



Putting the IPPF Monitoring and Evaluation Policy into practice

A handbook on collecting, analyzing and utilizing data for improved performance

Who we are

IPPF is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.

We work towards a world where women, men and young people everywhere have control over their own bodies, and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they will have and when; free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections, including HIV. A world where gender or sexuality are no longer a source of inequality or stigma. We will not retreat from doing everything we can to safeguard these important choices and rights for current and future generations.

Acknowledgements

Our colleagues at IPPF, most notably those working on evaluation, have provided us with much inspiration, insight and expertise. We have shared opportunities for reflection on IPPF's approach to evaluation, and have jointly taken forward initiatives to promote a stronger culture of monitoring, evaluation and learning throughout the Federation.

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Foreword by the Director-General

In IPPF we are committed to improving how we carry out our work and to being better able to demonstrate our progress. The Federation's results are reflected in the numbers of quality services being provided to clients, and by effective advocacy at national, regional and global levels that makes a difference to the sexual and reproductive health and rights of people in over 150 countries.

This handbook is a practical guide for volunteers and staff at IPPF who are committed to increasing effectiveness, evidence-based decision making, and improving accountability through monitoring and evaluation.

For evaluation studies to be useful they must be used – both for learning and accountability.

Monitoring and evaluation play such a key role in any healthy learning organization because they strongly encourage three key questions to be asked: are we doing the right thing; are we doing it well; and are there better ways of doing it?

Investing in monitoring and evaluation means that IPPF is working hard to strengthen our ability to collect high quality data and ensure that the data are used to identify gaps and areas for improvement, to feed into our annual planning and budgeting exercises, support our advocacy work, review progress in implementing the IPPF Strategic Framework, and set ourselves increasingly ambitious goals in the future.

Through these processes, we ensure transparency and openness, increased effectiveness, a healthy learning culture, and stronger working relations with our partners.

Next steps

I would like to encourage each Member Association to use the monitoring, evaluation and learning checklist provided in Appendix 1 to assess their capacity in monitoring, evaluation and learning, to identify areas of weakness, and to use this handbook to implement the changes needed to put IPPF's Monitoring and Evaluation Policy into action.

The handbook is also a clarion call for IPPF's management and governing bodies to recognize the essential role that monitoring and evaluation play in the effective management of projects. Financial, human and technological resources for monitoring and evaluation need to be prioritized, and both policy and decision making must be based on evidence drawn from evaluation findings.

We are determined to use this handbook to build a strong culture of monitoring, evaluation and learning in an organization that is more effective in meeting the sexual and reproductive health needs of women, men and young people across the globe.



Dr Gill Greer
Director-General, IPPF



Photo: IPPF/Chloe Hall 2007

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Introduction

Putting IPPF's Monitoring and Evaluation Policy into practice

IPPF's Monitoring and Evaluation Policy

In May 2006, IPPF's Governing Council approved revisions to IPPF's policy 4.12 on evaluation which dated from 1990. The revised policy (see opposite) reflects a renewed commitment to monitoring, evaluation and learning throughout the Federation. The policy stresses the importance of monitoring, evaluation and learning to effective management and improved performance. It also reflects the need for IPPF to be able to demonstrate its results to itself and to others, at national, regional and global levels of the Federation, and to monitor progress in implementing IPPF's Strategic Framework 2005–2015.

The policy describes the principles and commitments of IPPF towards monitoring and evaluation and the roles of staff and volunteers in IPPF in supporting and implementing the policy.

About this handbook

The handbook is divided into three main sections, as follows:

Section 1 describes the basics of monitoring and evaluation. We have included simple definitions of monitoring, evaluation and learning and explained their purpose in making informed strategic decisions. We also discuss some of the challenges in implementing monitoring and evaluation activities, describe some common myths relating to monitoring and evaluation, and highlight the importance of ethics in evaluation.

Section 2 examines monitoring and evaluating projects at IPPF. Here, we discuss developing a monitoring and evaluation plan, developing indicators, project evaluation step by step, needs assessments, and baseline and endline studies. We also describe data collection, reporting, and utilizing monitoring and evaluation findings.

Section 3 describes IPPF's global indicators programme with an introduction and explanation of how we collect and analyze the data, how we report and utilize data at Member Association, regional and global levels, what the global indicators do and don't do, and an overview of each of the 30 indicators.

Following the three main sections, a number of appendices are provided, as follows:

- a monitoring, evaluation and learning checklist to be used by Member Associations to assess their capacity in monitoring, evaluation and learning (Appendix 1)
- a sample monitoring and evaluation plan (Appendix 2)
- a sample terms of reference (Appendix 3)

- IPPF's Organizational Learning Strategy (Appendix 4)
- a list of consistency checks of the global indicators survey data (Appendix 5)
- the annual reporting schedule for IPPF's global indicators programme (Appendix 6)
- a list of service statistics and global indicators reports available on IPPF's electronic integrated management system (eIMS) (Appendix 7)
- an explanation of how IPPF's global indicators are calculated (Appendix 8)
- an explanation of how the couple years of protection (CYP) values are calculated for different methods of contraception (Appendix 9)

The glossary includes general monitoring and evaluation terminologies, service statistics definitions and other definitions used in the global indicators online survey questionnaire.

In the bibliography, we have included references for further reading which might be of interest to the reader who wishes to learn more about monitoring and evaluation.

Intended users

The handbook is designed to support all those with a role in monitoring and evaluating projects across IPPF. This includes volunteers, programme managers, project coordinators, project officers, and clinic and medical staff. On a practical level, the handbook is designed to support volunteers and staff who are committed to increasing effectiveness, evidence-based decision making, and improving accountability through monitoring and evaluation.

The handbook provides the necessary tools for IPPF's management and governing bodies to translate the Federation's Monitoring and Evaluation Policy into action. Only through continuous learning and improvement will the Federation be able to achieve the objectives in its Strategic Framework 2005–2015. It is vital, therefore, that resources, both financial and human, are prioritized for evaluation activities, and that decisions are based on evidence drawn from evaluation findings.

Use of this handbook will contribute towards a stronger culture of monitoring, evaluation and learning throughout the Federation, and an organization that is more effective in meeting the sexual and reproductive health needs of women, men and young people across the globe.

IPPF's Monitoring and Evaluation Policy

Introduction

- 1 The most important work of IPPF takes place at the country level where Member Associations advocate to their governments and serve their clients through the implementation of sexual and reproductive health and rights programmes.
- 2 This policy makes clear the importance that the Federation attaches to the monitoring and evaluation¹ of its work, and highlights key principles and commitments that volunteers and staff should be guided by in its implementation.

