volunteers and give each of them a card with one of the steps to the design process. Ask them to put the cards in the order they think the different steps should occur. Encourage the other participants to stand up and help their colleagues in the discussion.

After the discussion, add the poster of the design process to the blank results framework.

2. Present first three steps of Design Process - PPT slides # 19-25 *(40 minutes)*

Emphasize that the design process is an iterative process that will occur at least 2-3 times during the course of a project with differing levels of depth and detail. (e.g. before writing the proposal, while developing the implementation plan, and during the midterm evaluation).

Explain the first three steps of the design process:

- Situation analysis and data collection options
- Describe current situation and analyze data to define desired result
- Development of intermediate results—the necessary and sufficient elements to achieve the vision.
- Identification of strategies to address intermediate results

(Note: Allow time for questions.)

3. Work in triads to practice developing strategies PPT slide # 26 *(40 minutes)*

Divide people up into threes and have them brainstorm ideas for strategies to address the gaps identified on the slide. Point out that at this point we are talking about strategies and not activities. Strategies represent the general approach that the project will take to achieve the intermediate results, while activities are what the project will do every day to achieve the result. (10 minutes)

Note: It is not worth getting into the difference between strategies and activities at this point because there is not a solid line between the two. The essential understanding is that there are lower level elements of a project (activities and strategies) that need to contribute to higher level intermediate results and strategic objectives.

After 10 minutes, ask the group at large for examples of strategies they selected to address the identified problems. (15 minutes)

4. Present development of indicators - PPT slides # 27-34 *(20 minutes)*

(Note: Allow time for questions.)

5. Work in triads to practice indicator selection - PPT slide #35 *(40 minutes)*

Using the same triads, have the groups go back to the strategies they identified in the previous exercise and suggest possible indicators for measuring the change in the result those strategies are meant to achieve. (e.g. change in knowledge/demand, quality, access, or policy/social environment)

After ten minutes, ask the group at large for examples of the indicators they selected, mentioning the results they are meant to measure and the reason for their selection.

(Note: you may end up with indicators for both the intermediate results (impact) and the strategies (process) It is not essential to emphasize the difference between the two at this point – only to point out that they are measuring different levels of the results framework.)

6. Present development of M&E plan and design for collection of baseline data - PPT slides # 36-42 *(15 minutes)*

Point out that we have now briefly gone and begun working with the different elements of the results framework, and the different steps that go into building a results framework during project design. It is okay to feel confused right now, since this was a quick overview of the content that we will be covering in more depth throughout the rest of the week.

(Note: Allow time for questions.)

Handouts for Participants:

1. Participant needs assessment form
2. Diagram of the design process 3.
   Handout of PPT presentation

Useful References for Module 1

1. "Health and Family Planning Indicators: A Tool for Results Frameworks, Volume I" Health and Human Resources Analysis For Africa (HHRAA) Project, USAID
2. "Health Family Planning Indicators: Measuring Sustainability, Volume II"

MODULE 2

Use of Secondary Data and Policy Environment Scan for Program Design

Purpose

The purpose of this module is to give participants an understanding of the different sources of secondary data and their use for program design.

Achievement-based Objectives

By the end of this module, participants will have:

1. Defined secondary data
2. Listed sources of secondary data
3. Described the importance of secondary data and how it contributes to developing a program design results framework
4. Identified the limitations of secondary data

Activities *(approximately 1 hour 35 minutes)*

Activity 1 – Large group discussion on secondary data sources (20 minutes)

Activity 2 – Introduction to secondary data (15 minutes)

Activity 3 – Case study groups practice using secondary data (60 minutes)

Supplies and Handouts for Participants

- PowerPoint – Module 2 (Participants should have printouts.)
- Blank flip chart matrix to list secondary data sources and limitations
- Enough copies for each small group to have a set of examples of secondary data sources for small group practice (For example: DHS, UNFPA studies, HMIS quarterly report, gender studies/ reports, MOH standards, MOH RH policy, LMIS report, old project surveys, etc.)
- Copies of blank tools for situation analysis (organization of secondary data according to the 4 intermediate results)

Activity 1 – Brainstorming to Identify Secondary Data and Their Uses

(20 minutes)

1. Ask the group what they understand by the term "Secondary Data."
2. Going around the room, ask different participants to list an example of a secondary data source they are familiar with or may have used in project design – encouraging everyone to participate. As the obvious sources are already mentioned, encourage people to think creatively about where they would find information about family planning. Note their responses in the first column of the flip chart.
3. Once the list is complete, proceed down the list, asking participants to identify what they might consider as the strengths and limitations of the different sources.

Finally, ask people to think about which components of the results framework are most likely to be informed by data from secondary sources. For example, it is more likely that the goal and strategic objective be informed by quantitative survey data, whereas information on the socio-cultural context which informs the strategies and activities components can be found in qualitative studies. Information on access to and the use of health services may come from routine MOH reporting.

Example *(Answers to be generated by participants)*

Data Sources	Limitations
Demographic and Health Surveys (DHS)/Multiple Indicator Cluster Surveys (MICS), national surveys	Not specific to project area Not enough detail about specific project interventions May be out of date
MOH reproductive health policy, family planning standards and guidelines, protocols, training plans	Doesn't reflect reality on the ground
Gender and health studies, other specialized qualitative studies	May have bias May not be specific to family planning May not be specific to family planning
HMIS/LMIS quarterly report, national information system reports	Is only as good as the data collected Does not represent people who don't use services
Clinic records	May be subjective and have gaps (or may be a good complement to other data)
Special prevalence reports (e.g. HIV/STI)	Are narrow and may not have program focus, but may complement other data
Previous project area surveys	May be outdated May have different target population or focus interventions
Description of MOH structure in project area	Doesn't reflect other barriers to access Doesn't reflect community perspective Doesn't represent the quality of those services

Activity 2 – Overview of Secondary Data *(15 minutes)*

PPT slides # 1-8

Point out that review of secondary data and the policy environment are two of the five components of the situation analysis. Therefore, identification and review of secondary data should be the first step in project design. Secondary data are often used in proposal design because of the low cost. We will be discussing the other components (participatory community assessment, health services assessment, organizational capacity assessments) in coming sessions.

Activity 3 - Case Study Group Work Using Secondary Data *(1 hour)*

PPT slide #9

Flip chart Explanation

Each small group has one assigned IR to work on (knowledge/demand, quality, access, policy/social environment). For the assigned IR, groups will identify pertinent qualitative information extracted from the secondary data.

- Review the secondary data and identify any information pertinent to the assigned IR.
- Fill in pertinent information on the Tool for Synthesizing Situation Analysis Data under the section for secondary data

1. Divide the participants into small groups that will work together during the next three modules. Each group should have a good representation of members from different projects as well as a mix of people reflecting a range of experience in PDME. Ideally, there are at least four groups with no more than 5-6 people per group. Assign each group one of the IRs to work on. This IR will be their focus during all of the situation analysis exercises.

2. Give each group a selection of the secondary data with instructions to review the data and pull out key information on their assigned IR. They should make notes of the pertinent information in the first section (secondary analysis) of the first tool. Finally, have them think about what implications this information might have for project design.

   (Note: This is making the assumption that the secondary data are somewhat consistent with the case study because these data form the basis for completion of the subsequent sections. The purpose of this exercise is to practice skills.)

3. Have groups briefly share examples of the information they found if appropriate and time is available.

Below are examples of the kinds of information and implications participants might identify in their review of secondary data. In preparation, the facilitators might want to find specific examples in the data the triads will be using.

Overview of the health situation: DHS data reveals that in the district where the project will be implemented only 15% of women of reproductive age (WRA) in union use modern methods of contraceptives or that the unmet need for FP is 80%.

Access: Clinic records may reveal that per month, an average of 10 women come to the clinic for family planning services. However the number of WRA in the service area of the clinic is 2,000. DHS may reveal that although the country as a whole has a ratio of ___ health centers/ ____ population, in the department where the project will be implemented the ratio is actually ____.

Note: This can be complemented with information / maps from the MOH about location of health centers and may reveal that the majority of these centers are located in main towns and therefore difficult for most of the population to reach.

Quality: Clinic records may reveal stock outs of condoms 5 months out of the year. A focus group study in a neighboring district revealed that women do not feel comfortable discussing family planning with male health professionals.

Knowledge: The DHS survey may reveal that only 40% of WRA in the district where the project will be implemented know of at least three methods of family planning.

Social environment: A focus group study in a neighboring district revealed men and mother in-laws are uncomfortable with women going to health clinics to discuss family planning methods.

Policy: Health facility assessment revealed that teens are unable to receive family planning services.

MODULE 3

Using Participatory Qualitative Assessments as Part of the Situation Analysis

Purpose

Participants will understand how participatory qualitative assessments contribute to the project design process through review of the options and tools for carrying out such assessments and practice in adapting or using some of the tools.

Objectives

By the end of this module, participants will have:

1. Identified benefits and limitations of participatory qualitative assessments
2. Described qualitative research methods and tools, especially Participatory Learning and Action (PLA), Focus Group Discussion (FGD), and Positive Deviance
3. Assessed types of information obtained from PLA, its limitations, and how it contributes to project design
4. Analyzed the unique perspective offered by a positive deviance approach
5. Practiced drawing conclusions from the case study PRA for program design consideration

Activities *(approximately 4 hours 35 minutes)*

Activity 1 – Brainstorming Introduction to Qualitative Methods (10 minutes)

Activity 2 – Presentation of Qualitative Methods (1 hour, 40 minutes)

Activity 3 – Exercise in extracting information from a PRA *(case study)* (1 hour, 15 minutes)

Activity 4 – Practice focus group discussion (1 hour)

Activity 5 – Discussion of PLA and Positive Deviance (30 minutes)

(*Note: Depending on time available, these last two activities may be shortened)*

Supplies and Handouts for Participants

- PowerPoint presentation – Module 3
- Case study – PRA report
- Copies of synthesis of situation analysis tool distributed for module 2
- Copies of focus group discussion guides for Activity 4

Activity 1 – Introductory Exercise *(10 minutes)*

Participatory methods

Ask participants to brainstorm a list of examples of the kinds of information related to reproductive health and family planning that might be collected using qualitative methods. These should be noted on a flip chart. Examples include:

1. Belief about risk of HIV/AIDS
2. Local names for body parts, sexual organs
3. Reasons for delaying marriage
4. Reasons for not using family planning methods
5. Gender attitudes towards decision making around contraception, pregnancy care, HIV prevention, etc.
6. People's sense of relative importance of different health problems
7. The community perspective: cultural attitudes and beliefs, barriers to health behaviors and services, etc.
8. The perspective of the local community structures – formal and informal: Understanding formal decision-making and community authority roles, levels of accountability, relationship between different levels of authority or different community institutions
9. The perspective of partners – partner activities and priorities, partner's understanding of the local situation
10. Perspective of health service providers: capacity and competency, constraints and barriers to delivering or receiving services

Once a reasonable list has been generated, ask participants for ideas about how they might best collect this information. The discussion should include suggestions for the kinds of tools that might be used (observation, interviews, focus groups, visual techniques such as mapping, etc.) and who might be the best sources of information.

Finally, use it as an opportunity to assess if or what experience the participants have with any of these methods.

Activity 2 – Presentation of Qualitative Methods and Tools
(1 hour 40 minutes)

1. PPT slides #1-17

Explanation of benefits and limitations of qualitative research, qualitative research tools including observation, in-depth interviews, focus group discussions, and a variety of visual techniques.

It is important to emphasize again that this is meant to be a brief overview of different options, but is not meant as a training in qualitative methods. Participants can be referred to the references on qualitative research tools. The concepts of triangulation, controlling for bias and rigor are important to emphasize since qualitative research is often mistakenly seen as "easy."

If there are participants who have experience with qualitative research, a brief presentation about their experiences may complement the slide presentation before or after the exercise in triads which follows below.

Participant presentation slide #18

These complementary presentations should focus on the process and address the following:

1. Purpose of the research and questions to be answered
2. Tools and methodology selected and why
3. What went well or not so well with the research
4. Recommendations and suggestions for participants who might be considering qualitative research activities.

(Note: While difficult, the presentation should focus on what was done and learned during the research process and ***not*** *presenting the research results.)*

2. Exercise in Triads PPT slide #19

Ask participants in groups of three to discuss their experience with qualitative research. Using a specific example of qualitative research they are familiar with, ask them to discuss:

- How did the qualitative research match the information needed and what were the advantages of the approach?
- What were the challenges in getting good information from the qualitative research approach?
- How was triangulation used to validate the information collected?

3. Complete the PPT presentation slides #20-28

(*Note: The slides are to be used at the facilitator's discretion. Even though time may be limited for the FGD practicum and discussion of PLA and Positive Deviance approaches, the slides can be used to touch on these methods.)*

Activity 3 – Exercise to Practice Extracting Relevant Project Design Information

(1 hour, 15 min.)

Flip chart explanation

Participants will work in the same groups as for secondary data, with the same assigned IRs. Groups will identify pertinent qualitative information extracted from the case study for the assigned IR. (Module 3: Handout 1)

- Review the Health Services and FP/HIV case studies and identify any information pertinent to the assigned IR.
- Write-in pertinent information on the "Tool for Synthesizing Situation Analysis" under the section for qualitative data.

1. Have the group return to the same small groups they worked with during the previous module. Again, each small group will focus on the same IR they were working on for secondary data. However, now they will be filling in the second section on the situation analysis tool, for their assigned IR. The source of their information will be the PRA data from the case study.

2. Give the groups 55 minutes to review their reports, identify information that is significant to their IR for an eventual project, and think about the kinds of results a project intervening to address the challenges might aspire to.

(Note: The facilitator must make it clear that the secondary data comes from other sources than the case study, but that the IR they established can be applied to a potential design using the PRA case study.)

It is up to the facilitator, with the rest of the group, to ensure the IR and the strategies really take the information from the PRA into account. While this moves towards a pre-defined approach to project design, we need to guide people to think rigorously about what they are doing and why.

Activity 4 – Practice Focus Group Discussion *(1 hour)*

Flip chart explanation slide #29

1. Carry out a practice focus group focusing on two questions.
2. Observers observe strengths and weaknesses of the facilitator.
3. Small group discussion of observations.
4. Large group reporting on observations and recommendations/lessons learned.

The main purpose of this exercise is to practice probing questions and management of group dynamics. These are essential skills for effective focus groups. It should be emphasized that while anyone can follow a list of questions in question and answer style, it is difficult to maximize the depth and breadth of information that may be available through a focus group. As a result, while a full facilitation guide can be distributed to give participants an idea of what a general family planning FGD might entail, the facilitators are encouraged to acknowledge but skip over the introduction steps, and to focus on 2 questions only – with the goal being to obtain the maximum practice with the skills of probing, questioning flexibly, and managing group dynamics.

1. Organization of focus groups *(10 minutes)*

Divide the group, making groups of 10–12 participants each. Assign a facilitator, and identify 6– 10 participants as focus group members. Discretely give different group "roles" to 2-3 of the focus group participants in each group. (For example, quiet and shy, highly opinionated, dominating, with others who will participate appropriately.) Assign the remaining participants as observers.

Distribute the question guides to the facilitator and observers. Ask the facilitators to choose 2 questions only (e.g. number 6 and 7). They should select these out of questions 4-8 from the proposed guide, since these cover the essential general information for family planning. Set up the room with the focus group members, facilitator, and note-takers in a circle, with observers around the outside.

2. Practice focus group *(10-15 minutes)*

People should practice doing a focus group for 15 minutes, briefly acknowledging introductions and then focus on the 2 selected questions for discussion. Facilitators should use different group management and probing skills to get the maximum information on these two questions.

Observers should note the challenges and successes demonstrated by the facilitator.

3. Small group discussion slide #30 *(20 minutes)*

After the focus group is complete, facilitators can help the group address the discussion questions bringing both the observations and the experience of the facilitator and group members to bear.

- How did the facilitator manage getting relevant and useful information? How did they probe to get additional detail?
- What did you observe about the group dynamics? How did the facilitator handle the group? What worked? What didn't work?
- Suggestions for improvement?

4. Summary *(10 minutes)*

Finally, bring the group together and informally ask the group to summarize their conclusions about:

- How to handle group dynamics
- How to get in-depth information from a group—probing, validation, etc.
- What to do when the community wants something different than the donor.