Principles

- 3 Organizational effectiveness in IPPF means the ability of the Federation to fulfil its mission through a combination of sound management, good governance and a persistent dedication to achieving results.
- 4 Monitoring, evaluation and learning:
 - are integral to organizational effectiveness since they are concerned with measuring results achieved, and analyzing and reflecting upon the process that led to those results in ways that enable continuous improvement
 - empower volunteers and staff to understand what works well and not so well, to improve projects and to inform the design of new ones
 - lead to good reporting on the performance of the Federation, which increases accountability to those we serve (our clients) and to those who support our work (our donors and all other partners)

Commitments

- 5 IPPF is therefore committed to:
 - providing support to volunteers and staff to increase their evaluation skills and improve decision making
 - implementing a participatory approach to monitoring and evaluation in which key people who have a concern and interest in a project are actively and meaningfully involved in its evaluation
 - monitoring and reporting on results to assess whether or not the Federation is achieving its strategic goals and objectives
 - demonstrating the effects of the Federation's work at national, regional and global levels in ways that are convincing, easy to understand and intellectually honest

Implementation

- 6 To realize these principles and commitments, the Director-General, Regional Directors and the Executive Directors of Member Associations will ensure that, as far as possible:
 - resources are available, and systems and procedures are in place, to undertake ongoing monitoring and evaluation of projects
 - programme and resource allocation decisions are based on analyses of both performance and needs
 - IPPF's governing bodies at all levels of the Federation are provided with the evidence they need to monitor the work of IPPF in relation to strategic and operational plans and to fulfil other governance responsibilities
- 7 Member Associations will endeavour to implement ongoing, participatory and robust monitoring and evaluation practices to ensure project effectiveness. These will include:
 - needs assessments
 - monitoring and evaluation plans with indicators of performance
 - baseline and endline/end of project surveys
- 8 Regional Offices will:
 - support Member Associations to monitor and evaluate their work. This will involve the provision of technical assistance and advice on monitoring, evaluation, learning and reporting
- 9 The Secretariat will:
 - develop guidelines and procedures on monitoring and evaluation
 - monitor the quality of evaluation throughout the Federation
 - measure progress in implementing IPPF's Strategic Framework by analyzing data on the Federation's global performance indicators; these data will be supplemented with in-depth programme reviews
- 10 Evaluation reports will be available on IPPF's intranet to share lessons learned and good practice across the Federation's global network.

¹ Monitoring is the ongoing collection and analysis of data to review progress and make adjustments where necessary. Evaluation is the assessment of results achieved.

Section 1

Monitoring and evaluation: the basics

What are monitoring, evaluation and learning?

Monitoring: is an ongoing and systematic activity used to track whether activities are carried out according to plan. Monitoring provides project managers with important information on progress, or lack of progress, in relation to project objectives.

Monitoring helps to answer questions such as:

- How well are we doing?
- Are we doing the activities we planned to do?
- Are we following the designated timeline?
- Are we over/under-spending?
- What are the strengths and weaknesses in the project?

As a routine activity, monitoring enables those responsible for the project to identify strengths and weaknesses, to review progress being made and to make necessary adjustments. Monitoring keeps the project on track and provides the information necessary to make key decisions at the right time. Systematically generated monitoring data are also required to support project evaluations.

Evaluation: is an assessment of the relevance, efficiency, effectiveness, performance and sustainability of a project. Evaluation requires an in-depth review at specific points in the life of the project, usually at the mid-point or end of a project. Evaluation verifies whether project objectives have been achieved or not. It is a management tool which can assist in evidence-based decision making, and which provides valuable lessons for implementing organizations and their partners.

Evaluation helps to answer questions such as:

- How relevant was our work in relation to the primary stakeholders and beneficiaries?
- To what extent were the project objectives achieved?
- What contributed to and/or hindered these achievements?
- Were the available resources (human, financial) utilized as planned and used in an effective way?
- What are the key results, including intended and unintended results?
- What evidence is there that the project has changed the lives of individuals and communities?
- How has the project helped to strengthen the management and institutional capacity of the organization?
- What is the potential for sustainability, expansion and replication of similar interventions?
- What are the lessons learned from the intervention?
- How should those lessons be utilized in future planning and decision making?

Learning: is the process by which knowledge and experience directly influence changes in behaviour. If the information provided by monitoring and evaluation is not used, then the exercise is essentially a waste of time and effort. One of the most important tasks of any project manager or evaluator is to ensure that the information is presented in a way that makes it accessible to those who need it to make decisions. Both monitoring and evaluation will be ineffective if they do not lead to learning at the project level. Evaluation findings, recommendations and learning should also contribute to improved programmes, policies and practices, evidence-based advocacy and effective resource mobilization.

“We are all too busy...”

It is vital that monitoring and evaluation take place in an environment conducive to learning, risk-taking and reflection. It is often heard that “we are all too busy doing, to find time to reflect and learn” but we all need to know if what we are doing is the most effective way of achieving our objectives and meeting the needs of our clients.

Monitoring, evaluation and learning provide us with the tools needed to help us stay on the right track throughout the project life span, to make informed programme, policy and strategy decisions on the basis of our accumulated learning, and to contribute more broadly to the sexual and reproductive health and rights sector.

Monitoring and evaluation are often linked together but it is evident from the definitions above that there are clear differences between the two processes (Table 1.1).

In the lifetime of any project, it is vital that each of the stages of preparation, implementation, monitoring and evaluation benefit from and contribute to learning. Figure 1.2 illustrates the importance of monitoring, evaluation and learning during the life cycle of a project to maximise success, as well as beyond the life cycle to contribute to future policy and programme development, strategic planning, effective advocacy and resource mobilization.

Table 1.1 Differences between monitoring and evaluation¹

Monitoring	Evaluation
<ul style="list-style-type: none"> ongoing 	<ul style="list-style-type: none"> periodic: at the midterm, at the end, a substantial period after the project has ended
<ul style="list-style-type: none"> keeps track, reviews and reflects on progress, or lack thereof, in relation to project objectives 	<ul style="list-style-type: none"> in-depth analysis to compare planned with actual achievements in relation to project objectives
<ul style="list-style-type: none"> answers what activities were implemented and what results were achieved 	<ul style="list-style-type: none"> plus: answers how the results were achieved
<ul style="list-style-type: none"> alerts project managers to problems and provides options for corrective actions 	<ul style="list-style-type: none"> plus: contributes to building theories and models for change; provides project managers with strategy and policy options; increases accountability to project beneficiaries, donors and other partners
<ul style="list-style-type: none"> internal process 	<ul style="list-style-type: none"> internal and/or external process

Why monitor, evaluate and learn?

Only by monitoring, evaluating and learning from projects can we be sure of their progress and performance.

Why monitor?

We monitor:

- to review progress and/or lack of progress
- to make necessary adjustments in the implementation of activities
- to prioritize allocation of resources for the various project activities
- to gather information for evaluation purposes

Why evaluate?

We evaluate:

- to assess overall project performance
- to improve project design
- to make decisions based on concrete evidence
- to increase knowledge of what works, what does not work – and why
- to be accountable to project beneficiaries and to donors
- to assess the cost effectiveness of the project
- to provide evidence for future resource mobilization
- to identify successful strategies for extension, expansion, replication

Why learn?

We learn:

- to increase effectiveness and efficiency
- to increase the ability to initiate and manage change
- to utilize institutional knowledge and promote organizational learning
- to improve cohesion among different units of the organization
- to increase adaptability – for opportunities, challenges and unpredictable events
- to increase motivation, confidence and proactive learning

There has been a long tradition in the international development sector to view the purpose of evaluation solely in terms of accountability to donors. However, more recently it has become clear that monitoring, evaluation and learning are essential components of effective project management, and that although it is important to undertake evaluation for accountability purposes, to both our beneficiaries and our donors, the most important reason is to learn and increase the effectiveness of what we do. Table 1.3 illustrates the differences in focus between an evaluation undertaken for learning as opposed to an evaluation done for accountability, both to beneficiaries and to donors.

Figure 1.2 Learning throughout the project life cycle and beyond

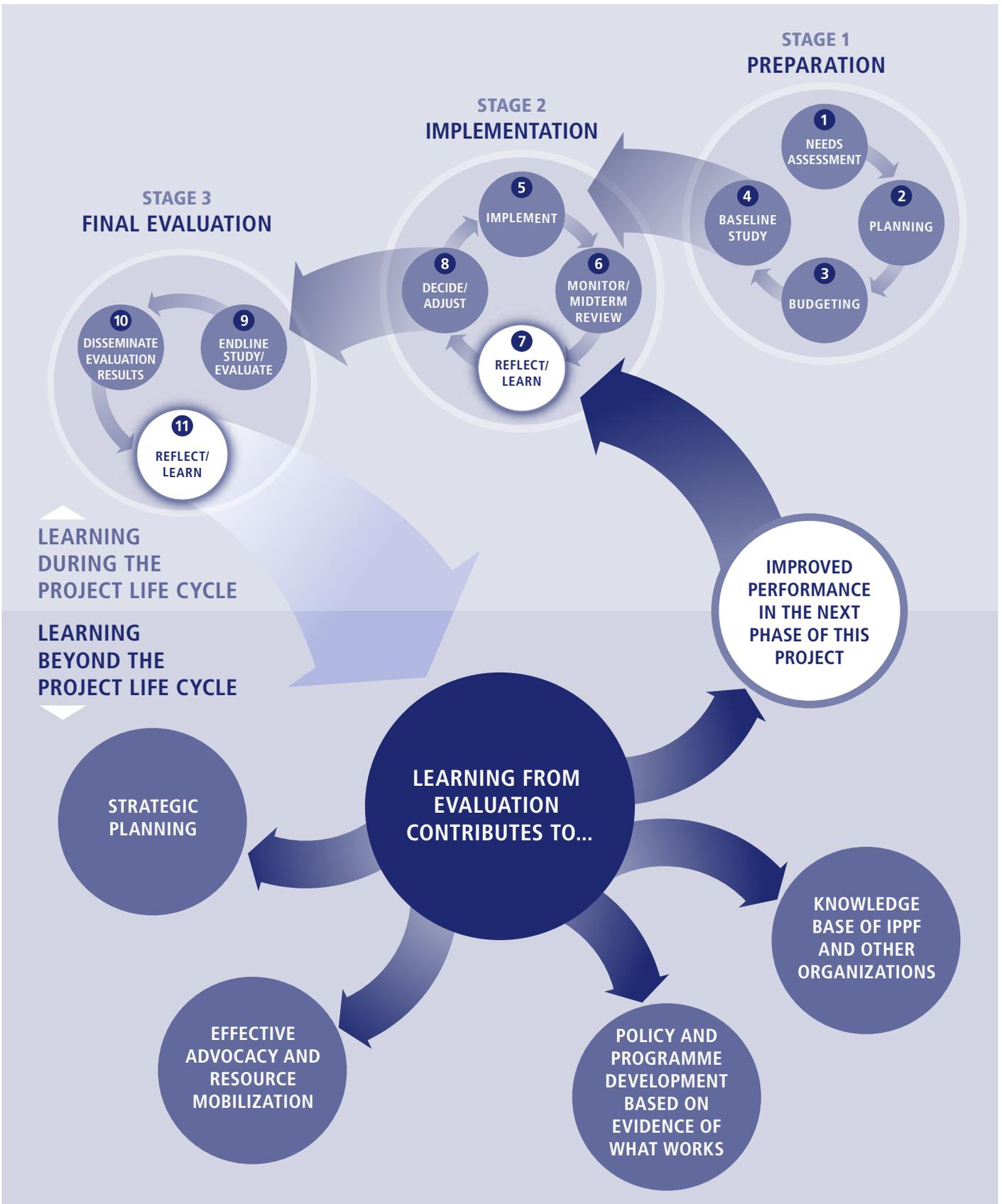


Table 1.3 Differences between evaluation for learning and evaluation for accountability²

	Evaluation for learning	Evaluation for accountability to beneficiaries	Evaluation for accountability to donors
Main purpose	<ul style="list-style-type: none"> • learning and improvement 	<ul style="list-style-type: none"> • accountability and learning 	<ul style="list-style-type: none"> • accountability
Focus of questions	<ul style="list-style-type: none"> • what worked, what didn't, and why? 	<ul style="list-style-type: none"> • what was supposed to happen, what actually happened, what are the perceived changes by the beneficiaries? 	<ul style="list-style-type: none"> • were the goals and objectives achieved?
Stakeholder roles	<ul style="list-style-type: none"> • engage actively in all stages of the evaluation 	<ul style="list-style-type: none"> • engage in key stages of the evaluation, provide feedback 	<ul style="list-style-type: none"> • provide information and review report
Assumptions about activities implemented	<ul style="list-style-type: none"> • many interlinked factors contribute to change and the end results may not be solely due to the project activities 	<ul style="list-style-type: none"> • project activities lead to the results achieved 	<ul style="list-style-type: none"> • project activities lead to the results achieved

Challenges in evaluation

A major threat to an organization's ability to remain relevant, competitive and successful is its resistance to change, and one of the main challenges for monitoring and evaluation is for organizations to use the recommendations and learning from monitoring and evaluation to reflect, reassess and be proactive in influencing change. If the findings, recommendations and lessons do not feed back into the decision making, budgeting and planning processes, then monitoring, evaluation and learning are essentially of little value.

The main practical challenges to monitoring and evaluation can be summarized as follows:

Lack of commitment/political will: monitoring and evaluation are essential components of learning and accountability. A lack of commitment, however, can result in low prioritization of these activities. A lack of political will can also impose significant challenges, for example, when evaluations are conducted in a context where the political, economic, ethical and/or ideological influences affect the terms of reference, design and use of recommendations, and learning generated from evaluation.