Activity 5 – Presentation of PLA and Positive Deviance Methods slides #31-42 *(30 minutes)*

This is an explanation of two specific methodologies of qualitative research. Both of these methodologies have a high emphasis on community participation, and the involvement of the community in analysis and problem solving as well as in providing information. They also emphasize identification of specific interventions or behaviors, based on the research, which can then be promoted to positively influence health status.

Useful References for Module 3

1. FHI, *Qualitative Research methods: A Data Collector's Field Guide,* 2005.
2. AED, Making Sense of Focus Group Findings: A Systematic Participatory Analysis Approach, 2003.
   For the PDF file, go to
   http://www.aed.org/ToolsandPublications/upload/Making%20Sensefinal.pdf
3. Curriculum: Training in Qualitative Research Methods.
   For the PDF file, go to http://www.coregroup.org/working groups/qrm/qrm complete.pdf
4. CARE, *Embracing Participation in Development,* 1999.
5. CRS, *Volume 1: Introduction, Field Research and Methodology*

MODULE 4

Using Health Service Delivery Assessments and Health Facility Assessments as Part of the Situation Analysis

Purpose

Participants will understand how health service delivery assessments (HSDA) contribute to project design through review of the different components of health service delivery assessments, tools for carrying out such assessments and practice in designing a HSDA.

Objectives

By the end of this module, participants will have:

1. Discussed the role of HSDA in program design and monitoring and evaluation
2. Identified the key components of HSDA and appropriate tools to assess them
3. Described when to conduct HSDAs, their advantages and limitations
4. Identified with a key HSDA tool for family planning and discussed how to adapt it
5. Practiced designing a HSDA
6. Discussed other resources for HSDA.

Activities *(approximately 2 hours, 15 min.)*

Activity 1 – Introductory brainstorm of HSDA components and HSDA design (45 minutes) Activity 2 – Presentation of HSDA components and methods (45 minutes) Activity 3 – Review HSDA information provided to small groups (45 minutes)

Optional Activity

Tool Adaptation (45 min.)

(Note: The optional activity adds 45 minutes.)

Supplies and Handouts for Participants

- PowerPoint presentation – Module 4 (printouts for participants)
- Overview of HFA tools
- Extracted data for each IR from HFA Case Study
- Case Study: Findings from District HFA
- Copies of *Quick Investigation of Quality (QIQ), A User's Guide to Monitoring Quality of Care in Family Planning* tools for optional small group work

Activity 1 – Introductory Brainstorm of HSDA Components and HSDA Design *(45 minutes)*

Gather the group around a flip chart and ask the group to brainstorm a list of the kinds of information they would expect to get out of health service delivery assessment. Once they have a list of the kinds of information they might be looking for, ask them what kinds of tools they think they might need to gather that information.

Examples of information

- What services are available and when
- Who uses what services
- How do people (providers and clients) feel about the services
- Availability of necessary equipment and supplies
- Management systems in place
- Technical competence of providers
- Training needs of staff
- Case management practices—protocols and what is normally done
- Staffing patterns
- Barriers to utilization/fees
- Infrastructure: water, bathrooms, privacy, waiting space, ventilation
- Provider attitudes
- Patient flow
- Job descriptions/staff roles
- HIS – quality and content
- Referral system
- Hygiene and infection prevention
- Waste disposal
- Client rights

Examples of tools

1. Inventories

- Service delivery points
- Infrastructure
- Equipment and supplies
- Personnel and training

2. Observations

- Reception of patients and patient flow
- Provider-client interaction
- Hygiene and infection prevention

3. Provider interviews

    - Management systems
    - Competency
    - Common practices
    - Factors affecting utilization

4. Client interviews (exit interviews)

    - Satisfaction
    - Common practice
    - Factors affecting utilization

5. Record review

    - Patient registers
    - Stock cards
    - Monthly reports

Referring to this list, the QIQ Manual, and their own experience, people should then work in groups of three to develop a design for a Health Service Delivery Assessment for a new family planning project. Information from the previous module on qualitative assessments should be taken into account. We have learned from this qualitative assessment that people feel the health center staff does not treat them well; they complain that medicines are not available, and they are concerned the health center is trying to make them sterile.

1. Identify the information they will need.
2. Identify the sources of information.
3. Identify the tools they will use to gather that information.
4. Define the steps they need to go through to execute the HSDA**.**

Completion of Activity 1

Finally, facilitate a general discussion asking triads to identify the tools they would use and the steps they need to follow to do a HSDA. *(10 minutes)*

(Note: Instead of using the more common term HFA, the term HSDA has been purposely selected in order to emphasize the importance of assessing health services at the community level (e.g. CBD, TBAs and other community based workers) along with assessments at the health facility level. This distinction may help ensure that a more comprehensive assessment of health services is carried out.)

Activity 2 – Presentation of HSDA *(45 minutes)*

PPT slides # 1-13

Overview of uses for the HSDA, the different components of the assessment, and ways information is collected for each.

Participant presentation

If there are participants who have experience with health facility assessments, a brief presentation can complement the slide presentation. These complementary presentations should focus on the process and address the following:

1. Purpose of the research and questions to be answered
2. Tools and methodology selected and why
3. What went well or not so well with the research
4. Recommendations and suggestions for participants who might be considering a HSDA

(Note: The presentation should focus on what was done and learned during the research process and NOT spend time presenting the research results.)

Activity 3 – Review HSDA Information Provided to Small Groups slide #14 *(45 minutes)*

For this exercise the facilitators should hand out extracted data from the HFA (Module 4: Handout 3) for each of the IRs to the appropriate group. The groups may then read the information and integrate it with the other information they have already extracted. They may copy the distributed information onto their data synthesis tool.

Note: The full HFA Case Study findings are in Module 4: Handout 2. The facilitator may choose to use this instead of the extracted data.

Optional Activity – Tool Adaptation *(45 minutes)*

Depending on the availability of time and the needs of the group, it may be useful to offer experience in tool adaptation. This exercise gives participants the practice in deciding when to include or exclude information from an assessment tool based on the focus of their project. This requires careful definition of the purpose of the assessment and the questions to be answered, then rigorous selection of questions that are most likely to contribute the necessary information.

Use either a HSDA tool that has been used in country or one of the HSDA tools listed under resources. Clarify that they will be working with only a very small piece of the HSDA, but that they should use it as an opportunity to think about how to adapt available tools.

Participants are designing a project that focuses on increasing the use of modern family planning, particularly among first-time users. Poor quality services at the health center have been identified as a barrier to use of contraception.

1. Divide the group into small groups of 3-4 people to work on tool adaptation. Give each group the appropriate tools for:

- Facility Audit including IEC materials assessment
- Client Exit Interview

2. Using the tool they were given, each group should review the tool with the following questions in mind:

- Are there questions on the tool that we don't need for our project assessment?
- Are there questions that we need for the project assessment that are not on the tool?
- What other components of the HSDA might we integrate into the same interview/observation?
- Are there parts of the tool that we might want to extract for monitoring quality improvement?

(Note: The goal is not to develop a perfect tool, but rather to get an understanding of how adaptation is done related to the specific questions to be answered.)

3. Have each group report back on what they added or subtracted and why.

Answers to group work

(Note: these are only suggestions, not necessarily right or wrong.)

IEC/Facility Audit group

Remove:

- The child health elements of IEC materials and services because the focus is family planning and reproductive health unless the clinic is emphasizing integrated MCH/FP care.

Other components:

(Note: The tool covers service availability, infrastructure, equipment and supply inventory, staff inventory, and a little about patient flow and logistics management.)

- Might add a brief patient flow analysis if waiting time seems excessive with initial questions.
- Might consider other facilities offering services within reach of targeted clients, particularly if addition of VCT is proposed.
- Might explore more detail for logistic management for equipment and supplies

Client exit interview group Remove:

- The questions related to treatment for malaria if the project is not working in this area or in MCH

• Questions related to family planning methods that are not available in the country if necessary

(Note: During adaptation, one might add questions related to family planning services available during postpartum care, family planning education during ANC, etc.)

Handouts for Participants

1. PowerPoint slides for Module 4
2. Overview of HFA Tools
3. Extracted data from HFA Case Study
4. Case Study: Findings from District HFA
5. Copies of sample tools from resource books (BASICS, MAQ QIQ Tool, Safe Motherhood Needs Assessment Tool)
6. Tool from analyzing situation analysis data that was distributed to participants during Module 2

Useful References for Module 4

1. HFA Tools at www.coregroup.org/tools/monitoring/HFA table.html
2. Safe Motherhood Assessment guide (on CORE website)
3. BASICS Health Facilities Assessment
4. Quality of Care/Quality improvement (MAQ QIQ, COPE, AED, PDQ, etc.) manuals, www.communitybasedfp.org (quality improvement link)
5. MEASURE DHS, Service Provision Assessments (SPA), www.measuredhs.com – look for MCH and RH Core Questionnaire, June 2005
6. Checklist for FP Service Delivery with Selected Linkages to RH, http://www.maqweb.org/maqchecklist/FamPlan1.pdf (Please refer to the website for other languages)
7. Aga Khan, *Primary Health Care Monitoring, Assessment and Planning (PHC MAP)* modules

MODULE 5

Using Organizational Capacity Assessments as Part of the Situation Analysis

Purpose

The purpose of this module is to orient participants to using organizational capacity assessments and their relevance to program design.

Objectives

By the end of this module, participants will have:

1. Described the elements of organizational capacity framework
2. Discussed NGO capacity assessment tools
3. Explored organizational capacity framework's application to program planning
4. Synthesized case study information to inform project design

Activities (3 hours 5 minutes)

Activity 1 – Introductory brainstorm/discussion of organizational elements that contribute to the capacity and viability of an organization (30 minutes)

Activity 2 – Presentation on organizational capacity (45 minutes)

Activity 3 – Exercise to identify pertinent information for project design (1 hour, 20 minutes)

Activity 4 – Synthesis of situation analysis (30 minutes)

Supplies and Handouts for Participants

- PowerPoint presentation – Module 5
- Resource materials with examples of tools to be used in organizational capacity assessment
- Organizational Capacity Assessment Case Study
- Tool for synthesizing situation analysis data that was distributed to participants in Module 2

Activity 1 – Introductory Brainstorm/Discussion of Organizational Capacity *(30 minutes)*

Divide the group in triads and ask each small group to identify different elements or functions of their own organization (or of their collaborating/partner organization) that contribute to:

1. The ability to effectively do the job
2. Long-term viability of the organization

Bring the group together and, going around the room, ask each triad to suggest one of the elements they came up with. Continue until the group has run out.

Finally, briefly discuss with the group at large:

- Why do we care about capacity?
- Whose capacity do we measure? (health services, and health service management/District MOH, other partners)

Activity 2 – Presentation on Organizational Capacity Assessments *(45 minutes)*

All Module 5 PPT slides

Provide an overview of the characteristics of organizational capacity, considerations for measuring capacity and examples of capacity assessment tools. Use of some questions and answers will allow the presenter to be sure people are following the content.

Participant presentation

If there are participants who have experience with organizational capacity assessments, a brief presentation can complement the slide presentation. These complementary presentations should focus on the process and address the following:

- Purpose of the research and questions to be answered
- Tools and methodology selected and why
- What went well or not so well with the research
- Recommendations and suggestions for participants who might be considering an organizational capacity assessment

(Note: The presentation should focus on what was done and learned during the research process and not the research results.)

Activity 3 – Exercise to Practice Identifying Pertinent Information

(1 hour, 20 minutes)

Flip Chart Explanation

Working in the same groups as for previous module group work, identify pertinent organizational capacity information.

a. Review the NGO assessment case study and identify any information pertinent to the assigned IR. Identify 2 strengths and 2 points to improve upon.

(Note: The typical partner is MOH, but this experience may be adapted to the NGO situation.)

b. Write in pertinent information on "Tool for Synthesizing Situation Analysis Data" under the section for organizational capacity assessment.

Activity 4 – Synthesis of Information from Situation Analysis for Case Study *(30 minutes)*

When all the information has been collected for the Situation Analysis (secondary data, qualitative data, health facility data, and organizational capacity data), each small group should take 30 minutes to do the following:

1. Develop a legible copy of the situation analysis tool with the most pertinent information for their IR. This should include information from all four sources of situation analysis data.
2. Formulate an intermediate result that states the general IR they have been working on, but taking into account the specific situation in Nakasongola.
3. Identify 3-5 key challenges or issues the project will need to address in order to assure that it will achieve the desired result. This list should be completed on the second page of the situation analysis tool they have been working on. It is not necessary for them to develop the list of strategies at this time since the next groups will do this.

Flip Chart Explanation

Reminder: The overall goal is development of a results framework based on situation analysis.

Tasks

1. Synthesize and summarize situation analysis findings for developing your IR.

- Review secondary data for your IR.
- Review qualitative data for your IR.
- Review HFA findings for your IR.
- Review organizational capacity findings for your IR

2. Complete the second page of the synthesis tool.

   - Define your IR, making it specific to the case study situation.
   - Identify principle gaps and challenges you have identified through your situation analysis that a project should address.

3. Develop a legible copy of your situation analysis tool with the most pertinent information for your IR.

   - Formulate one IR that summarizes what the project should aspire to achieve for their particular topic (demand, quality, access, environment).
   - Synthesize a list of 3-5 of the key challenges or gaps the project will need to address in order to assure that it will achieve the desired result. This list will be completed on the second page of the tool they have been working on for synthesizing situation analysis data.

   (Note: Next, groups will identify strategies, so that should **not** *be done at this time.)*

   Each group should prepare a (relatively) clean and legible copy of their situation analysis, proposed IR, and identified challenges tool as well as their sustainability framework working page for photocopying. Copies will then be distributed to the working groups for use during the next exercise in developing a results framework.

   (Note: The groups will not fill out the list of possible strategies—this will be done during the next module.

   IMPORTANT NOTE TO THE FACILITATORS: Once the groups have completed their situation analysis tools, these need to be copied for distribution to the working groups for the next exercise in Module 6.)

Useful References for Module 5

1. MOST – Management and Organizational Sustainability Tool: A Guide for Users and facilitators, 2nd Edition, http://www.msh.org/resources/publications/most.html
2. The Manager's Electronic Resource Center, http://erc.msh.org/
3. MSI, Institutional Development Toolkit, http://www.msiworldwide.com/gral/nwproductsinfo/institutional_dev.htm
4. Save the Children, www.savethechildren.org for factors on managing community participation.
5. TIPS for Measuring Institutional Capacity, http://pdf.dec.org/pdf_docs/pnacg612.pdf

MODULE 6

Completing the Results Framework and Selecting Strategies for Impact and Sustainability

Purpose

Participants will have the opportunity to complete the results framework part of the project design process, using the information they have been collecting during the situation analysis.

Objectives

By the end of this module, participants will have:

1. Analyzed the sustainability framework
2. Developed a results framework for their case study based on the situation analysis
3. Practiced applying the sustainability triangle to project design and strategy selection in order to maximize the likelihood of sustainability.

Activities (approximately 4 hours, 5 minutes)

Activity 1 – Brainstorm discussion on sustainability (15 minutes)

Activity 2 – Presentation of the sustainability framework and review of first three steps of the Design Process (20 minutes)

Activity 3 – Small group work developing a results framework and applying the sustainability triangle (2 hours)

Activity 4 – Presentation and discussion of results frameworks (1 hour, 30 minutes)

Supplies and Handouts for Participants

PPT presentation – Module 6

- Examples of completed results frameworks
- Reproductive health strategies
- Project summary results framework
- Project design strategies for sustainability worksheet
- Examples of results frameworks, RH strategies, *Project Summary Results Framework,* Flexible Fund Guidelines (obtain the latest version at http://www.flexfund.org)

Activity 1 – Brainstorm Discussion on Sustainability *(15 minutes)*

Have the group gather around a flip chart to brainstorm responses to the following question: "When we think of sustainability for health programs, what do we mean?" Write their responses on the flip chart.

Ask the group to then identify whether there are ways to group or categorize the items they have listed. (They will likely reflect the 3 corners of the sustainability triangle: community/social, organizational, and health status/health services)

Activity 2 – Presentation of Sustainability Framework and Review of the First Three Steps of Project Design *(20 minutes)*

Overview of sustainability framework and its application to project design PPT slides.