Budgetary constraints: good quality monitoring and evaluation require adequate financial investment to ensure that systems are in place to collect the data for monitoring purposes and that sufficient budget is allocated for evaluation activities (costs may include travel expenses, salaries, training, technology, etc).

Lack of skilled personnel/expertise: strong monitoring and evaluation require adequate numbers of staff who have the capacity, skills and experience to conduct

monitoring and evaluation activities. In many parts of the world, there is a gap in evaluation capacity due to the low priority given to evaluation. Also, evaluation staff may be allocated other work responsibilities which leave less time to engage in evaluation.

Limited data availability and/or poor quality of data: a monitoring, evaluation and learning plan should be developed before implementation of activities begins – to ensure the availability of baseline data and adequate monitoring data to support ongoing management decisions, to provide the information required for evaluation at specific times during the lifetime of the project, and to provide endline data to compare against the baseline. Regarding the quality of data, it is important to ensure that the sample represents the study population. Wherever possible, both qualitative and quantitative data should be collected using a combination of methodologies to minimize the chance of bias and to ensure high quality data.

Limited involvement of stakeholders: participatory evaluation, with beneficiaries and stakeholders playing an active role in monitoring and evaluation activities, can be of significant benefit to both parties: the stakeholders themselves in terms of empowerment, skills acquired, and a sense of ownership and influence over a project's direction, and the project and evaluation teams in terms of the insight from the perspective of beneficiaries and what the projects mean to them. The challenges involved in participatory evaluation may be practical in terms of the training, supervision and logistics involved. Furthermore, some evaluators believe they and they alone have the skills to conduct an evaluation, and beneficiaries should only be involved as interviewees.

Using the findings and follow up: the results of evaluation need to be disseminated internally, used proactively by decision makers to influence policy and programming, monitored to ensure recommendations are implemented, and shared externally with partners and donors to fulfil accountability requirements. Furthermore, internal mechanisms within organizations to share and learn from lessons in a systematic way need to be prioritized.

Impact evaluation: increased debate about the effectiveness of aid has raised the profile of impact evaluation and increased the need for reporting at the outcome and impact levels. There are, however, a number of practical constraints to conducting rigorous impact evaluations for an organization like IPPF. They can be time consuming and costly, they usually require comprehensive baseline and endline data on a fixed set of indicators, and a control group which does not benefit from the intervention. This can be difficult in practical terms as well as judged unethical. The evaluation needs to be conducted after a significant amount of time has passed since the project ended and this is challenging in an environment where funding support, including funding for the project evaluation itself, often ceases at the same time as the project ends. Being able to identify attribution and/or causality of effect in complex situations, often involving multiple stakeholders and determinants, can also be highly problematic.

These challenges mean that for IPPF Member Associations, impact evaluations are not realistic in the majority of cases. However, more attention is being paid to measuring results at the outcome level in terms of the intended short to medium term effects on the target group and being able to demonstrate the difference our interventions have on people's lives and/or their sexual and reproductive health and rights.

Setting targets: when designing objectives and indicators, the potential negative effects of setting unrealistic targets need to be considered. These negative effects include misreporting or falsification of data, especially when future funding is dependent on targets being reached.

Independence: IPPF's Monitoring and Evaluation Policy supports an internal approach to monitoring, evaluation and learning. It has a focus on internal reviews and self-evaluation for purposes of learning and increasing organizational effectiveness. However, external 'independent' evaluation also has a role to play, and one which is becoming more important as resources become increasingly constrained, and results and value for money, as reported from an external perspective, are valued.

The challenges involved in independent evaluation may include the cost of commissions, the lack of integration with staff and stakeholders, the resistance to implement recommendations made by external parties, and the reluctance by external evaluators to be critical when their livelihood is dependent on commissions from the organizations they are evaluating.

Myths about evaluation

In training sessions, an interesting exercise is to ask participants to complete the sentence:

“One thing about monitoring and evaluation that bothers me is _____”

Here are some of the answers given during this exercise which illustrate many of the myths about evaluation that abound, followed by some clarification on the different opinions given.

“Evaluation is a fault finding mission.”

No! Evaluation is an assessment of project performance and a learning exercise.

“Evaluation is a performance appraisal of the project managers and/or staff.”

No! Evaluation is about the project, not the people. Involvement in and ownership of both the project and the evaluation process ensure that findings and recommendations can be used to increase performance, and not viewed as personal criticism.

“Evaluation is a tool to gather evidence for punishing and blaming.”

No! Evaluation is a participatory process to reflect and learn.

“All evaluation does is result in written reports.”

No! The prime objectives of evaluation are utilization of information and learning from the experience. Evaluation is a waste of time if informed decision making and policy formulation do not follow from the findings, recommendations and written reports that are generated.

“Evaluation is important only for research-based organizations. We do not need it.”

No! Evaluation is an assessment of the relevance and performance of any project. Without reflecting on how we are doing, we cannot improve effectiveness. This is true for any organization in any business.

“I always know what my clients need – I don’t need evaluation to tell me if I’m really meeting the needs of my clients or not.”

No! You may be right, but how do you know for sure? You may know some of their needs but not all, and needs and the context in which you work can change over time. An evaluation can help clarify, convince and identify ways to improve quality and increase effectiveness.

“Evaluation is an event to get over with and then move on.”

No! It is a periodic activity during the project life cycle, and the results should be integrated into management planning, strategy development and policy formulation.

“Evaluation requires a whole new set of activities – we don’t have the resources.”

No! Most monitoring and evaluation activities involve ongoing management activities which are carried out to improve performance, and to assess whether objectives are being met. Where evaluation resources are required (financial and/or human), these should be prioritized by senior management as the benefits far outweigh the costs.

“There’s only one ‘right’ way to do an evaluation. What if I don’t get it right?”

No! Each evaluation process is somewhat different, depending on the needs and nature of each project. The only failed evaluation is one where no learning takes place.

“In evaluation, we always have to follow the donor’s way of doing things.”

No! Most donors appreciate open consultation and experience sharing while planning an evaluation mission. Request that time is made available to discuss your concerns and contribution, and your participation in the evaluation.

“Doing is more important than evaluating.”

No! Both are required – the first is to ensure that projects are implemented and needs are met. The second ensures that projects do not lose touch with reality, are managed effectively and that the desired results are achieved.

“What I’m doing couldn’t possibly be measured.”

Maybe but to justify what you are doing, and the money being spent, you still need to answer the question ‘what changed?’ Most well-designed evaluations involve a combination of both quantitative and qualitative methodologies which provide evidence of change.

Ethics of evaluation

In this section, we consider the rights and responsibilities of both the participants and evaluators with regard to ethical issues.

Rights of participants

Right to information

Participants are entitled to know the purpose of the evaluation and the feedback they will receive after the process is completed.

Right to non-participation

Participants have the right to express freely if they do not want to answer any questions or do not want to participate in a discussion.

Right to privacy

Participants should be able to provide information in a private setting.

Right to anonymity and confidentiality

Participants should be assured of anonymity and confidentiality of any information they provide. Anonymity means that names and addresses are not recorded, and therefore specific information cannot be traced back to any participant. In situations where tracing back is necessary for credibility or follow up purposes, this needs to be mentioned clearly at the very beginning.

Right to own opinion

Participants have the right to express their own opinion no matter how much it contradicts with that of the evaluators or other participants.

Right to dignity

Participants have a right to be treated with respect, courtesy and consideration for their time. They also have the right to the undivided attention of the interviewer.

Responsibilities of participants

Be honest and open

It is crucial that participants provide honest opinions and factual information.

Clarify questions

Participants must stop and ask for clarification if needed, otherwise the evaluator might collect distorted information.

Express concerns

It is important that participants feel comfortable to express concerns with the evaluator, for example, use of certain language or terminology, or a lack of privacy.

Rights of evaluators

Right to information

At the stage when the terms of reference are put together, evaluators have the right to know the purpose of the evaluation in the wider context of the organization, and the roles and backgrounds of team members.

Right to access and continuity

Evaluators have the right to access any documentation, data sources and informants/interviewees that are needed to complete the evaluation.

Right to support and infrastructure

Evaluators, like other service providers, should have the support and infrastructure they need to implement the task in an efficient and effective manner.

Right of inclusions or omissions

Evaluators have the right to include additional facts as relevant which may be outside the agreed terms of reference. At the same time, they have the right to omit facts and information in the public document, if they have the potential to disclose participants' identities with negative consequences.

Right to be free of any influence

Evaluators should have the freedom and flexibility to provide feedback on evidence-based findings and recommendations without having to worry about personal repercussions.

Responsibilities of evaluators

Seek the truth

Evaluators should always put the facts together in an independent and objective manner on the basis of evidence. If evidence of wrongdoing comes to light during the process, it is always advisable to consult with key stakeholders to agree on whether this evidence is reported widely.

Know your approach

Evaluators should be knowledgeable about which approaches/methodologies to use, when and where. They should possess the right set of skills, have the necessary experience, and be methodical and systematic in following these approaches.

Validate information

It is the responsibility of evaluators to cross-check the validity of the data gathered from multiple sources. In situations where triangulation (cross-checking the data from at least three different sources or methods) is not possible, it is still important that some validity checks are put in place.

Be non-judgemental

Evaluators should accept all the information and responses as they come and not allow their own opinions or beliefs to distort them in any way.

Clarify the terms of reference

Evaluators should clarify the terms of reference with the whole team and flag up any concerns before the evaluation process begins. This will avoid confusion later if any of the team members do not want to take part in a certain aspect of the process due to cultural, religious or any other reason.

Request permission, clearance and informed consent

Evaluators should always request permission and consent as appropriate before any information is sought. Any clearance from relevant senior management should be obtained before publishing information, pictures and observed facts.

Consider and respect the needs of the respondents

Evaluators should always be aware that participating in an evaluation process can be uncomfortable for participants. Therefore it is the evaluator's responsibility to make the participants feel at ease in providing information, particularly when it involves sensitive issues and personal questions.

Beware of restrictions and limitations

In some situations, participants are not allowed to give certain information, nor can the evaluator report on particular issues. The reasons may be political, cultural or religious, and it is important that the evaluator and those commissioning the evaluation understand these issues at the outset.

Manage expectations

It is important that the evaluator is honest and open about the purpose and scope of the evaluation and does not make any false promises to the respondents. For example, participants sometimes expect renewed funding or other resources. It is the evaluator's responsibility to clarify that the purpose of the evaluation is to reflect and learn and to improve effectiveness, and will not necessarily result in future funding.

Provide feedback

It is crucial that the evaluators share their findings with as many stakeholders as possible and all those involved in the evaluation. This may involve dissemination of the final evaluation report but feedback should also be provided in ways more appropriate to, for example, participants and other stakeholders, via debriefing meetings and in short summary reports produced in the local language where relevant.

Safeguard participants' anonymity and confidentiality

Evaluators have a responsibility to protect the confidentiality and anonymity of the participants. Where there is an exception to this, the evaluator should seek informed consent from the participant at all times.

Be culturally sensitive

Evaluators should learn about the diverse way of life and customs in different parts of the world, acknowledging and respecting these.

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- 1 Adapted from: UNFPA. (2004) *Programme manager's planning monitoring and evaluation toolkit, tool number 2: Defining evaluation*. New York.
 - 2 Watts, J. (2005) *Learning-oriented evaluation: A tool for promoting institutional learning and program improvement*. ILAC Brief No.3. Institutional Learning and Change (ILAC) Initiative. Rome.

Section 2

Monitoring and evaluating projects at IPPF

Developing a monitoring and evaluation plan

A monitoring and evaluation plan ensures that project information is available as and when it is needed to make decisions and improve performance. It also provides information to demonstrate accountability to service users, other beneficiaries, donors and stakeholders.

Drawing on lessons learned from previous interventions, a monitoring and evaluation plan should be developed for each project. Monitoring and evaluation plans support regular monitoring of projects so that decisions can be taken and adjustments made as necessary throughout the duration of each project, and to ensure that progress is documented and lessons are learned. Monitoring and evaluation plans should be finalized shortly after the project logical framework is signed off and before project activities are implemented.

A monitoring and evaluation plan should seek answers to the following questions:

- What do we need to monitor and evaluate – and why?
- What tools and/or methodologies will we use?
- Who will do what?
- When will we do it?
- How much time will it take to implement each of the planned monitoring and evaluation activities?
- How much will it cost?
- How will the findings be shared and utilized?

Before developing a monitoring and evaluation plan, we need to have clarity on the following:

- project logical framework and activities
- indicators and targets set against the project objectives
- evaluation questions
- studies previously undertaken on similar interventions
- data collection and analysis mechanisms, including collection of age and gender data
- how the data will be used, and by whom
- resources available (people, time and finance)

Here are some practical steps to follow when developing a monitoring and evaluation plan.¹

Step 1: Check the project design

- review the project logical framework and work plan
- ensure that objectives are clearly stated and measurable
- ensure that evaluation questions are focused on the primary purpose of the evaluation activities and prioritize the critical questions to ask
- ensure that indicators are clearly stated including quantity and quality

Step 2: Assess capacity for monitoring and evaluation

- identify what human and financial resources are available
- assess training requirements for all staff who will be involved in monitoring and evaluation
- specify training requirements

Step 3: Plan for data collection and analysis

- check existing information sources for reliability and accuracy to determine what data are already available
- decide what information should be collected for baseline purposes, and for monitoring and evaluation needs
- ensure that data on age and gender are collected to permit age and gender analysis
- set a timeframe and schedule for data collection and processing, and agree on responsibilities

Step 4: Prepare the monitoring and evaluation plan and budget

- summarize agreed evaluation questions, information needs, data collection, information use, reporting and presentation
- summarize capacity building and support requirements
- budget for all monitoring and evaluation activities and identify funding sources

Step 5: Plan for reporting, sharing and feedback

- design a reporting and feedback system to ensure that management have the information they need to take decisions

A sample monitoring and evaluation plan from one of IPPF's projects is provided in Appendix 2. However, it should be noted that each monitoring and evaluation plan should be tailored to the specific project, and this plan provides an illustrative example only.