Facilitator Note on Group Work for Modules 6 and 7

For the group work during these next 2 modules (6 and 7), the facilitator can either maintain the same working groups, or they can take the opportunity to reshuffle groups. The benefit of maintaining the same groups is they are already used to working together, and they will lose time if they have to do this again. Also, if groups are working well together, it may not be worth risking the change. The benefit of changing groups is it gives people the opportunity to work with different people, allows for representation during the design process of people who worked on different IRs, and gives the facilitator the option to change groups around if certain groups are not working well.

Powerpoint presentations should be discouraged as they tend to be less participatory than poster presentations and gallery walks in which people get up and walk around to look at group flip charts.

(Note: See introduction for comments on electronic presentations.)

Activity 3 – Small Group Work *(2 hours)*

Flip Chart Explanation

1. Using the compiled data sheets and proposed IRs from the previous group work, each group will complete a results framework.
    a. Review the other groups' work in order to have a complete picture of the situation analysis, taking all four IRs into account.
    b. Complete the SO and IR sections using the proposed IRs from the previous groups. Adjust if necessary.
    c. Review the vision to determine if the proposed SO and IRs are still consistent.
    d. Brainstorm possible strategies using the list of challenges from the previous group work as a guide.
    e. Prioritize strategies for each of the IRs and enter them into the strategy section of the results framework.

f. Identify (mark with an *) the strategies that will contribute to the elements of sustainability identified in the triangle.

2. Complete the results framework using the selected IRs and strategies.
3. Complete the sustainability triangle using the strategies that contribute to sustainability.
4. Prepare the results for a poster presentation on a flip chart.

Activity 4 - Poster Presentations by Participants of Their Results Framework

(1 hour, 30 minutes)

Bring the groups back together and have each small group present their project design in a semi-poster session format. Each group should post a flip chart of their results framework on the wall. The whole group can then move from one poster to the next, discussing observations and suggestions for each one. Group members should be prepared to justify their selection of IRs, strategies, and assumptions based on their situation analysis data. Emphasize that participants should critique the posters by highlighting strengths and providing concrete suggestions for improvement, rather than just pointing out what was not done well.

Useful Reference for Module 6

1. U.S. Agency for International Development (USAID). 2000. Building a results framework. *TIPS* Number 13. http://pdf.dec.org/pdf docs/PNACA947.pdf

MODULE 7

Selecting Indicators and Developing a Monitoring and Evaluation Plan Linked to the Results Framework

Purpose

Participants will learn to design, monitor and evaluate plans that measure progress toward defined results.

Objectives

By the end of this module, participants will have:

1. Discussed the different purposes of evaluation, monitoring for progress and monitoring for management
2. Practiced selecting and defining indicators that meet criteria for good indicators
3. Reviewed the Flexible Fund guidelines document instructions on indicators
4. Identified sources of information, their advantages and disadvantages for tracking monitoring and evaluation indicators
5. Incorporated who and how information will be used as part of an M&E plan
6. Practiced using a M&E Planning Matrix to develop a plan for the case study

Activities (approximately 4 hours)

Activity 1 – Exercise matching indicators with results (45 minutes)

Activity 2 – Presentation on indicators for M&E (1 hour)

Activity 3 – Practice selecting and defining case study indicators (1 hour, 15 minutes)

Activity 4 – Poster presentation of M&E indicators and matrix (1 hour)

(Note: More time may be needed if participants are not somewhat familiar with M&E for health programs.)

Supplies and handouts for participants

- PPT presentation for Module 7
- Cards with one indicator or matching result on each for matching indicators and results exercise
- Participants should have copies of the results framework they developed previously – either the flip chart or individual
- Flexible Fund Results Framework and Indicator Guidelines for reference, www.flexfund.org
- Blank copies of M&E matrix

Activity 1 – Exercise Matching Indicators with Results *(45 minutes)*

Prepare one card (4x6 inches) for each participant. Each card should have either an indicator or a result on it, with the ultimate goal of matching indicators to results. However, if there is more than one indicator for a result, or a result with no indicator, it may facilitate discussion and learning. (See the list of options at the end of this module)

Hand out one card to each participant and ask people to move around until they find the result that matches their indicator or the indicator that matches their result. Ask each pair to read their cards and explain why they fit with each other.

Activity 2 – Presentation on Indicators for M&E *(1 hour)*

Module 7 presentation

Facilitate a discussion on defining indicators and sources of indicator information for evaluation, monitoring, and as a tool for project management. These are based on the SO, IRs, and strategies as defined during the design process.

It may be necessary to clarify that we are now talking about data for M&E. Data for the situation analysis and data for M&E may or may not be the same. You may take a subset of the situation analysis tools for monitoring and supervision checklists. Some of the data may be the same as that used for government health services coverage and quality measures.

After reviewing some of the existing sources of data, actual examples of data from the MOH may be handed to participants. The participants are encouraged to identify which FP indicators might be monitored with this data and what the limitations might be.

Activity 3 – Practice Selecting Indicators for Defined Results

(1 hour, 15 minutes)

Flip Chart Explanation

Introduce the Flexible Fund Guidelines core indicators and ask participants in their groups to:

a. Review the options in the Flexible Fund Guidelines core indicators and determine if any apply
b. Identify where they would be most appropriate on the group's Results Framework
c. Adopt and adjust core indicators as needed
d. Complete the M&E matrix for the defined indicators
e. Prepare a poster presentation on flip chart paper

Have participants break into the same groups they worked with to develop their results framework based on data from the situation analysis. They will use the strategic objective, intermediate results and strategies they defined during that exercise to now select indicators as the first step in developing an M&E plan based on their results framework.

For the purpose of this exercise, assign each group one IR (depending on the strategies identified) for which they will develop indicators. It should be clear that for a real project they need to complete the process for all 4 IRs.

Activity 4 – Semi-poster Session to Share Indicators *(1 hour)*

Have participants post their flip charts on the wall. Participants can then move from one to the next, commenting on the selected indicators and discussing pros and cons for their selection. Make corrections as necessary. Emphasize that there should be indicators for evaluation, monitoring, and management.

Flexible Fund core indicators will mostly fit at the IR level. Examples of monitoring and management indicators at the strategy level are:

Strategy	Illustrative Indicators
Community-based delivery points for pill refills	Number of CBD workers trained and supplied
Counseling to include education on different methods, how they work, GATHER approach and side effects management	Number of doctors trained in counseling Number and percentage of doctors and health workers performing according to standards
Home visits to educate the community about FP methods	Number of home visits reported by health workers in each village each month
Community health workers will expand their role to provide the first month of pills pending examination at the health center	Number of CBD workers reporting distribution of pills to new acceptors Number of referrals from CBD workers for new acceptor examinations received at the health center
Village health committees meet monthly and discuss CBD reports.	Meeting minutes indicating regular meetings and discussion of reports

Note: you may want to point out how the higher level indicators (for the SO) tend to be measured less frequently and usually depend on surveys; however, we can measure the number of users (new and continuing) and couple-year protection (CYP) through regular program data. Lower level indicators (IR and interventions) will be measured more frequently and will tend to take advantage of existing data sources such as the regular MOH information system.

List of Indicators and Results for Module 7: Activity 1

Result	Indicator
1. Increased use of modern family planning methods	• Couple-years of protection – estimated contraceptive protection provided by family planning services during 12 months • Contraceptive prevalence rate – percentage of married women of childbearing age who report using modern contraceptive methods
2. Sexually active people are discussing family planning with their partner	• Percentage of sexually active respondents who report discussing family planning issues with their partner during the past 12 months.
3. Clients receive improved quality of family planning services at the health center	• Percentage of family planning clients who receive "adequate" counseling on family planning at the health center • Percentage of family planning providers who received training in family planning provision during the past 12 months
4. Clients have reliable access to modern contraceptive methods	• Percentage of health centers that report no stockouts of approved methods during the past 12 months • Indicator for # 3 also applicable here
5. Women have access to information on modern family planning methods	• Percentage of respondents who report discussing family planning with a community health worker during the past 12 months • Percentage of women of reproductive age who recall hearing or seeing a family planning-related message being promoted by the program

Result	Indicator
6. Women have improved access to family planning services	• Percent of the population who lives within 5 km. of a health center or other service delivery point that provides family planning services
7. Women who start using family planning continue to be satisfied users	• Percentage of women of reproductive age who started using an accepted method of family planning during the past 12 months who are still using the method.
8. Increased use of LAM among women with children less than 6 months old	• Percentage of women with children less than 6 months old who report using LAM [1]
9. Increased use of family planning methods by new users	• Number of women reproductive age who report starting to use family planning (being a new user) during the past 12 months.
10. Increased use of STI protection among couples in non-stable unions	• Percentage of people (men/women) of reproductive age who report using a condom during their last intercourse with non-regular partner
11. Community structures support family planning promotion	• Number of functioning village health committees

[1] Lactational amenorrhea method

Useful References for Module 7

- Program Manager's Planning, Monitoring, and Evaluation Toolkit
  http://www.unfpa.org/ monitoring/toolkit htm
  - Tool Number 2: Defining Evaluation
    http://www.unfpa.org/monitoring/toolkit/ defining.pdf
  - Tool Number 3: Purposes of Evaluation
    http://www.unfpa.org/monitoring/toolkit/purposes.pdf
  - Tool Number 4: Stakeholder Participation in Monitoring and Evaluation
    http://www.unfpa.org/monitoring/toolkit/stakeholder.pdf
  - Tool Number 6: Program Indicators
    http://www.unfpa.org/monitoring/toolkit/tool6.pdf
    - Part I: Identifying Output Indicators – The Basic Concepts
      http://www.unfpa.org/monitoring/toolkit/tool6 1.pdf
    - Part II: Indicators for Reducing Maternal Mortality
      http://www.unfpa.org/monitoring/toolkit/tool6 2.pdf

- Selecting Reproductive Health Indicators: A Guide for District Managers. Field-testing Version.
  http://www.who.int/reproductive-health/publications/HRP 97 25/selecting reproductive health indicators.pdf

MODULE 8

Selecting Methods for Systematic Collection of Baseline Data Linked to the M&E Plan

Purpose

Participants will review sources for baseline data collection with an emphasis on the 30 cluster and LQAS methodologies for quantitative surveys.

Objectives

By the end of the module participants will have:

- Discussed the sources and methodologies for collecting baseline data
- Reviewed the Flexible Fund Guidelines document for collecting baseline data

Activities (approximately 3 hours, 30 min.)

Activity 1 – Introductory exercise on planning a survey (30 minutes)

Activity 2 – Overview on options for baseline data collection (45 minutes)

Activity 3 – Methodological exercise reviewing 30 Cluster and LQAS sampling techniques (1 hour)

Activity 4 – Presentation and discussion of methodologies (1 hour, 15 minutes)

Optional Activities (OA)

OA 1 – Review of Flex Fund guidelines and exercise in adapting indicators (1 hour, 20 minutes)

OA 2 – Practicing household interviews

Supplies and Handouts for Participants

- Module 8 PPT presentation
- Flip chart or bulletin board with LQAS and 30 cluster "titles" for categorizing card characteristics
- Cards with characteristics of LQAS and 30 cluster sampling for matching
- Copies of the Flexible Fund Survey Questionnaire. For the latest version of the questionnaire, go to http://www.flexfund.org and look under resources and grantee tools.

Note: As with the other modules, people need to be reminded that this workshop does not provide them with enough skills to actually carry out these techniques. Rather, the purpose is to familiarize them with the options, the advantages and disadvantages of these methods, and how to get the right technical assistance to conduct these studies.

Activity 1 – Introductory Exercise Identifying Steps to Planning a Survey *(30 min.)*

Ask for a show of hands regarding who has experience with doing household surveys. Assuming there is significant experience among the participants, ask them to work in groups of three to identify significant steps in planning a survey.

Then go around the room asking each group to identify the next step in the survey process. Discuss where there may be differences of opinion.

1. Review the purpose of the survey – identify essential content
2. Adapt questionnaire according to project design / desired indicators
3. Define the target population from which to draw the sample
4. Identify the sampling method and select the sample
5. Identify and train interviewers
6. Interview respondents in selected households
7. Check questionnaires for completion
8. Tally and/or enter data
9. Analyze
10. Use the data for project adaptation and improvement

Alternative Introductory Exercise

Similar to the introduction to the planning process in module 1, participants can be given cards with one of these steps printed on each card. They are then asked to put themselves in order according to the steps for planning and doing a survey.

Activity 2 – Overview of Baseline Data Collection Methods *(45 min.)*

Module 8 PPT slides # 1–10

Present an overview of data sources and methods for baseline data collection and begin to focus on quantitative surveys.

Activity 3 – Group Exercise on the Relative Characteristics of 30 Cluster and LQAS Sampling *(1 hour)*

Give each participant a card with one of the sampling characteristics listed below (note make two cards when the characteristic applies to both) Ask each person to post their card on the wall under the category (LQAS or 30 cluster) where they think it fits. Then ask the group as a whole to suggest corrections or adjustments. Note that some of the characteristics are applicable to both.

Note: This exercise may be carried out before or after the following presentation.

LQAS	30 Cluster
Depends on minimum sample of 95 to calculate coverage	Depends on a sample of at least 300
Can provide categorical information with sample of 19 at the unit level	Surveyors must visit at least 30 different geographical sites
Requires visiting at a different site for each household selected	Uses a standard household KPC questionnaire
Uses a standard household KPC questionnaire	Can be used to calculate coverage
Analysis depends on decision rule to determine acceptable levels	Analysis is logical and uncomplicated
Sample selection depends on identifying each household in a targeted village.	Can be biased by the accidental selection of high or low performance clusters
Can also be used for monitoring in a simplified form	Is primarily used for baseline and final evaluation
Data collection occurs at the household level	Data collection occurs at the household level
Can be used to calculate coverage	

Activity 4 – Presentation and Discussion of Methods *(1 hour, 15 minutes)*

Module 8 PPT slides # 11-24

After the presentation, discuss the advantages and disadvantages of the two methods and how they serve your PDME.

Optional Activity 1 – Group Exercise Adapting Standard Survey to Case Study M&E Plan (group work - 1 hour, presentation - 20 minutes)

Note: Based on the level of experience of the participants and the time available, facilitators may determine that this is not an essential activity for the training. However, the training makes several references to the importance of adapting both the project design and the data collection tools to the identified purpose and needs of the project. If the adaptation exercise in module 4, Health Service Delivery Assessment, and this exercise are both dropped, it may be important to at least have a brief discussion on the elements to consider when adapting a data collection tool and how it is done.

Flip Chart Explanation

1. Identify which of the proposed indicators must be measured through a survey
2. Review the Flexible Fund Survey Questionnaire to determine if additional questions must be added in order to measure the proposed indicators
3. Adjust and adapt questions where necessary
4. Decide which sampling method (30 cluster or LQAS) would be most appropriate and why

1. Ask participants to return to their previous groups.

2. Using the M&E plan the group developed, have them highlight which of their indicators needs to be measured with a quantitative baseline survey.

3. They should then review the Flexible Fund Survey Questionnaire to make sure all their indicators are covered by the survey. They should also review the sections of the survey that cover their results and strategies to determine whether there are any questions that may not be necessary for their particular M&E plan.

4. Based on their findings, the group should then adapt the survey to their particular M&E plan, adding questions where necessary and removing questions where they are not necessary – and be able to justify why they are doing so.

5. Finally, assuming the group is planning to do a baseline survey for the proposed project, they should think about whether they would use an LQAS or 30 cluster sample methodology and explain why.

Bring the group back together and have each group:

1. Explain the changes they made in the survey and why.
2. Identify which methodology they might use and why.

Optional Activity 2 - Exercise Practicing Household Interviews
(Depending on participant experience and time available)

1. Divide the group up in pairs. Pass out copies of the Flexible Fund Questionnaire.

2. Each person in the pair will take turns going through the interview process. However, in order to save time and not repeat the questions, person A will assume their interview questionnaire only includes the first half of the Flex Fund questions while person B will assume their interview questionnaire only includes the second half. Therefore, person A will ask questions (a) through (g), while person B will ask questions (h) through (z). Both people will practice the introduction and conclusion of the interview process.