Developing indicators

“An indicator is a marker of performance. It can be compared to a road sign which shows whether you are on the right road, how far you have travelled and how far you have to travel to reach your destination. Indicators show progress and help measure change.”²

Indicators are signs of progress and change that result from an activity, project or programme. The word indicator stems from the Latin words ‘in’ (towards) and ‘dicare’ (make known). Once developed, indicators provide guidance about what information should be collected and used to track progress.

Types of indicators

The following indicators are defined by what they set out to measure:

- 1 Input indicators:** these indicators measure the provision of resources, for example the number of full time staff working on the project.
- 2 Process indicators:** these indicators provide evidence of whether the project is moving in the right direction to achieve the set objectives. Process indicators relate to multiple activities that are carried out to achieve project objectives, such as:
 - What has been done? Examples include training outlines, policies/procedures developed, level of media coverage generated.
 - Who and how many people have been involved? Examples include number of participants, proportion of ethnic groups, age groups, number of partner organizations involved.
 - How well have things been done? Examples include proportion of participants who report they are satisfied with the service or information provided, proportion of standards, such as in quality, that have been met.
- 3 Output indicators:** these indicators demonstrate the change at project level as a result of activities undertaken. Examples include numbers of sexual and reproductive health services provided, and having a written HIV and AIDS workplace policy in place.
- 4 Outcome indicators:** these indicators illustrate the change with regard to the beneficiaries of the project in terms of knowledge, attitudes, skills or behaviour. These indicators can usually be monitored after a medium to long term period. Examples include the number of new contraceptive users in a community and the number of young women aged 12 to 13 years vaccinated with HPV vaccine.

- 5 Output and outcome indicators** are usually expressed as numbers, percentages, ratios/proportions, or as a binary (yes/no) value.

Point to remember:

In IPPF we refer to output and outcome indicators together as ‘results’ indicators.

- 6 Impact indicators:** these indicators measure the long term effect of a programme, often at the national or population level. Examples of impact indicators in sexual and reproductive health include maternal mortality ratio, HIV prevalence rate and total fertility rate. Impact measurement requires rigorous evaluation methods, longitudinal study and an experimental design involving control groups in order to assess the extent to which any change observed can be directly attributed to project activities.

For the reasons stated above, measuring impact is rarely feasible, nor appropriate, for most projects implemented by IPPF Member Associations.

The indicators used to measure the Millennium Development Goal 5 on improving maternal health are examples of impact indicators:³

Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

- 5.1 Maternal mortality ratio
- 5.2 Proportion of births attended by skilled health personnel

Target 5.B: Achieve, by 2015, universal access to reproductive health

- 5.3 Contraceptive prevalence rate
- 5.4 Adolescent birth rate
- 5.5 Antenatal care coverage (at least one visit and at least four visits)
- 5.6 Unmet need for family planning

Other types of indicators

Proxy indicators: these indicators provide supplementary information where direct measurement is unavailable or impossible to collect. For instance, if the contraceptive prevalence rate in a target population is unavailable, a proxy indicator derived from the contraceptive inventory data in the local clinics might be useful. Interpretation of proxy indicators should be done in a cautious and careful manner.

Quantitative and qualitative indicators: all the indicators discussed above can be categorized as qualitative or quantitative indicators on the basis of the way they are expressed. Quantitative indicators are essentially numerical and are expressed in terms of absolute numbers, percentages, ratios, binary values (yes/no), etc. Qualitative indicators are narrative descriptions of phenomena measured through people's opinions, beliefs and perceptions and the reality of people's lives in terms of non-quantitative facts. Qualitative information often provides information which explains the quantitative evidence, for example, what are the reasons for low levels of condom use; why do so few young people attend a sexual and reproductive health clinic; what are the cultural determinants that contribute to high levels of gender-based violence? Qualitative information supplements quantitative data with a richness of detail that brings a project's results to life.

It is important to select a limited number of key indicators that will best measure any change in the project objectives and which will not impose unnecessary data collection. As there is no standard list of indicators, each project will require a collaborative planning exercise to develop indicators related to each specific objective and on the basis of the needs, theme and requirements of each project.

Table 2.1 highlights some issues to consider when developing indicators.⁴

Table 2.1 Do's and don'ts when developing indicators

Do	Don't
<ul style="list-style-type: none"> • do choose indicators that are specific, simple and have clear meaning • do choose indicators that are comparable across the target population and over time • do agree with key stakeholders on the choice of indicators • do choose data that are easily available and inexpensive to collect where possible 	<ul style="list-style-type: none"> • don't lose sight of the objectives • don't assume that data will be available – confirm it beforehand • don't specify the direction of change (increase or decrease) expected (this is relevant only for the objective) • don't use indicators that need expert analysis unless you have the expertise • don't use more indicators than necessary

Project evaluation step by step

In this section, we present some simple steps to follow before, during and after a project evaluation, as well as guidelines on developing terms of reference to support the evaluation process.

Before the evaluation:

- identify clear objectives for the evaluation based on the approved project proposal and the logical framework
- identify and prioritize evaluation questions based on the monitoring and evaluation plan and the resources available
- identify methodologies and tools to be used throughout the evaluation
- develop terms of reference outlining the plan, timeline, methodology/data collection, costs, roles of team members, logistics requirements (see section on developing a terms of reference below)
- carry out a further review of documents

During the evaluation:

- conduct an initial briefing including a presentation, and question and answer session with the project implementation team
- carry out a further review of documents
- conduct in-depth interviews with key stakeholders
- hold meetings, interviews and/or focus group discussions with primary beneficiaries at a number of different sites
- undertake observation at the different sites
- review the functioning of the project management systems in place (data management, finance, logistics, human resources)

After the evaluation:

- process and analyze data collected
- produce draft report
- share findings and draft recommendations with all stakeholders and discuss
- finalize report
- disseminate report with a view to making the information accessible to as many people as possible in the most appropriate format

Developing a terms of reference

A terms of reference refers to a structured document explaining the purpose and guiding principles of an evaluation exercise. The terms of reference will specify the roles, responsibilities, organizations concerned, information required and expected output of the evaluation. It is a useful written plan of action and should answer questions on, for example:⁵

- Why is the exercise necessary?
- Why now?
- What will be covered and what will not be covered?
- How will the findings and learning be used?
- Who should be involved?
- What questions should be asked?
- What methodologies should be used for data collection and analysis?
- How much time is available for planning, implementing and reporting?
- What resources are needed/available?
- How should the findings and recommendations be presented and disseminated?
- How will the results be used?
- How will learning from the evaluation be implemented?

It is always a good idea to include the following with a terms of reference:

- conceptual framework of the project or project logical framework
- budget details
- map of project sites
- list of projects/sites to be visited
- evaluation mission schedule
- list of people to be interviewed
- project statistics, documents, reports already available

A sample terms of reference is provided in Appendix 3.

Needs assessments, baseline and endline studies

A needs assessment identifies the needs of the community and helps to design a project which responds directly to those needs as well as prioritizing activities in a resource-poor setting.

Baseline and endline studies collect and analyze data before and after the project intervention respectively. They help to demonstrate changes that take place over the lifetime of the intervention. Conducting baseline and endline studies is vital in providing evidence of progress made as a result of the intervention.

Table 2.2 highlights some of the differences between a needs assessment and a baseline study.

At IPPF, we strongly recommend that every project:

- is designed following a needs assessment to decide whether the intervention is necessary, to identify the target group and the most effective approaches to use, and to take into account previous experience and lessons drawn from similar interventions
- should be preceded by a baseline study to ensure that any changes resulting from the project's activities can be measured over time
- should be monitored to assess to what extent planned activities are carried out
- should conduct an endline study and a cost effectiveness analysis during the final evaluation

The following points outline the questions to be considered when planning a baseline or endline study.⁶

- What information is already available?
- What will the studies measure?
- Which data will effectively measure the indicators?
- Which methodology should be used to measure progress and results achieved against the project objectives?
- What logistical preparations are needed for collecting, analyzing, storing and sharing data?
- How will the data be analyzed?
- Who should be involved in conducting the studies?

Table 2.2 Differences between a needs assessment and a baseline study

Needs assessment	Baseline study
<ul style="list-style-type: none"> • a tool for project designing and planning • conducted before the project logical framework is finalized • to identify the needs of target community, and the programme strategies and activities that are best suited to meet the needs 	<ul style="list-style-type: none"> • a tool for project monitoring and evaluation • conducted after the project logical framework is finalized but before implementation of activities begin • to provide data against which progress can be monitored and assessed

- Does the team have all the skills needed to conduct the studies? If not, how will additional expertise be obtained?
- What will the financial and management costs of the study be?
- Are the estimated costs of the studies proportionate to the overall project costs?
- Are adequate quality control procedures in place?
- How will the study results/recommendations be used?

Point to remember:

Both baseline and endline studies should use the same methods of sampling, data collection and analysis, and collect the same data (set of indicators) for comparison.

Data collection

Once the monitoring and evaluation plan, including indicators, is finalized, we need to think about data collection. The key questions to address include:

- What type of data should we collect?
- When should we collect data (how often)?
- What methods and tools will we use to collect data?
- Where do we get the data from?
- How do we ensure good quality data?

What type of data should we collect?

There are two main types of data – qualitative and quantitative – and the type of data most appropriate for a project will depend on the indicators developed. Table 2.3 gives an overview of the key differences between qualitative and quantitative data.⁷

Qualitative data consist of perceptions, experience and opinions, and common questions to collect qualitative information might begin with ‘How did...?’, ‘In what way...?’, ‘In your opinion...?’ etc. Quantitative data involve numbers, percentages and ratios, and common questions to collect quantitative information might start with ‘How many?’, ‘What proportion of...?’ etc. The most common methods used in qualitative data collection are observation, focus group discussions and in-depth interviews. The most common methods of collecting quantitative data are quantitative surveys and secondary data review. Qualitative data can be categorized and quantified for the purpose of data analysis.

Table 2.3 Differences between quantitative and qualitative data

	Quantitative data	Qualitative data
Purpose	<ul style="list-style-type: none"> • provide quantifiable data to describe a situation (but not why the situation occurs) 	<ul style="list-style-type: none"> • provide an understanding of reasons, background information, perception, opinion and motivations
Sample	<ul style="list-style-type: none"> • usually a random sampling technique and a larger sample size are used; the samples are generally representative of the target group 	<ul style="list-style-type: none"> • usually a non-random sampling technique and a small sample size are used; the samples are not necessarily representative of the target group
Data collection	<ul style="list-style-type: none"> • structured questionnaire-based surveys and secondary document reviews 	<ul style="list-style-type: none"> • observation, focus group discussions and unstructured or semi-structured in-depth interviews
Data analysis	<ul style="list-style-type: none"> • most commonly statistical; findings are more conclusive 	<ul style="list-style-type: none"> • usually non-statistical; findings are non-conclusive and usually descriptive in nature
Presentation of findings	<ul style="list-style-type: none"> • easier to present and generalize findings with charts, tables and using statistical analysis 	<ul style="list-style-type: none"> • harder to interpret and therefore presenting findings as information can appear anecdotal
Utilization	<ul style="list-style-type: none"> • measure quantifiable changes to demonstrate results 	<ul style="list-style-type: none"> • develop understanding and sound basis for further decision making; answers the ‘why?’

Point to remember:

In the majority of cases, it is necessary to collect both quantitative and qualitative data and to use a variety of different methodologies to collect the data. This strengthens the results of the evaluation and reduces the chance of bias caused by any one particular method.

When should we collect data (how often)?

Frequency refers to how often the data should be collected (for example, annually, biannually, quarterly or monthly).

Timing refers to exactly when to collect data. Needs assessment data are collected before a project is designed, baseline data after the design but before implementation, and endline data can be collected at a point in time during the lifetime of the project (for example, at the mid-point) or after the project has ended. It is important to agree on both the frequency and the timing of data collection at the design and planning phase of the project.

It takes time and other resources to develop evaluation tools and instruments, administer them, and analyze and interpret the data. Data collection should therefore be frequent enough to provide the information needed to identify and correct problems but not so frequent that the burden outweighs the benefits and not enough time is available to analyze and actually use the data.

What methods and tools will we use to collect data?⁸

There are a variety of methods used to collect data, and the most common methodologies are described below. For each methodological approach, the advantages and disadvantages are presented in Table 2.4.

Surveys

Surveys are used by evaluators to gather data on specific questions. Performance data, demographic information, satisfaction levels and opinions can be collected through surveys which usually involve pre-set questions in a particular order or flow. The questions can be structured or semi-structured, open or close-ended in format. Surveys can be conducted face to face, by email or telephone, and they can also be self-administered.

Interviews

An interview is used when interpersonal contact is important and when the follow up of any interesting comments provided is desired. Interviews are best conducted face to face although, in some situations, telephone or online interviewing can be successful.

In structured interviews, a carefully worded questionnaire is administered. The emphasis is on obtaining answers to pre-prepared questions. Interviewers are trained

to deviate only minimally from the question wording to ensure uniformity of interview administration.