Note: Focus this exercise based upon the skills of the participants. In general the participants will be managers or trainers and need to be warned of typical pitfalls in conducting quantitative surveys on RH related topics. For example, the participants will need to train interviewers on how to manage culturally sensitive questions by remaining neutral when asking survey questions. For more information on interviewing techniques, the facilitator should refer to the "KPC Survey Training Trainer's Guides," CORE Group.

3. After everyone has practiced interviewing, bring the group back together for discussion. Encourage people to bring in real-life experience with household interviews in addition to those of the exercise:

    a. What do you find easy about these (household) interviews? (in this exercise and/or in general)

    b. What do you find challenging about these (household) interviews (in this exercise and/or in general)?

Keeping these difficulties in mind, how can we better teach people to do effective household interviews?

Useful References for Module 8

1. KPC 30 Cluster Survey Manual, www.childsurvival.com

2. LQAS survey tool and manual, www.childsurvival.com

3. Copies of the Flex Fund documentation guidelines, www.flexfund.org

4. Valadez, J.J. et al, 2003, "Assessing Community Health Programs: Using LQAS for Baseline Surveys and Regular Monitoring", TALC, www.talcuk.org, email: info@talcuk.org, telephone: 00 44 (0) 1727 853869 (Participant Manual and Trainer's Guide)

MODULE 9

Application of Skills Learned: Critique of Real Project Designs Using a Results Framework Approach

Purpose

Using the skills and logical thinking they have been learning this week, participants will now apply the results framework approach to an actual project they are currently working on.

Objectives

By the end of this module, participants will have:

1. Critiqued (or developed) their own project designs using results framework tools
2. Reviewed their selection of strategies and activities
3. Recommended adjustments where necessary
4. Reviewed their M&E plans to ensure that indicators, measurement tools, and resources are consistent with desired results

Activities (approximately 6 hours 15 minutes)

Activity 1 – Application of results framework in project teams (1 hour)

Activity 2 – Application of Sustainability Triangle (1 hour)

Activity 3 – Development of monitoring and evaluation plan (1 hour)

Activity 4 – Discussion of project teams' results in large group (1 hour, 30 minutes)

Activity 5 – Workshop summary, evaluation, and closing (1 hour, 45 minutes)

Supplies and Handouts for Participants

- Module 9 PPT presentation
- RH Preliminary Action Plan
- Project Design Strategies for Sustainability
- Monitoring and Evaluation Matrix
- Project Summary Results Framework
- Tool for Synthesizing Situation Analysis Data
- Prizes for team review competition
- Workshop final evaluation

Note to facilitator: While we have made an effort to mix groups all week, now is the time for people to work with their own project colleagues to apply what they have learned during the practice sessions to their actual project. The timing on this exercise as well as the outputs can be flexible. The essential element of the exercise is for people to use the thinking process they have learned this week, and to critically apply it to their current project design, monitoring and evaluation system.

As a facilitator, it is important to identify and/or suggest an appropriate focus for each group in this exercise. This will be based on understanding the individual projects, participant capacity, and their roles when they leave the workshop. Depending on the implementation phase of a given project and/or the range of interventions, the outputs of this activity will vary widely.

Participants should complete the following for current projects:

- *Project summary results framework*
- *Sustainability framework*
- *Monitoring and evaluation planning matrix*
- *Tool for synthesizing situation analysis data (if appropriate)*
- *Reproductive Health Preliminary Action Plan (if there is time)*

If they don't actually have working copies of their project documents with them, they can probably work from the information they have in their heads. Alternatively, if there are different but similar projects represented (e.g. child survival projects with similar interventions and strategies) groups may choose to work together. It is more important that individuals work through the process until they understand it than it is for them to complete the task.

This is a unique opportunity for projects to get individual technical assistance in project design and evaluation. It is important for facilitators to work with the groups throughout this session to make suggestions or corrections for improvement as they go since there will not be time during the group presentation session to give individual feedback in adequate detail. This means that facilitators need to plan to be fully involved with group work and will not have time to work on other wrap-up activities during this time. A maximum of 2-3 project groups per facilitator is suggested in order for facilitators to have adequate time to support the process. If there are more projects than there are facilitators, it may be helpful to bring in additional technical assistance from within the country (e.g., a representative from one of the USAID contractors or USAID Mission funded bilateral may be available to join the workshop for this time) to assure each project gets adequate individual time and feedback.

Note on Options for Results Frameworks

As long as a project has one focus such as the Flexible Fund family planning projects, the development of a results framework with one family planning SO is straight-forward. However, if a project has multiple interventions such as a child survival project or a comprehensive reproductive health project, it may make sense to develop a results framework with an SO for each of the interventions. This allows for a lot of detail and assures that the selected strategies are appropriate and sufficient to achieve the desired results. However, this format leads to duplication in the listing of strategies that contribute to more than one intervention, and doesn't graphically demonstrate the integration or potential of strategies that contribute to more than one result.

Alternatively, all of the interventions can be collapsed into one SO with multiple components. The IRs would then also be stated to include the multiple components, but as they pertain to each IR (e.g. improved quality of services through implementation of an IMCI approach to case management of malaria and diarrhea, and improved capacity in delivery of family planning and safe motherhood services). This avoids duplication in the listing of strategies and activities, but risks losing the cause and effect clarity through lumping the final results together.

There is no right answer to this choice and encourage the managers to follow the most useful format for them.

Activity 1 – Application of the Results Framework in Project Teams

(1 hour)

Instructions to the participants:

1. Using the blank results framework, complete the boxes for the SO, IRs and strategies as they reflect your project

2. Critique your list of strategies and interventions to be sure they are both necessary and sufficient for efficiently achieving your desired results. If not, recommend the necessary adjustments and justify why you are making these recommendations.

3. Prepare a flip chart with your complete results framework through the strategy level. Highlight the changes you made and why you made them as a result of what you learned this week.

4. If there is time, teams may also work on completing the "Reproductive Health Preliminary Action Plan" or keep this for use in their projects.

Activity 2 – Application of the Sustainability Triangle *(1 hour)*

Instructions to the participants:

This activity takes the results framework you just developed and asks you to consider how your proposed strategies and activities also fit into the sustainability framework.

1. Review the results framework you developed and identify which of the activities or strategies you identified to achieve your desired impact also contribute to each of the elements of sustainability.

2. Using the sustainability triangle worksheet, fill in activities from your results framework which contribute to the respective corners of the triangle (health status/services, organizational capacity, and community / environment)

3. If you notice there are gaps in the sustainability framework which need to be in place in order for your desired impact to be sustained you may want to go back and reconsider your proposed strategies and activities.

Activity 3 – Development of M&E Plan *(1 hour)*

Instructions to the participants:

1. For your SO, each IR, and strategies, complete the M&E tool, identifying the indicators you are using for evaluation, how you are measuring them, and how you are monitoring them. Make any adjustments or changes necessary to improve the selection, definition, and/or collection and use of data for your M&E system. Keep in mind that indicators at the IR and SO level should be more evaluation (impact) oriented, while indicators for strategies *ma*y me more for monitoring and management.

2. Prepare a flip chart of key indicators and plan for measurement, and be prepared to justify it. Please highlight any changes you made as a result of what you have learned this week.

Activity 4 – Discussion of Project Teams' Results in Large Group

(1 hour, 30 min.)

Have each group present their flip charts for the RF, M&E plan, and recommendations. Similar to the previous exercises, these can be posted on the wall and the group can walk from one to the next for review and feedback. Encourage the group at large to ask questions and make suggestions. Hopefully, individual details and corrections have been made during the course of the morning session such that the focus of the discussion should be on concerns and confusion that may be similar across the different groups. The facilitator is encouraged to guide the discussion to maximize the relevance of the week's learning to the project review.

It is sometimes frustrating because these are all "works in progress" requiring continual review and revision. It is important to reinforce the improvements they have made as a result of what they have learned, and how much stronger their project designs are now.

Activity 5 – Workshop Summary and Evaluation *(1 hour, 45 min.)*

Note: The facilitators can use any kind of review or evaluation format they like. The following are two suggestions:

1. Team review competition

   Divide the group into groups of 3-4 and ask each group to take 10 minutes to brainstorm the highlights of what they learned this week, using the 6 steps of the design process as the framework. They should not use their notes, but rather focus on what they remember. They should then think about how they want to briefly present this to the rest of the group, making the presentation fun (drama, pictures, interview format, etc.)

   Then have everyone vote on the best presentation and offer prizes accordingly.

2. Review of vision, workshop objectives, and participant expectations

   - If the flip charts are still available, refer the group back to their vision for FP/RH as an opportunity to maintain the focus on the ideal we are all striving for.

- Review participant expectations to determine if and how they were met (or how they might be).
- Review workshop objectives and discuss what was accomplished during the workshop.

Reminder of Main Workshop Objectives

- Improve program design skills using a results framework
- Become more familiar with qualitative research tools, surveys, service data collection, health services assessment and other tools for gathering baseline, monitoring and evaluation data
- Improve skills in selecting and adapting data collection methods/sources for program design, monitoring and evaluation
- Practice analyzing primary and secondary data for use in PDME
- Develop a sample family planning project design using a results framework
- Select indicators and develop an M&E plan for the sample design including identification of necessary baseline data
- Practice using the results framework and data utilization skills they have learned to critique their own project design

Workshop Evaluation & Certificates

- After these activities, ask participants to complete the final workshop evaluation forms; present special acknowledgements to facilitation team, guest speakers, and host organization staff; and distribute certificates to participants.

HANDOUTS FOR MODULES

Daily Evaluation

What did you most appreciate about today?

What did you least appreciate about today?

Other Remarks:

Ideas to improve the training: (make it more useful, level of difficulty, level of interest, pace, etc.)

FINAL EVALUATION

Check the appropriate box for each statement below:

	Very Well	Well	Somewhat	Not Well
1. I was effectively able to apply the skills I learned this week to my own project.				
2. Overall, this workshop matched my needs.				
3. Overall, the training curriculum was effective in teaching me the skills.				

1. Why did you answer the second question above the way you did?

2. What are 3 things you will change in your project as a result of this workshop?

3. How might you share some of the ideas you have learned with other people in your project and/or with your partners?

4. What were the strengths of the training approach?

5. How might the training approach be more effective?

In general, how would you rank the following specific training elements?

Training element	Excellent	Good	Fair	Poor	Why?
Level of material					
Level of applicability					
Level of interest					
Course pace					
Proportion of practical work (group exercises) to presentation					

How would you rank these specific activities?

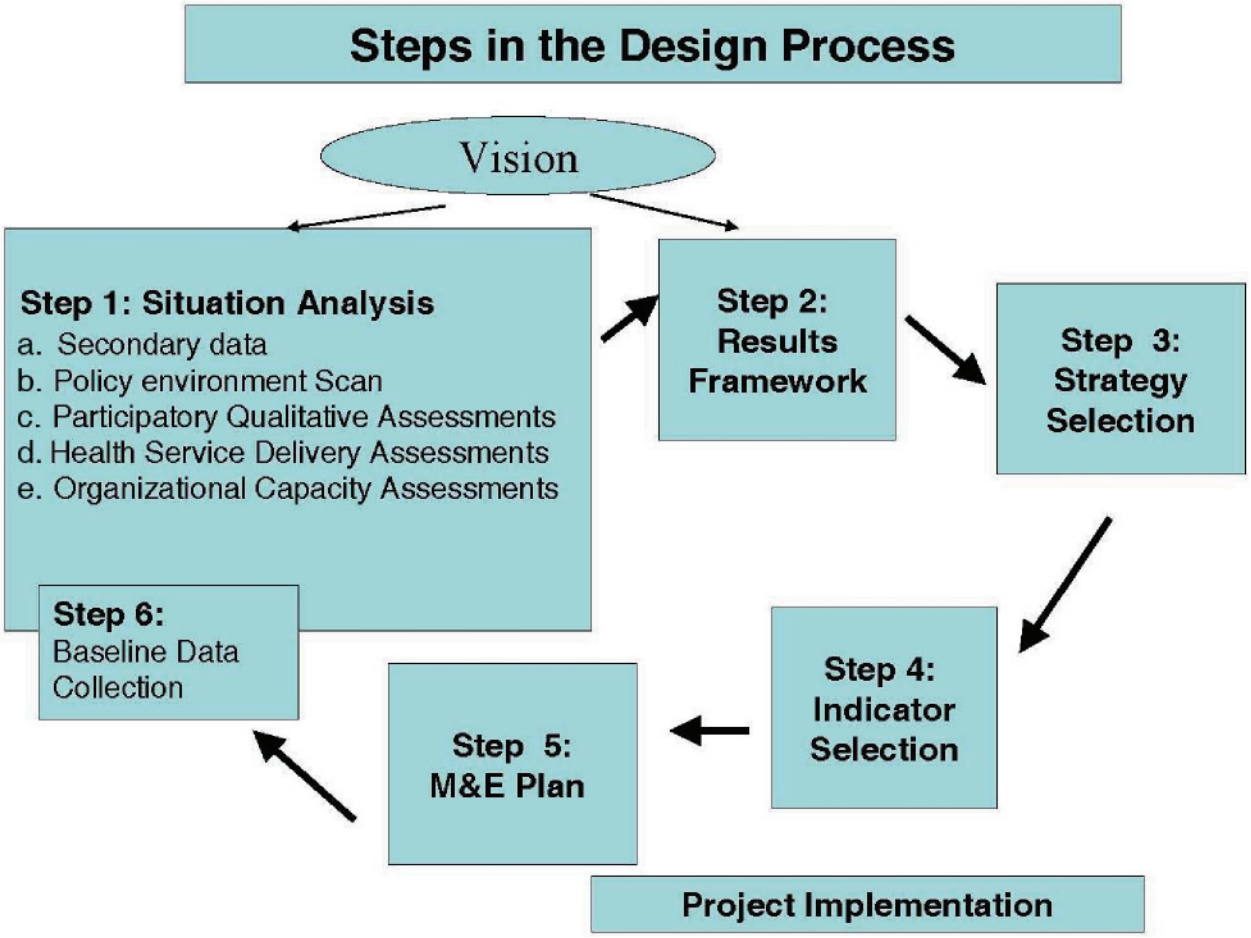
Activity	Excellent	Good	Fair	Poor	Why?
PDME introduction presentation					
Practice using secondary data					
Presentation of qualitative methods					
Analysis of qualitative data case study					
Presentation of HSDA methods					
Group work: Case study analysis of HSDA data					
Use of case study for practice in using data for program design					
Presentation on M&E					
Presentation on organizational capacity assessments					
Practice in selecting indicators and developing M&E plans for the case study					
Presentation on quantitative methods					
Application of skills to your project					

PARTICIPANT NEEDS ASSESSMENT

Please offer a self assessment of your knowledge and experience with the different tools and approaches mentioned below.

Topic	I know what it is	I have experience	I could help others to use it
Program implementation experience in family planning			
Other health program implementation experience			
Development of project design or logical framework			
Development of targets and objectives			
Development of indicators to measure objectives			
Development of a M&E plan to track indicators			
Familiarity with RH program strategies			
Familiarity with standard RH program indicators			
Reviewing secondary data to justify project priorities			
PRA or PLA (participatory learning appraisal) techniques			
Focus group discussions/Key informant interviews			
Health service delivery assessments			
30 cluster surveys			
LQAS surveys			

STEPS IN THE DESIGN PROCESS



TOOL FOR SYNTHESIZING SITUATION ANALYSIS DATA

Intermediate Result:_____

One tool per group – each group will complete the tool for their IR (e.g. one tool each for demand, access, quality, and social/policy environment)

DATA (Strengths, gaps, challenges, resources, opportunities, partners, etc.)
Secondary Analysis
Participatory Qualitative Assessments
DATA **(Strengths, gaps, challenges, resources, opportunities, partners, etc.)**

Health Facility Assessment (HFA)/Health Services Data Assessment (HSDA)

Organizational Capacity Assessments (community, potential partners, MOH)	
SUMMARY – Intermediate Result Statement:	
<u>Summary of Main Challenges</u> (to be filled out at end of Module 5)	**<u>Possible Strategies</u> (to be filled out for Module 6)**

CASE STUDY: FINDINGS FROM A PARTICIPATORY RAPID APPRAISAL

I. Analysis of the PRA Results: Knowledge, Attitudes, Beliefs, and Practices on Family Planning, and Barriers Identified in Using Family Planning

The residents represented in the PRA sessions from the two sub-counties of Lwampanga and Lwabiyata, demonstrated good knowledge on family planning. The PRA discussions revealed that they understood the definition of family planning, the different family planning methods - both traditional and modern - and the advantages of using family planning.

Identified Barriers in Using Family Planning

Results of the discussions on the disadvantages of family planning, other comments, and information from spouses pointed to factors that may act as barriers to use of family planning and prevent the residents/respondents from seeking family planning information and services and/or from actually using a family planning method. These barriers can be organized into three categories, which are discussed below:

Logistical Barriers

Barriers to health services and supplies

- The adult females mentioned the absence of trained health professionals to provide family planning information and services in the county, and they said that medical personnel are not always available in the HCs.
- The male youth mentioned that family planning services are unaffordable and unavailable – that family planning costs are too high, while HUs only prescribe but do not provide Family Planning drugs.
- The female youth believe that the HUs are inaccessible – thus they are forced to go to traditional practitioners who may exploit them.

Personal Barriers

Misconceptions, Fears and Misinformation

Discussions on the disadvantages of family planning glaringly showed the misconceptions, fears and misinformation of the residents about family planning, as well as about the side effects and complications of various family planning methods.

- Most of the groups mentioned that family planning itself or some of the family planning methods cause infertility, cancer, or damage to the reproductive organs ("damage to fallopian tubes," "condom causes chancroids," "IUDs or condoms may break and may get lost in the body/ may stick in the women's genitals"), and production of disabled children (deformed/abnormal children, hermaphrodites).
- Although the side effect of bleeding/prolonged menstruation was correctly mentioned by all the groups, they seemed to have magnified its severity.

- The female groups (adult and youth) mentioned conflicting knowledge on family planning causing weight gain or weight loss, as well as other misunderstood/misinformed side effects (dizziness, poor breathing, bad smell of foam tablets, loss of appetite, vomiting, back pains).
- The male adults believe that a blood test is needed prior to using family planning and that family planning hinders development.

Other Personal Barriers

- The adult females mentioned the inconvenience of using family planning because of the bothersome instructions.
- The male youth mentioned some people's preference for having more children.
- Both the male groups (adult and male) fear the side effects of family planning methods, not to mention that these fears are due to misinformation on family planning.
- The adult males fear using condoms because their wives might suspect them of sexual infidelity.

Social and Cultural Barriers

Gender-related Barriers

- The adult males mentioned that family planning leads to loss of trust with their partners, and leads to divorce especially if they do not agree with their wives about using family planning. (This is one of the reasons why some women who cannot negotiate with their husbands on using family planning, prefer to use a method (e.g. injectables) that they can easily hide).
- The adult males also believe that in a polygamous setting, the woman with more children gets more recognition/better status.
- The adult females mentioned that only younger men support the practice of family planning and not the elderly men.
- The female youth believe that men sometimes break the condoms in order to impregnate them, while the male youth think that women are afraid to talk about family planning because their husbands may not like it.

Myths and Beliefs

- The adult females think that family planning serves the aim that "whites (white people) want to kill blacks (black people)."
- The adult males believe that men like to have many wives so that the "better" children produced can make up for their "dull" children.
- The youth males believe that if there were only a few children, and if the children die, the parents would be left without a successor (particularly a son) or no children at all.

Reasons for Low Preference for Various Family Planning Methods

Discussions on this issue revealed that:

- Most of the residents prefer using condoms because of their accessibility, availability, and affordability (in situations where condoms are free). However, the adult males also mentioned that condoms are costly.

- Both of the male groups (adult and youth) are aware of the dual purpose of condoms in preventing STDs and avoiding pregnancy. However, the female groups (adult and youth) are apparently not aware of this.
- Both of the adult groups mentioned the convenience of the injectables as compared to the pills, although the adult females believe that it also causes women to gain weight.
- Although the pills were mentioned as accessible by some of the groups, the adult females mentioned its inconvenience ("bothersome," "one could easily forget to take it"), while both of the male groups have a lot of misconceptions about it (e.g., "destroys the womb and causes infertility and death," "results in birth of abnormal babies").
- The adult females least preferred the foam tablets because they are unavailable.
- The adult females particularly mentioned the advantage of secrecy in using injectables as compared with the pill. This is apparently an issue that has more underlying reasons in it (see gender-related barriers).

Sources of Family Planning Information

On the sources of family planning information, the two most highly ranked sources listed by most of the groups are radios and the health units. The adult males also mentioned the effectiveness of the NGO-trained local counselors as educators. Among the lowest ranked sources of information, the adult males disliked the hospital health unit because it doesn't have local counselors and it doesn't organize seminars. The adult females also ranked community seminars low because of their limited number. While the male youth mentioned the limitations of getting information from radio, both of the youth groups (male and female) ranked peers and hearsay information the lowest because of the inaccurate information.

Suggestions given by the male groups (adult and youth) on improving family planning information and services:

- Request for family planning services within the community, or from the health units, and for the provision of family planning education at the grassroots level,
- Suggestion for RH education in schools,
- Need for trained local health workers/family planning educators who will provide accurate information (the youth males prefer someone from among their peers),
- Need for a distribution center for free supply of condoms,
- Request for more effective methods of family planning (better pills, tubal ligation that will not fail).

Possible "Positive Deviants" in the Community

Some adult females mentioned that they had been using family planning methods successfully for five years. The positive experience of these residents should be studied and documented as they could be potentially tapped as good examples, models or "positive deviants" who could help the project in advocating family planning and serving as educators in the community.

II. Analysis of the PRA Results: Knowledge, Attitudes, Behaviors and Practices on STDs

The residents represented in the PRA sessions from the two sub-counties of Lwampanga and Lwabiyata, demon-

strated knowledge of STDs. They were able to accurately list signs and symptoms, modes of transmission, preventive measures, and effects of the untreated disease.

Knowledge on the definition of STDs, kinds of STDs, signs and symptoms, modes of transmission and preventative measures:

When all four groups were asked to define STDs, they identified STDs as sexually transmitted diseases that cause discomfort (i.e. itching fluids, wounds) of the "private parts." However, comments within groups provided additional definitions that reflected uncertainty about the meaning of STDs:

- Adult males offered other definitions of STDs that included mother-to-child transmission and blood transfusions.
- Some adult females believed STDs were inherited.
- Youth males gave definitions of STDs as a disease that results from the used sharp equipment and a disease that it is "prostitute related."

Despite there being many definitions of STDs, all the PRA groups clearly identified some STDs found in the community. The top three STDs cited in the community were (1) AIDS, (2) syphilis, and (3) gonorrhea, with chancroids also mentioned. Symptoms of abnormal discharge such as blockage of a man's tubes, swollen lymph nodes, prolapse of the rectum, and skin rash also appeared in the list of types of STDs, indicating that residents have knowledge of STDs but may not know the exact names. However, there was evidence that some residents were not sure what STDs were, as the list also included diseases like scabies, epilepsy, and hernia that are not sexually transmitted.

As to the reasons AIDS was ranked highest by the residents, three groups mentioned lack of a cure for AIDS as the main reason. Lack of information about the disease and various socio-cultural issues affecting AIDS transmission were also listed. These include the following:

- Many polygamous marriages,
- Inheritance of widows and widowers,
- "Women seeking satisfaction elsewhere due to lack of attention by husbands, women providing sex for material gain/prostitution since husbands do not sufficiently provide for them, and that men are attracted to beautiful women,"
- Belief that "Infected people spread the disease maliciously,"
- Refusal to use condoms, or when condoms break due to use of Vaseline

Although the groups varied in reports of some of the signs and symptoms of STDs, many overlapped. Most of those listed were general signs and symptoms that provide evidence of STDs, such as: loss of weight, abnormal discharges (i.e. pus, bloody urine) from "private parts," skin rash, wounds over the body/boils, herpes zoster, persistent fever, cough, diarrhea, loss of appetite, red lips, walking with legs far apart/difficulty walking or sitting properly, loss of hair, vomiting, blockage of urinary tract/difficulty in excretion, joint pains, discoloration and loss of nails, white/shiny eyes, miscarriages, feeling cold, pale skin, vomiting, loss of sexual desire, pain/itching in "private parts."

In addition to recognizing the signs and symptoms of STDs, residents' knowledge of the modes of transmission and preventive measures was good. All groups knew that sexual intercourse was the main mode of transmission of STDs. Contact such as parents to babies, sharing a towel with an infected person, blood mixing during accident, and sharing of sharp equipment like razors and needles were also accurate modes of transmissions of STDs. However, responses such as discos, sitting together, use of infected equipment for tooth extraction, injections, latrine, or exchanging clothing are more ambiguous and not conclusive. On the

issue of preventative measures, all the groups listed correctly these measures: (1) use of condoms, (2) abstinence, (3) faithfulness to one sexual partner/mutual faithfulness/monogamy, (4) self-control and avoiding prostitution, (5) avoiding use/sharing of unsterilized/sharp equipment, (6) having blood tests (before sex), and (7) having treatment.

However, there were also some incorrect knowledge and misbeliefs by the residents like Immunization, and taking drugs to prevent STDs.

Finally, other socio-cultural issues that promote STD prevention such as "having a health unit in the community," and "convening many sensitization meetings" (for health education) were also mentioned by the residents.

Sources of Treatment and Information for STDs

On the questions regarding the residents' sources of treatment and information, the following responses were given:

- Two groups ranked highly the Nakasongola Health center and Nakasongola Barracks hospital due to its accessibility (within 7 km), and availability of drugs.
- Lwampanga health center, and other health units/centers, clinics and shops were also mentioned.
- Treatment given by nurses and midwives, as well as mobile medical person in the village (called Amooti), and Nalongo.
- The youth groups mentioned the accessibility of the traditional herbalists as a source for treatment, while the male youth group mentioned the domestic use of a cattle drug, "(ngombemycin) with penicillin," as a treatment.
- Radio was a major source of information for the adult groups,
- Health units and clinics (Nakasongola HU & Barracks Hospital, Nabiswera, Lwampanga), community centers and dispensaries were listed by adult females and the youth groups.
- Youth groups listed health workers (from AMREF & health units), schools, church leaders, shopkeepers, elder relatives, and peers as additional sources of information.

Comments Given by the Groups on Issues Related to STDs

- The adult males believe that the youth are reckless and that they have a care-free attitude ("since they will not be monumentalized, there is no need to try and live long").
- Both male groups mentioned the difficulty of communicating sex-related issues between parents and children, especially across the gender. The youth males think that "some parents are illiterate, do not care and fear discussing sex with their children."
- The youth males also ranked the schools highly because "issues on sex are taught by topics and that pupils are free to share ideas with teachers." While they gave a low rank to the community centers because of its' late night film schedules thus their parents discourage them to view.
- The adult females articulated their "need to learn more about STDs and their relation to pregnancy because they cause abortion."

III. Analysis of the PRA Results: Knowledge, Attitudes, Behaviors and Practices on AIDS

The residents represented in the PRA sessions from the two sub-counties of Lwampanga and Lwabiyata, dem-

onstrated knowledge of AIDS. They were able to correctly list signs and symptoms, modes of transmission, and preventative measures.

- While the groups varied in their reports of some of the signs and symptoms of AIDS, many did overlap. Most of those listed were generalized symptoms that provide evidence of AIDS: loss of weight (although weight gain occurs during treatment), persistent fever, presence of Herpes Zoster, boils and skin rashes, TB/coughing, changes in the skin/hair/eyes, stomach disturbances (swelling & diarrhea), and feeling cold. Although the youth group also erroneously listed syphilis and gonorrhea as signs & symptoms of AIDS.
- In addition to recognizing the signs and symptoms of AIDS, residents' knowledge of the modes of transmission and preventive measures was good. All groups knew that sexual intercourse was the main mode of transmission of AIDS. Other modes mentioned, such as contact with infected blood through blood transfusions, sharing injection needles and razor blades, tattooing, ear piercing and tooth extraction, as well as mother-to-child transmission are also accurate modes of transmissions of AIDS. However, there were also incorrect responses such as witchcraft, fornication/adultery, giving birth in the village, celebratory functions (for entertainment and other ceremonies), and washing the clothes of infected persons. Kissing and drunkenness were also mentioned. Some of these modes were probably mentioned regarding factors that predispose one to contract AIDS. The groups also added a list of AIDS predisposing factors, namely:

    - Attending discos
    - Accepting offers from men
    - Practicing prostitution
    - Separation and divorce of partners

On the issue of preventative measures, all the groups listed the following measures correctly:

- (1) Use of condoms, (2) faithfulness to one sexual partner, (3) abstinence, (4) having blood tests (before sex), and (5) avoiding use/sharing of unsterilized/sharp equipment.
- The youth groups listed practicing safe sex, and discouraging unprotected sex as means to prevent AIDS transmission. They also included other items such as counseling youth, attending education sessions, stop in attending celebrations/ceremonies and drinking alcohol as preventive measures although probably the idea behind these items being mentioned were more on health services and socio-cultural circumstances that would prevent one from getting AIDS.

However, there was also some incorrect knowledge by the residents like practice of the withdrawal method, vasectomy, and family planning, as well as the use of government-supplied drugs. This incorrect knowledge apparently relates back to some of their misconceptions about family planning, and as such must be corrected.

On the reasons why AIDS was highly ranked by the residents, the groups mainly mentioned sexual intercourse as a major reason. The personal, economic and socio-cultural issues related to sexual intercourse that affect AIDS transmission were also listed, namely:

Personal reasons (these responses were mainly from the male youth, and may just reflect their attitudes towards sex)

- Sex is natural (everyone is involved in it) and is enjoyed by most people.

- It is natural for one not to stick to one partner, and many people want to have more children.
- Sex is more enjoyable without using condom.

Economic reasons

- Men have a lot of money and women are so "money-hungry."
- Some women use prostitution to earn a living.

Socio-cultural reasons

- Widows get married off.
- Witch doctors sometimes demand sex from their clients.

Effects/Results of AIDS and What Should Be Done to Persons with AIDS

On the questions regarding the residents' view of effects/results of AIDS, and what should be done to persons with AIDS, the responses below were given.

Only the youth groups gave their views on effects/results of AIDS that could be summed up into 2 categories:

- Effects on the economy and development as a result of deaths due to AIDS (decline in population and the economy, loss of productive people, increased poverty)
- Socio-cultural effects on the families and their children (persons with AIDS are stigmatized, sorrow/pain/loss for bereaved families, increase in the number of orphans and street children, increase in the number of school drop-outs, destitution/hopelessness of children, break-up and destabilization of families).

On the issue of what should be done to AIDS victims, most of the groups' responses reflected caring attitudes - i.e. caring for and taking them to hospital; giving treatment, counseling and visiting/helping/looking after them; taking advantage of TASO services; local and modern drugs should be provided to prolong their lives. There were also negative attitudes that were shown in a few responses, such as, infected people should be isolated, and they should be excluded from the community.

Other Comments on AIDS

Comments by the group on the topic of AIDS reflected their attitudes, practices and beliefs, as well as myths and misconceptions about various issues surrounding AIDS.

- The adult males believed that among people with AIDS, women take longer to die than men and youth.
- The adult females noted the attitude that while some people sympathize with AIDS victims, others do not. They also mentioned that "condomed sex is not enjoyable," and that "condoms are most appropriate for singles who do not want to get married," which may reflect some of their attitude towards the use of condoms. While some of their beliefs showed misconceptions about condoms and vasectomy (i.e. "frequent use of condoms wears out the vaginal ridges" and "vasectomy reduces men's sexual power").
- The youth males believe that "God had brought AIDS so He should help in taking it away." While the youth females believe that "AIDS results from witchcraft." They also mentioned the

attitude of "Having sympathy for 'innocents' and condemnation for 'wrong doers' who deserve it, as well as "the stigma attached to AIDS."

- The youth groups also mentioned some economic and personal barriers (mistrust) on the use of condoms related to AIDS, as well as some gender-based barriers:
- "Condoms are good but other people cannot afford them."
- "Coping with AIDS is difficult without money."
- "The condom material is very thin and should not be trusted; vaseline ruptures the condom."

- "Men in general do not allow their wives to attend education seminars." Suggestions by the group to improve quality of services for AIDS:

- Most of the groups strongly suggested that AIDS education and services should be brought to the community. This could be through the services of TASO or through trained local workers. The youth should be given emphasis and they should also be educated on the use of condoms.
- It was also suggested that blood/HIV testing should be made available either through a voluntary or compulsory method.
- One group suggested for the identification and marking of infected persons while another group suggested for infected mothers not to breastfeed.
- Finally, it was also suggested that drugs and condoms should be provided at various sites.

PRACTICE FOCUS GROUP DISCUSSION GUIDE

Community Attitudes Related to Family Planning

1. Welcome and explanation of the purpose of the focus group, explanation that responses are confidential and there are no right and wrong answers

2. Introductions of participants

3. What family planning methods have you heard about? Where around here can you get these methods? (Ideas for probing: Are there any other methods you have heard about...? Where else can people get family planning methods?

4. What are reasons some people use family planning? (Ideas for probing: Why do people have these ideas? – where do they come from? What do you see as the benefits or disadvantages of using family planning?)

5. What are some of the rumors or negative ideas you hear about family planning? (Ideas for probing: Why do you think people have those ideas?)

6. What experience have you or friends of yours had with using family planning methods? (Ideas for probing: Why were the experiences positive or negative? How have these experiences influenced your current ideas about family planning?)

7. Have you discussed family planning with your husband or wife? Why or why not? (Ideas for probing: What made it easier or harder to discuss this together? Why were these factors significant?)

8. Why do or don't you and your husband or wife use/consider using family planning? (Ideas for probing: What would make it easier for you and your husband to use family planning?)

OVERVIEW OF HEALTH FACILITY ASSESSMENT TOOLS

Tool	Type of Information	Benefits / Limitations
Client Exit Survey	• Client satisfaction • Report on what was or was not done or discussed during visit (may be specific to family planning issues) • Perception of provider client interaction, communication and provider listening • Actual costs to client of visit • Client understanding of their health and expected treatment • Barriers to accessing services • Barriers to compliance with orders • Duration of visit and wait time • General health knowledge and practices	• Is direct source of information about what happened • Client perceptions and understanding determines their behavior • Client may be hesitant to report negative findings for fear of jeopardizing future care • Time consuming – clients are anxious to leave
Provider Interview	• Provider report of what they do during client visits for specific conditions or situations (e.g. new family planning user, STI, etc.) • Review of training, refresher training and supervisory support they have received • Availability of services • Review of clinic support systems - management of supplies, infection prevention, supervision, etc. • Identification of barriers to good practice • Staffing levels and work load	• Providers get a chance to explain "their side of the story" (and there usually is one) • Assessing appropriate clinical practice may be difficult if they report what they think they are supposed to do
Provider Observations	• Observation check lists to identify whether provider completes expected behaviors for a particular kind of consultation – competent case management • Competency in carrying out medical procedures. • Provider completion of accurate patient history • Provider-client interaction and communication skills • Provider attitude • Duration of visit • Availability of privacy	• Negative findings are significant – they occur in spite of being observed. • Observation bias – may not be representative of actual practice • Time consuming, particularly if wanting to assess a specific clinical condition

Clinic observations	• Hygiene – cleanliness, water, electricity, toilets • Check lists for availability of essential drugs and supplies • Commodity storage and management • Availability of privacy • Clinic hours • Patient flow • Availability of signs, posters and health educations materials • Staffing • Record keeping and use of statistics	• Efficient way to take in a lot of information • May be less accurate if they knew you were coming
Interviews with Management	• Commodity storage and management/ availability of essential drugs and supplies • Clinic hours • Availability of signs, posters and health educations materials • Staffing and human resources • Supervision and support • Infection prevention practices • Record keeping and use of statistics • Barriers to delivering good quality services • Costs and financial management	• Management challenges may provide explanations for other findings • May have a tendency to focus on what they think they should be doing

Note: All tools are used to validate each other by getting the same information from two or more sources. It is possible to probe further if discrepancies arise in findings between sources.

EXTRACTED DATA FROM HFA CASE STUDY

IR1 – Demand

- Awareness of contraception is high, but not of long-term methods.
- 5% of the population are teenagers
- Injectables are the preferred method of family planning.
- Low CPR

IR2 – Quality

- Approximately half of the facilities had adequate waiting areas, running water, and toilets. 60% had electricity, a clean exam room and adequate water in the room.
- Sterile IUD insertion equipment is lacking.
- Counseling for natural methods of LAM is not offered and health workers are not trained in LAM. Providers do not see the importance of breastfeeding and may not consider it when providing pills.
- Most clinics had the essential equipment, but more than half did not have adequate gloves and specula for IUD insertion or STI diagnosis.
- Most of staff had family planning training during their pre-service training, and 60% had refresher training in family planning. Few had training in STIs or HIV.
- Supervision does not occur regularly with only 45% of clinics having been visited during the past 6 months. Visits are mostly administrative.
- 90% of clinics had no stock-outs during the previous 6 months, and 60% had logistics systems in place.
- FP education materials were available, but not on HIV or STIs.
- 96% of clients reported satisfaction with their visit and that they felt welcome.
- 35% of providers explained their procedures ahead of time, and 54% of clients asked at least one question.
- Half of the clients were asked about their reproductive intentions or their method of preference. Few clients were asked about their discussion of family planning or their sexual relationship with their partners.
- 90% of clients were told how to use their method and half were informed of side effects. 20% were given information how to protect themselves from STIs.

IR3 – Access

- There are no private facilities in the region, MOH has one hospital and 33 clinics for a population of 800,000 and 215,000 WRA.
- Less then 33% of clinics open on time.
- All clinics offer oral contraceptives and injectables while 70% offer IUDs.
- Sterilization is not available and clinical methods tend to not be offered.
- 70% of clinics had a nurse on duty and 20% had a doctor.

- The hospital (for IUD insertion and sterilization) is a long way away and costly.
- 70% of clients felt the wait was too long and 60% felt services were too expensive.

IR4 – Context

- Nurses provide most of the FP services except clinical methods.

CASE STUDY: FINDINGS FROM DISTRICT HEALTH FACILITY ASSESSMENT

Background

Family planning services in this country have been available since 1960. However, the MOH only started improving services in 1992, after the population policy it put in place in 1990.

While access to and use of family planning methods has increased in recent years, use of family planning methods continues to be low. The 1997 DHS found a CPR among all women of reproductive age of 10%.

The most common methods include:

1) Oral contraceptives (30%)
2) Injectables (30%)
3) Condoms (10%)

Awareness of contraception methods is relatively high. Over half of the women and men interviewed in the 1997 DHS survey knew about modern contraception. However, only 15% of the women knew about long-term planning methods.

This current assessment was conducted prior to starting a new project, which will try to improve access to family planning services with a focus on long-term planning methods.

The program area has a total population of 800,000 including approximately 215,000 women of reproductive age. The average age among clients is 30 and only 5% are teenagers.

Sixty-six percent of the client population can read in a local language. The main religions represented are Protestant and Catholic.

The region does not have any private facilities. MOH facilities include the 120-bed referral hospital and 33 clinics. The referral hospital is located in Y town approximately 300 km from the capital city.

Methodology

Design of the Facility Assessment Instruments

The instruments were selected based on their applicability to project interventions and indicators, and the project's previous experience using these instruments.

The instruments were adapted from the Population Council's Situational Analysis Assessment instruments. All 5 modules of the Situation Analysis study were adapted and used to better understand the availability and quality of health care services provided at local health facilities. These include:

- Equipment and supplies inventory list.
- Review of service statistics: records of service statistics from the past 12 months were reviewed to check for quality of record keeping and client volume.
- FP provider interview: all the FP service providers present at the time of the assessment were interviewed regarding family planning and other reproductive health and work-related issues.

- Client-provider observation: at clinics with a high client flow (>20/day), observations were conducted of the interaction between service providers and every (third) family planning client including new and continuing clients.
- Family planning client exit interviews. All clients who had been observed were interviewed as they exited the facility.
- MCH client interview: a few clients attending antenatal, postnatal and immunization services were interviewed to check for missed opportunities to provide information on family planning services.

The survey questionnaires were translated and administered in the primary local language.

Health Service Delivery Assessment Modules		
Questionnaire	**Questionnaires Per Facility**	**Total Questionnaires**
Inventory Checklist	1	12
Observation Client-Provider Interaction	10	120
Health Worker Interview	2	24
Family Planning Client Exit Interview	10	120
MCH Client Interview	5	60

Sampling Design

Health facilities were randomly sampled in proportion to the number of health facilities. The only district hospital was automatically included. A total of 12 health facilities were selected for the HFA (11 clinics and 1 district hospital) out of a total of 34 HFs.

Data Collection

A total of 3 teams conducted the assessment. Each team spent one day in each facility where it implemented the HSDA survey. Each team was composed of 4 surveyors including an MOH doctor. At each facility the team supervisor was responsible for introducing the team and explaining the purpose of the visit. The supervisor conducted the inventory section of the survey and the review of service statistics. One surveyor was stationed in the consulting room and conducted the client-provider interaction observation component of the survey, and the second surveyor conducted the exit interviews with the clients as they left the health facility. Others surveyors conducted the health worker interviews.

The supervisor monitored the performance of the surveyors regularly to ensure that questionnaires were correctly completed.

Data Entry and Analysis

Completed questionnaires were collected and reviewed for completeness and accuracy and sent to the data entry person at the end of each day. Questionnaires were ordered by date of visit and site. Questionnaire numbers were then filled in for each instrument to identify individual questionnaires. Data entry was done using EPI INFO.

Results were computed and a report was written for discussion with the program management, clinic personnel and representatives from the MOH.

Findings

1. Facility and Services

Facility Infrastructure

Half of the facilities visited had adequate waiting areas. 60% of the clinics had access to electricity and clean water. Sterile instruments are needed for IUD insertion. Half the clinics also had working toilets for clients who have to wait for services to be provided.

Conditions such as a clean exam room, adequate water in the room were met in 60 to 65% of facilities.

Indicator	Percentage (%)
Percentage of facilities with an adequate waiting area	50
Percentage of facilities with working electricity	60
Percentage of facilities with piped running water	60
Percentage of facilities with working toilets for clients	65
Percentage of facilities with adequate light in exam room	80
Percentage of facilities with clean exam room	65
Percentage of facilities with adequate water in exam room	60

Accessibility

Less than a third of clinics open on time and only 42% have signs announcing services and hours of operation.

Services: Methods Offered

Virtually all the clinics offered oral contraceptives and injectables. IUDs are available in 70% of the clinics and condoms can be obtained from 70 % of the clinics. Very few facilities offer clinical methods such as sterilization both male and female or Norplant. Natural family planning and LAM are not offered in most clinics.

A large proportion of women breastfeed their babies almost exclusively for the first 4-6 months and this is a missed opportunity. Family planning providers do not emphasize the importance of breastfeeding as an appropriate method for the first 6 months. Staff has not been trained to counsel women on the benefits of LAM and this is reflected in the information taken from clients regarding their breastfeeding status. Accordingly, some oral contraceptive acceptors are given pills without taking into account whether the mother is breastfeeding.

Indicator	Percentage (%)
Percentage of facilities that offer oral contraceptives	95
Percentage of facilities that offer injectables	95
Percentage of facilities that offer progestin-only pills	75
Percentage of facilities that offer Norplant	5
Percentage of facilities that offer condoms	90
Percentage of facilities that offer dual-method counseling	
Percentage of facilities that offer IUDs	70
Percentage of facilities that offer tubal ligation	5
Percentage of facilities that offer vasectomy	3
Percentage of facilities that offer natural FP	3
Percentage of facilities that offer LAM	5

Equipment

Most of the clinics have the equipment required to provide services. 70% of the clinics had an adult weighing scale, a blood pressure machine and stethoscope to carry out basic physical examinations. However, more than half of the clinics visited did not have enough gloves and specula. These would be needed to perform pelvic examinations prior to inserting an IUD or in order to assess a client for an STD.

The equipment required for injectables (sterile needles and syringes) is available in 75% of the clinics assessed. Injectables are the preferred method for women in the region.

Indicator	Percentage (%)
Percentage of facilities with adult weighing scales	85
Percentage of facilities with blood pressure machines	70
Percentage of facilities with stethoscopes	70
Percentage of facilities with access to sterilizing equipment	70
Percentage of facilities with exam couches	70
Percentage of facilities with angle poise lamps or flashlights	55
Percentage of facilities with enough specula	40
Percentage of facilities with enough gloves	45
Percentage of facilities with enough sterilizing lotion	65
Percentage of facilities with enough tenacula	80
Percentage of facilities with enough uterine sounds	80
Percentage of facilities with enough needles and syringes	75
Percentage of facilities with enough Norplant kits	80

2. Staff, Training and Supervision

Family planning services are generally provided by non-physicians. In the region, nurses have been providing family planning services with the exception of clinical methods. During the assessment, 70% of clinics had a nurse on duty and 20% had a doctor on site.

On average, staff had been providing services for about 4 years. Most of them had had family planning training during their pre-service training and 60% of them had received refresher training in family planning.

Skills lacking include:

- Management of STDs and HIV
- Counseling in family planning or IEC
- Provision of clinical methods: IUD, tubal ligation

However, very few providers had received any training regarding STDs/HIV. Despite the low HIV prevalence rate (estimated at 1.2%), management of STDs and HIV-related conditions should be part of basic training.

Very few women are offered clinical methods when they come in for family planning as nurses are not allowed to insert IUDs and very few facilities have doctors available on site. Women are reluctant to travel to the hospital where a physician might be available to insert an IUD because of the distance, cost and the fact that waiting times at the hospital are much longer than at their local clinics and they are often asked to come back because of a long waiting list.

Indicator	**Percentage (%)**
Percentage of facilities with at least one nurse on duty on the day of the visit	70
Percentage of facilities with at least one doctor on duty on the day of the visit4	20
Mean years staff have been offering FP services (at this facility)	4
Percentage of staff whose basic training included FP	80
Percentage of staff who had training in clinical FP	20
Mean years clinical training took place	2
Percentage of staff who have had refresher training in FP	60
Percentage of staff who have had basic or refresher training in FP	80
Percentage of staff who provide STD/HIV services at this SDP	40
Percentage of staff whose basic training included STD/HIV	40
Percentage of staff who have had refresher training in STD/HIV	40
Percentage of staff who have had training in FP counseling or IEC	30
Mean years ago training in FP counseling or IEC took place	2
Percentage of staff who have had training in IUD insertion and removal	6
Mean years ago IUD training took place	5
Percentage of staff who have had training in tubal ligation	4
Mean years ago tubal ligation training took place	3

Supervision

Supervision does not occur on a regular basis and only 45% of the clinics had received a visit in the previous 6 months. Staff also mentioned that visits were mainly administrative, verifying if, rather than why, targets were not being met.

Staff also mentioned the need for supportive feedback despite difficult working conditions.

3. Inventory of Drugs and Commodities

Contraceptive Supplies and Logistics

The availability of methods has an important impact on contraceptive use and continuation as women are deterred from using services because of stock outs. This therefore has an effect on the quality of services provided. A woman expects her method of choice to be available when she makes

it to the clinic. If she is asked to come back, she is likely not to use another method and to come back with an unplanned pregnancy.

Only 10% of facilities have experienced a stock out of any of the methods in the last 6 months. 60% of the clinics have a commodity inventory in place and adequate storage (proper ventilation, protection from rain, sun and pests) for commodities. This ensures that most of the facilities should be able to identify which methods need to be reordered. However, problems with distribution of the methods affect the availability of methods despite keeping an inventory in the facility.

The low stock out rates in this country might be due to the low contraceptive prevalence rates; few women using methods and needing to be served and therefore more likely that methods are available in clinics but are not really used that much.

Indicator	Percentage (%)
Percentage of facilities that have experienced a stock out of condoms in the previous 6 months	6
Percentage of facilities that have experienced a stock out of oral contraceptives in the previous 6 months	10
Percentage of facilities that have experienced a stock out of progestin-only pills in the previous 6 months	10
Percentage of facilities that have experienced a stock out of IUDs in the previous 6 months	10
Percentage of facilities that have experienced a stock out of injectables in the previous 6 months	10
Percentage of facilities that have experienced a stock out of Norplant in the previous 6 months	0
Percentage of facilities that have experienced at least one stock out of an offered method in the last 6 months	10
Percentage of facilities with a commodity inventory	60
Percentage of facilities with adequate storage for commodities	60

IEC Materials and Activities

Well-designed job aids can help providers integrate their knowledge and skills into interactions with clients. Flipcharts for example, serve as memory aids for providers during consultations and keep interactions focused while at the same time giving clients essential information.

Most of the clinics have materials (poster, brochure and/or flipcharts) on family planning available. However, materials needed to educate clients on matters relating to HIV/AIDS and STDs are lacking. As a consequence, though most health talks include family planning issues, very little information regarding HIV/AIDS and STDs is imparted to the clients.

Indicator	Percentage (%)
Percentage of facilities with a poster on FP on the walls	70
Percentage of facilities with a brochure on FP	60
Percentage of facilities with a flipchart on FP	50
Percentage of facilities with a poster on HIV on the walls	49
Percentage of facilities with a poster on STDs on the walls	19
Percentage of facilities with a brochure on HIV	10
Percentage of facilities with a brochure on STDs	10
Percentage of facilities with a flipchart on HIV	3
Percentage of facilities with a flipchart on STDs	3
Percentage of health talks that included family planning	75
Percentage of health talks that included STDs	25
Percentage of health talks that included HIV	8

Recording Keeping

Most of the clinics have clients' records in good condition. Clients are also given a card with a return date and the method being used.

3. Quality of Services

Interpersonal Relations

An assessment of client-provider interactions revealed that clients are made to feel welcome. Ninety six percent of the clients reported satisfaction with responses to their questions and that responses were easy to understand. However, only 54% of the clients asked a question and this might be an indication that clients do not feel comfortable enough to do so. Most clients especially new ones would be expected to have at least one question. The high level of positive responses might be due to courtesy bias.
During the physical examination, only 35% of the clients were informed of the procedure ahead of time. Clients are often apprehensive and feel uncomfortable during invasive examinations and it is essential that the providers put them at ease by explaining the procedure before hand and what is expected to happen. This is especially critical as only doctors can insert an IUD and they are all male.

Indicator	Percentage (%)
Percentage of all clients given a friendly greeting	83
Percentage of clients who asked a question	54
Among clients who asked a question, percentage satisfied with the response	96
Percentage of clients who found the provider easy to understand	95
Percentage of pelvic exams in which the client was informed about the procedure beforehand	35
Percentage of pelvic exams in which client was informed about the procedure afterward	55
Percentage of IUDs in which the client was given moral support	83

Information Taken from Clients

Approximately half of the clients are asked about their reproductive intentions, breastfeeding status, method preference and previous method use. (Women should be asked if they intend to have more children and or when they want to have them so that information is provided on long-term methods if needed. Women wanting more children should receive information that will enable them to space their births appropriately. Women no longer desiring children should be offered methods that enable them to limits births. Other conditions such as breastfeeding should be looked at as some methods such as oral contraceptives are not appropriate for breastfeeding women. In addition, it is important to ask a woman about her method preference, as this will ensure better continuation.) Finally very few clients were asked about the nature of their sexual relationship or whether they had discussed FP with their partners. It is also very important to screen for STDs especially for clients who might consider using an IUD.

Indicator	Percentage (%)
Percentage of new clients asked about their reproductive intentions	63
Percentage of new clients asked their breastfeeding status	40
Percentage of COC acceptors asked their breastfeeding status	45
Percentage of new clients asked their method preference	53
Percentage of new clients asked about previous method use	48
Percentage of revisit clients asked about problems with their method	73
Percentage of clients asked if they discuss FP with their partner	23
Percentage of new clients asked the nature of their sexual relations	10
Percentage of revisit clients asked the nature of their sexual relations	5
Percentage of new clients asked about unusual bleeding	20
Percentage of revisit clients asked about unusual bleeding	15
Percentage of new clients asked about unusual discharge	34
Percentage of revisit clients asked about unusual discharge	5
Percentage of new clients asked about unusual discharge	

Indicator	Percentage (%)
Percentage of IUD clients asked about unusual bleeding	60
Percentage of IUD clients asked about unusual discharge	25

Choice of Methods

Though new clients are given information on at least 2 methods, too much emphasis is given to oral contraceptives and injectables. Oral contraceptives and injectables are widely available in clinics. There is very little mention of long-term methods; only 20 % of clients were told about the IUD or tubal ligation. Only 30% of clients were told about condoms in the clinics even though condoms were widely available in the clinics.

Indicator	Percentage (%)
Percentage of new clients told about at least 2 methods	75
Percentage of new clients to whom oral contraceptives were mentioned	75
Percentage of new clients to whom progestin-only pill were mentioned	30
Percentage of new clients to whom injectables were mentioned	80
Percentage of new clients to whom condoms were mentioned	30
Percentage of new clients to whom IUDs were mentioned	20
Percentage of new clients to whom tubal ligation was mentioned	20
Percentage of new clients to whom one method was overemphasized	50

Information Given to Clients

The quality of information given to clients regarding their method of choice is quite high. 90% of new acceptors are told how to use their method and more than a half are told about what to expect as side effects. Only 20% of clients are given information about the method's ability to protect against STDs and HIV. Health workers make use of job aids when talking to clients about the methods.

Indicator	Percentage (%)
Percentage of new acceptors told how to use their method	90
Percentage of new acceptors told the side effects of their method	60
Percentage of new acceptors told how to use their method and its side effects	60
Percentage of new acceptors told about their method's ability to protect against STD/HIV	20
Percentage of new clients told specifically that condoms protect against STD/HIV	20
Percentage of new clients with whom a flip chart was used	65
Percentage of new clients with whom a brochure was used	60
Percentage of new clients with whom a poster was used	60

Technical Competence

Weight, LMP and blood pressure are taken from almost all the clients. Physical exams are carried out in only 40% of new clients. There is more hand washing after than before pelvic exams: only 30% of the providers washed their hands before compared to 80% after the exam. Only 50% of clients had a pelvic exam performed with a clean or sterile speculum but clean gloves were used in 80% of pelvic exams. (To protect clients from infection, the best procedure would be to wash hands before, use clean or sterile gloves and wash hands after).

All the providers who inserted IUDs had received training in IUD insertion and removal.

85% of the providers used sterile instruments during the procedure.

The quality of injections was also very good though 30% did not massage the injection site as the normal procedure dictates.

Indicator	Percentage (%)
Percentage of new clients who were weighed	75
Percentage of new clients whose LMP was taken	88
Percentage of new clients whose BP was taken	78
Percentage of new clients whose medical history was taken	72
Percentage of new clients who were given a general physical exam	40
Percentage of pelvic exams before which the provider washed the hands	30
Percentage of pelvic exams after which the provider washed the hands	80
Percentage of pelvic exams during which clean/sterile speculum was used	50
Percentage of pelvic exams during which clean/sterile gloves were used	80
Percentage of IUD insertions during which the uterus was sounded	100
Percentage of IUD insertions during which the provider used sterile instruments	85
Percentage of injections during which a sterile needle was used	100
Percentage of injections before which the injection site was disinfected	100
Percentage of injections before which the vial was vigorously shaken	90
Percentage of injections after which the injection site was not massaged	30

Mechanisms to Encourage Continuation

Only 30% of clients were told they could switch methods if they had were not satisfied or due to side effects. 95% of clients were given a return date which should encourage them to continue their method.

5. Client Satisfaction

Appropriateness and Acceptability of Services

Exit interviews were conducted with clients who had been part of the observation. A high proportion of clients reported satisfaction with the information and services they had received. Most clients were happy about the time spent with the provider but only 30% of the clients found the wait reasonable and only 40% reported that the cost of services was acceptable.

Indicator	Percentage
Clients who received all the information and services they desired	90
Client satisfaction with time of consultation	
• Too long	40
• Just right	40
• Too short	20
Clients who found the wait reasonable	30
Clients who found the cost of services acceptable	40

ORGANIZATIONAL CAPACITY ASSESSMENT CASE STUDY: NGO Assessment

Introduction and Objectives

An organization seeks to expand the pool of NGO partners with the potential for delivering quality training and support to community health activities. The Nakasongola project has chosen to work with two NGOs already active in the districts, GAAPE (Groupe d'Appui à l'Auto Promotion Paysanne et à la Protection de l'Environnement – the Support Group for the Self-Promotion of the Land and the Protection of the Environment) and AJVDL (Association des Jeunes Volontaires pour le Développement de Lwabiyata - Association of Young Volunteers for the Development of Lwabiyata). These two NGOs will provide most of the direct training of the VHC volunteers and teachers for the child-to-child approach. In addition to the capacity-building training they receive, these organizations will be encouraged to build coalitions and networks with other NGOs working in the region.

The project objectives concerning the local NGOs were determined through an institutional capacity assessment using the tool to measure and profile the NGO partners' organizational capacities.

Methodology

Project managers visited Lwampanga and Lwabiayta in the Nakasongola district to conduct an initial assessment of the organizational capacity of the two NGOs retained. This evaluation covered the ten areas listed below and in Table 1 (Comparison of NGO Organizational Capacities). Each element and sub-element was given a numeric value according to its importance and evaluated by the NGO and the project staff team from SC.

Results of Assessment

GAAPE

The GAAPE was founded in 1997 and incorporated in 2001.

1. Structure

This NGO has statutes and internal rules adopted by the general assembly. The length of mandates is specified. The GAAPE has a physical and functional base office.

2. Mission and strategic plans

There exists a clear mission statement and short-term and long-term strategic plans are in place. These plans are indicated in annual action plans.

3. Monitoring and evaluation

This NGO uses collected data and conducts field visits to monitor and evaluate its activities.

4. Programs and services

The target group is involved in the implementation of the services and programs.

5. Financial resources

Locally, the GAAPE mobilizes funds.

6. Human resources

The NGO has a written recruitment policy, but employees do not have contracts. The amount received depends on the extent of their work. Qualified and competent personnel assure the direction and implementation of the activities.

7. Management and leadership

The personnel are kept informed of decisions and policy. The holdings of the NGO are subject to systematic inventory.

8. Financial system

There is a written procedure for the distribution of funds, but the NGO does not have an accountant. A founding GAAPE member who enjoys the trust of the group serves as treasurer. Check signing constitutes an internal monitoring.

9. External relations

The GAAPE maintains relationships with other local NGOs and with national authorities.

10. Gender

Women are included in decision-making.

AJVDL

The AJVDL was founded in 1998.

1. Structure

This NGO has statutes and internal rules adopted by the general assembly. The length of mandates is specified. AJVDL has a physical and functional base office.

2. Mission and strategic plans

There exists a clear mission statement and short-term and long-term strategic plans are in place.

3. Monitoring and evaluation

This NGO has a system in place to monitor and evaluate its activities.

4. Programs and services

The projects undertaken are based on community needs' assessments.

5. Financial resources

Locally, AJVDL mobilizes funds.

6. Human resources

The NGO does not have a written recruitment policy. Because it is young, it is developing a policy of voluntary adhesion. Qualified and competent personnel assure the direction and implementation of the activities.

7. Management and leadership

The group uses an organizational organigram and an administrative procedure manual.

8. Financial system

Financial reports are available. There is a trained accountant. Double check signing constitutes an internal monitoring device.

9. External relations

AJVDL maintains relationships with other NGOs on the local, national, and international levels.

10. Gender

Women are included in decision-making.

Table 1: Comparison of NGO Organizational Capacities

Evaluation Elements	*NGO*	
	GAAPE	**AJVDL**
	Founded 1997	**Founded 1998**
1. Structure		
Statutes and internal rules	3/3	3/3
Term limits	1/2	1/2
Functional structure	3/7	3/7
2. Mission and strategic plans		
Mission	1/4	3/ 4
Strategic plans	1/6	1/6
3. Monitoring and evaluation	3/8	1/8
4. Programs and services	7/7	1/7
5. Financial resources	2/6	2/6
6. Human resources		
Recruitment	1/5	Voluntary integration policy (0)
Evaluation of personnel	1/8	1/8
7. Management and Leadership		
Leadership	4/4	3/4
Administrative system	4/5	1/5
8. Financial system		
Financial management	3/4	2/4
Accountant	No accountant (0)	1/5
Internal monitoring	2/4	2/4
9. External relations	2/3	3/3
10. Gender awareness	1/3	1/3
Total	39/83(47%)	29/83(35%)

The GAAPE is at 47% organizational and institutional capacity.

AJVDL is at 35% organizational and institutional capacity.

Recommendations

The assessment identified 10 areas for organizational development. These are outlined in Table 2 (NGO Organizational Development) below. The needs identified in each of these areas will be addressed primarily through technical assistance from the project staff such as training and through joint implementation of the project activities.

Table 2: NGO Organizational Development

Key Element	Objective	Strategy
Animation techniques	NGO staff will be able to effectively lead group animation	Formal training
Health information systems	Ability to collect and analyze demographic and health information	HIS training
Four technical interventions of CS-18	Ability to lead the correctly supervise the VHCs in the technical interventions	Training in the four interventions areas
Supervision	NGO staff will be able to coordinate and supervise the VHC activities	Facilitative supervision training
Planning and budgeting	NGOs will be able to correctly budget and plan the project activities	On-the-job training in budgeting and planning
Limit of mandates for NGO positions	The NGOs will have set the length of mandates for elected positions	General Assemblies will discuss and vote on the mandates
Program monitoring and evaluation	NGOs will conduct systematic evaluations of themselves	Training in evaluation approaches and techniques
Financial resource management	NGOs will have a fund raising policy to continually secure cash	Training in fundraising approaches
Human resource management	A transparent system for recruitment and ongoing training and performance evaluation is established	Project staff will assist the NGOs to set up these systems
Gender awareness	The NGOs will encourage women's integration as members and leaders	Training in gender and development

TOOL FOR SYNTHESIZING SITUATION ANALYSIS DATA

Intermediate Result:_____

One tool per group – each group will complete the tool for their IR (e.g., one tool each for demand, access, quality, and social/policy environment)

DATA (Strengths, gaps, challenges, resources, opportunities, partners, etc.)
Secondary Analysis
Participatory Qualitative Assessments
DATA (Strengths, gaps, challenges, resources, opportunities, partners, etc.)
Health Facility Assessment (HFA)/Health Services Data Assessment (HSDA)

Organizational Capacity Assessments (community, potential partners, MOH)	
SUMMARY – Intermediate Result Statement:	
<u>Summary of Main Challenges</u> (to be filled out at end of Module 5)	**<u>Possible Strategies</u> (to be filled out for Module 6)**

PLAN ETHIOPIA RESULTS FRAMEWORK

Goal

To contribute to the reduction in morbidity and mortality among women of reproductive age in Bungna District.

Strategic Objective			
To increase the demand for and utilization of family planning services among women and men in 25 Kebeles of Bunga District			
Intermediate Results			
Improved quality of family planning service delivery in health institutions and communities of the program area	Increased knowledge and demand for family planning services among communities in the program area	Shared learning promoted among PVO/NGOs and government partners to improve coordination and promote policy environment	Increased access to family planning services in communities of program area

SAVE ETHIOPIA RESULTS FRAMEWORK

Strategic Objective		
Increased use of family planning and birth spacing by women of reproductive age		
Intermediate Results		
Increased quality of family planning/reproductive health services	Increased community access to family planning information and services	Increased community and individual awareness and acceptance of, and interest in using contraception for birth spacing/family planning Increased access to family planning services in communities of program area

ADRA ETHIOPIA RESULTS FRAMEWORK

Strategic Objective			
Increased use of family planning and improved FP/RH practices			
Intermediate Results			
Improved quality of FP Services Delivered by Providers in Facilities and in the community	Increased knowledge and interest in FP services through PVO/NGO involvement	Plans and Processes in place to continue FP activities beyond Flexible Fund support	Increased access of communities to FP services

REPRODUCTIVE HEALTH STRATEGIES

IR1: Improved Knowledge of, Attitude Toward, and Interest in Family Planning

Possible Strategies

- Design, manage, and evaluate information, education, and communication (IEC) activities
- Work with women's groups to increase awareness of family planning options
- Developing radio programming to increase awareness of availability of services

IR2: Increased Quality of Family Planning Service Delivery

Possible Strategies

- Improve service delivery infrastructure: renovating, equipping and supplying facilities
- Improve management of family planning organization/programs
- Establish a quality improvement mechanism for health centers

IR3: Increased Access/Availability of Family Planning Services and Supplies

Possible Strategies

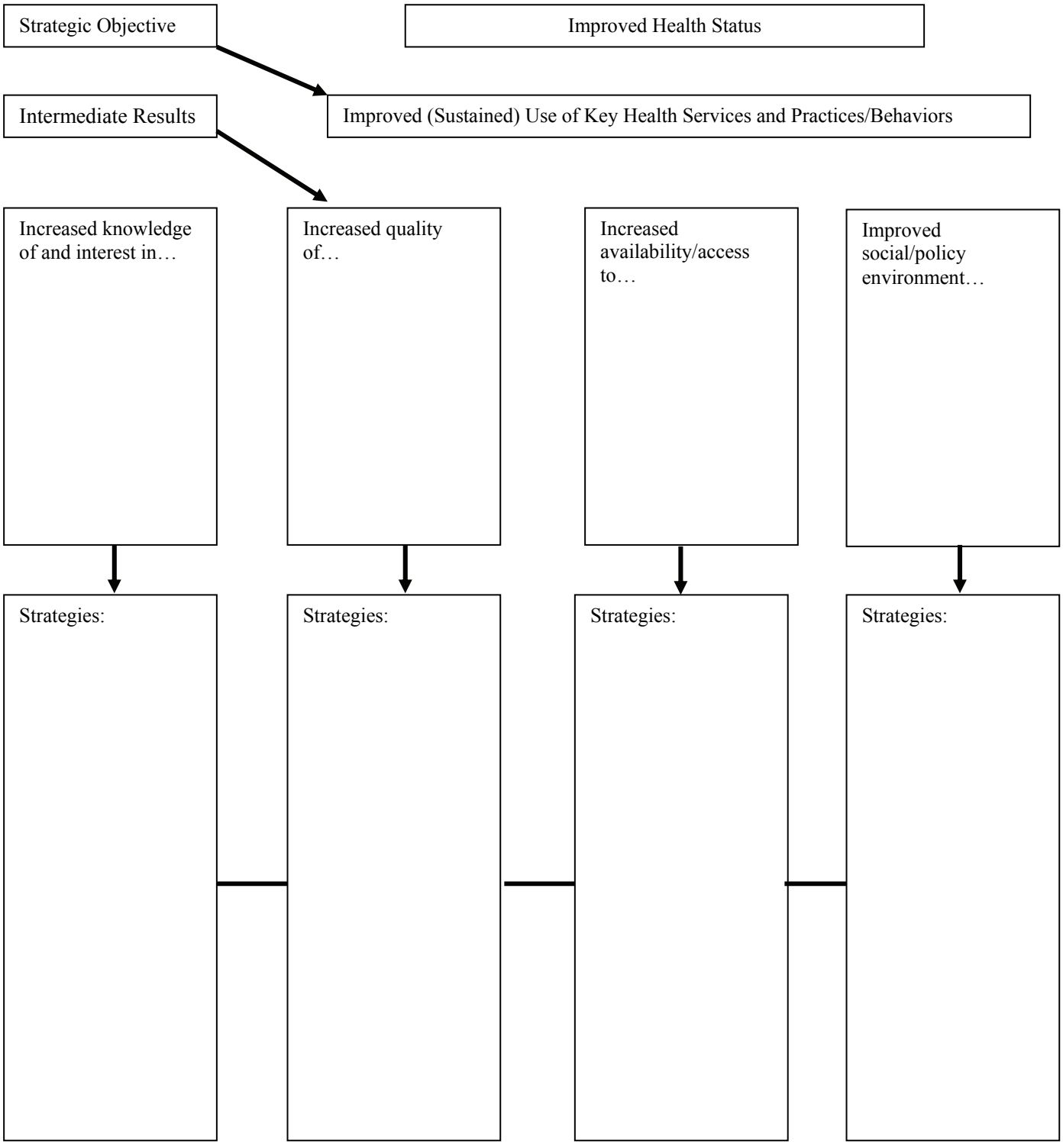
- Develop transport mechanisms to clinical service providers
- Minimize cost constraints for clinical methods
- Publicize location, times and mechanisms of services
- Develop a community based distribution system for family planning methods
- Work as a facilitator/catalyst for collaboration between public and private sector institutions and communities
- Directly provide family planning services

IR4: Improved Social and Policy Environment for Family Planning Services and Behaviors

Possible Strategies

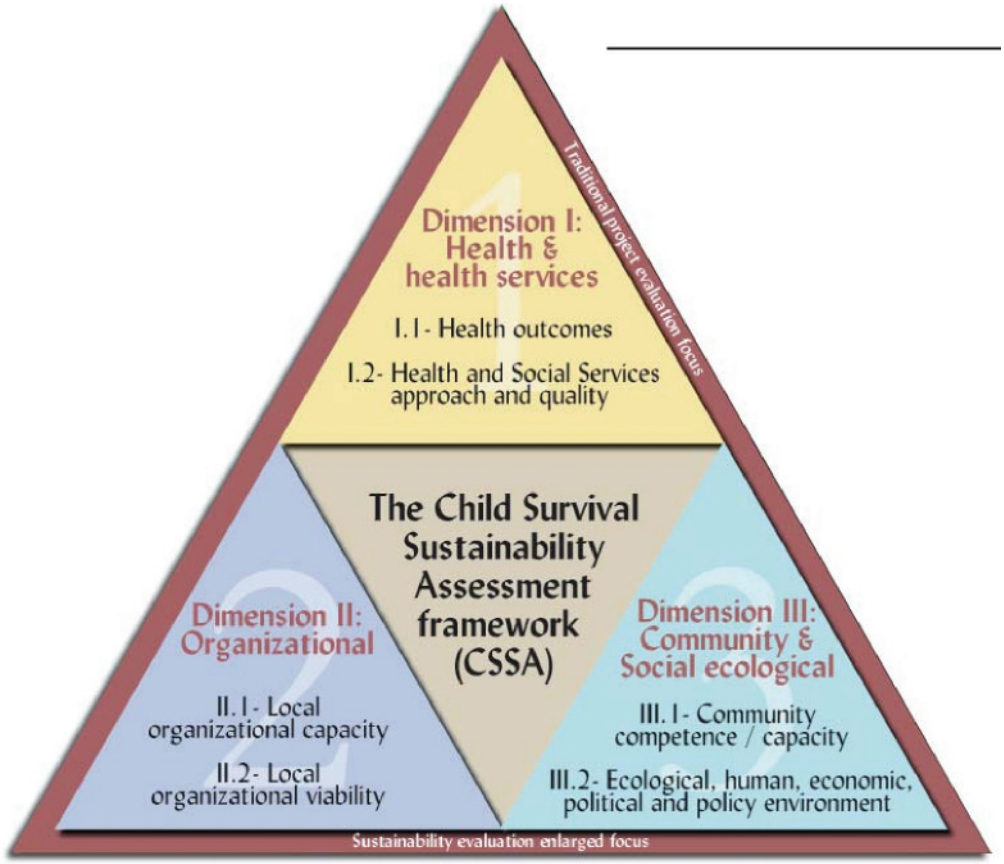
- Support the integration of women in the policy decision-making process
- Support advocacy efforts appropriate to individual national family planning contexts
- Work with community leaders to raise awareness about family planning

PROJECT SUMMARY RESULTS FRAMEWORK
IMPROVED HEALTH STATUS



PROJECT DESIGN STRATEGIES FOR SUSTAINABILITY

Dimension 1:



Dimension 2:

Dimension 3:

MONITORING AND EVALUATION MATRIX

Results	Indicator (evaluation and monitoring)	Description/ definition of indicator	Source of data	Frequency of collection	Point person	Baseline value
SO						
IR 1 Demand						
Strategies:						
IR 2 Quality						
Strategies:						

Results	Indicator (evaluation and monitoring)	Description/ definition of indicator	Source of data	Frequency of collection	Point person	Baseline value
IR 3 Access						
Strategies:						
IR 4 Social/ Policy						
Strategies:						

REPRODUCTIVE HEALTH PRELIMINARY ACTION PLAN

To be filled out for each IR – e.g. IR #1 – (Access/Availability)

Strategies/Activities	Person Responsible	Other Critical Institutions	Resources Available? Y/N	Time Frame											
				Year 1				Year 2				Year 3			
Strategy #1:															
Activities: 1.															
2.															
3.															
4.															
5.															
Strategy #2:															
Activities: 1.															
2.															
3.															

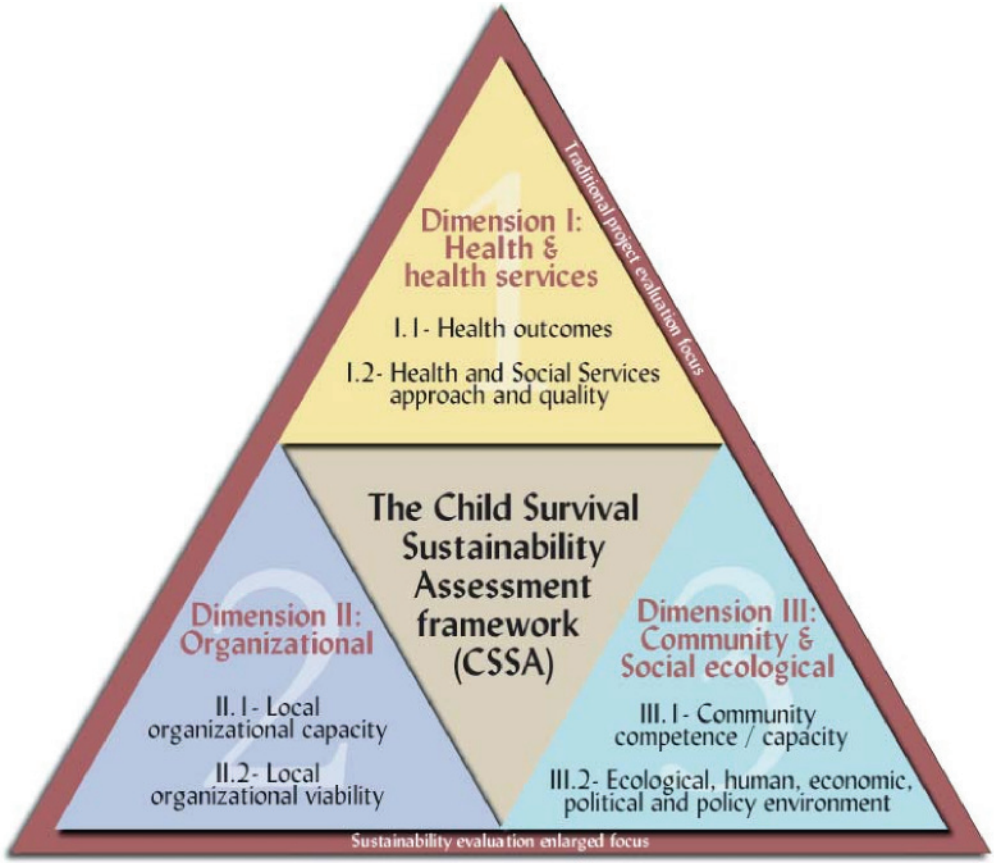
PROJECT DESIGN STRATEGIES FOR SUSTAINABILITY

Dimension 1:

_____

_____

_____



Dimension 2:

_____

_____

_____

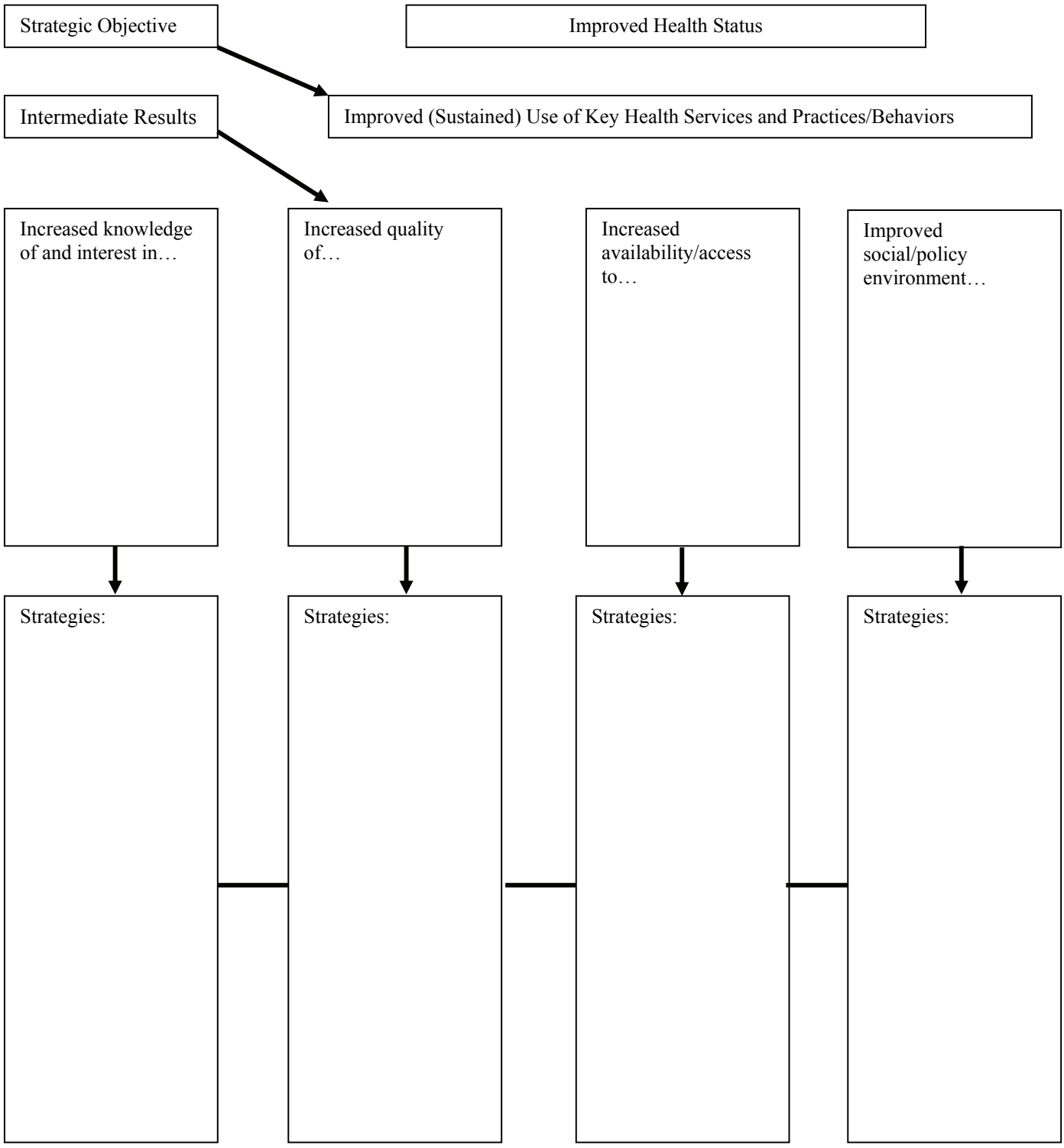
Dimension 3:

MONITORING AND EVALUATION MATRIX

Results	Indicator (evaluation and monitoring)	Description/ definition of indicator	Source of data	Frequency of collection	Point person	Baseline value
SO						
IR 1 Demand						
Strategies:						
IR 2 Quality						
Strategies:						

Results	Indicator (evaluation and monitoring)	Description/ definition of indicator	Source of data	Frequency of collection	Point person	Baseline value
IR 3 Access						
Strategies:						
IR 4 Social/ Policy						
Strategies:						

PROJECT SUMMARY RESULTS FRAMEWORK
IMPROVED HEALTH STATUS



TOOL FOR SYNTHESIZING SITUATION ANALYSIS DATA

Intermediate Result:_____

One tool per group – each group will complete the tool for their IR (e.g. one tool each for demand, access, quality, and social/policy environment)

DATA (Strengths, gaps, challenges, resources, opportunities, partners, etc.)
Secondary Analysis
Participatory Qualitative Assessments
DATA (Strengths, gaps, challenges, resources, opportunities, partners, etc.)
Health Facility Assessment (HFA)/Health Services Data Assessment (HSDA)

Organizational Capacity Assessments (community, potential partners, MOH)	
SUMMARY – Intermediate Result Statement:	
<u>Summary of Main Challenges</u> (to be filled out at end of Module 5)	**<u>Possible Strategies</u> (to be filled out for Module 6)**