For in-depth interviews, no rigid format is followed, although a series of open-ended questions is usually used to guide the conversation. There may be a trade-off between a comprehensive coverage of topics and in-depth exploration of a more limited set of issues. In-depth interviews capture the respondent's perceptions in his or her own words. This allows the evaluator to understand the experience from the respondent's perspective.

In both cases, it is good practice to prepare an interview guide and to hold mock interviews to estimate the time required, to amend difficult questions or wordings, and to ensure that none of the questions are leading or prompting a specific answer.

In terms of qualitative data that can be used to gain insight into the achievements and challenges of a project, interviews with project staff and beneficiaries can be especially useful to answer questions like:

- How has the project affected you personally?
- Which aspects of the project have been successful, and why?
- Which aspects of the project have not been successful, and why?
- What needs to be done to improve the project?

Point to remember:

An interview is not an informal conversation. Getting the settings right and the questions focused are crucial in obtaining good quality data.

Observation

Observation gathers data on activities, processes and behaviour. It can provide evaluators with an opportunity to understand the context within which the project operates and to learn about issues that the participants or staff may themselves be unaware of or unwilling to discuss in an interview or focus group. Observation is a useful way to collect data on physical settings, interactions between individuals or groups, non-verbal cues or the non-occurrence of something that is expected.⁹

Data collected through observation should be documented immediately. The descriptions must be factual, accurate and thorough without being opinionated or too detailed. The date and time of the observation should be recorded, and everything that the observer believes to be worth noting should be included. No information should be trusted to future recall.

Point to remember:

An observer is not an onlooker and he/she always enters the scene with a carefully developed set of steps, instruments and protocols.

Focus group discussions

Focus group discussions combine elements of both interviewing and observation, and the explicit use of group interaction is believed to generate data and insights that are unlikely to emerge without the interaction found in the group. The facilitator can also observe group dynamics and gain insight into the respondents' behaviours, attitudes and relationships with one another.

Focus groups involve a gathering of eight to 12 people who share characteristics relevant to the evaluation questions. Originally used as a market research tool to investigate the appeal of various products, the focus group technique has been adapted as a tool for data collection in many other sectors.

Focus group discussions are useful in answering the same type of questions as those posed in in-depth interviews but within a social, rather than individual, setting. Specific applications of the focus group method in evaluations include:

- identifying and defining achievements and constraints in project implementation
- identifying project strengths, weaknesses and opportunities
- assisting with interpretation of quantitative findings
- obtaining perceptions of project effects
- providing recommendations for similar future interventions
- generating new ideas

An important tool for conducting focus group discussions is the guide that clarifies a list of topics and questions to be covered in the discussion. The guide serves as a memory aid for the facilitator.

Focus group discussions should not last longer than one to one and a half hours. The facilitator must keep the discussion flowing and make sure that one or two people do not dominate the discussion. It is also important that the moderator facilitates the discussion so that the participants do not feel they have to agree with one another or reach any kind of consensus.

Document studies

Reviews of various documents that are not prepared for the purpose of the evaluation can provide insights into a setting and/or group of people that cannot be observed or noted in any other way.

For example, external public records include census and vital statistics reports, county office records, newspaper archives and local business records that can assist an evaluator in gathering information about the larger community and relevant trends. These may be helpful in understanding the characteristics of the project participants to make comparisons between communities. Examples of internal public records are organizational accounts, institutional mission statements, annual reports, budgets and policy manuals. They can help the evaluator understand the institution's resources, values, processes, priorities and concerns.

Personal documents are first person accounts of events and experiences such as diaries, field notes, portfolios, photographs, artwork, schedules, scrapbooks, poetry, letters to the paper and quotes. Personal documents can help the evaluator understand an individual's perspective with regard to the project.

Document studies are inexpensive, quick and unobtrusive. However, accuracy, authenticity and access always need to be considered.

Table 2.4 Advantages and disadvantages of different methodological approaches

Advantages	Disadvantages
Surveys	
<ul style="list-style-type: none"> • can be less time consuming and less expensive to administer than other methods • can provide highly credible data when constructed with built-in cross-checks • can be administered to large groups of individuals • can be administered for self-completion by the respondents and offer anonymity if required • require less training for data collectors compared to other methods • distortion is less likely as written questions are asked in a pre-set order and answers are mostly recorded in writing 	<ul style="list-style-type: none"> • data entry and analysis can be time consuming • may be difficult to receive completed surveys from certain groups of stakeholders • need expertise to design the questionnaire • a pilot study might be needed to investigate whether a survey is the appropriate methodology to collect sensitive information • self-reporting may not always provide high quality data
Interviews	
<ul style="list-style-type: none"> • usually provide detailed data and new insights • the interviewer can explain or help clarify questions, increasing the likelihood of useful responses • allow the interviewer to be flexible in administering questions to particular individuals or in particular circumstances • can be done face to face, by telephone or email • interviewees can be anyone who has been involved with the project (staff, volunteers, beneficiaries, stakeholders) 	<ul style="list-style-type: none"> • can be expensive and time consuming • need well-qualified, skilled and trained interviewers • interviewee may wittingly or unwittingly distort information through recall error, selective perceptions, a desire to please the interviewer, the influence of stigma (perceived or real), cultural expectations, normative behaviour • volume of information may become too large to transcribe and analyze
Observation	
<ul style="list-style-type: none"> • provides direct information about the behaviour of individuals and groups • permits evaluator to enter into and understand the situation/context • provides good opportunities for identifying unanticipated outcomes • exists in natural, unstructured and flexible setting 	<ul style="list-style-type: none"> • expensive and time consuming • needs well qualified, highly skilled, trained observers • may affect behaviour of participants • selective perception of the observer may distort data
Focus group discussions	
<ul style="list-style-type: none"> • usually provide high quality data and new ideas • participants can reflect on their own views in the context of the views of others • can be very creative • group dynamics may provide additional data on the project • may allow topics to be explored in greater detail than during individual interviews • can throw light on unexpected effects/results of projects 	<ul style="list-style-type: none"> • can be expensive and time consuming • recruiting a somewhat homogeneous group of participants can be difficult • physical facilities and other logistical arrangements need to be organized • information provided is from the individuals participating in the discussion and so it may not be possible to generalize the data to the wider study population • participants may influence each other's opinions • need an experienced moderator/facilitator to keep the discussion on track
Document studies	
<ul style="list-style-type: none"> • available from normal day to day work so there are no extra costs or time involved in generating data 	<ul style="list-style-type: none"> • accuracy depends on the ability of the people responsible for the records • may lack data which are more critical

Table 2.5 provides key questions and data collection methodologies according to the most common objectives of any evaluation. These include relevance, effectiveness,

efficiency, sustainability, design, delivery process, causality and longer term effects.

Table 2.5 Key questions and data collection methodology¹⁰

Evaluation objective	Key questions	Data collection methodology
Relevance	<ul style="list-style-type: none"> • To what extent are project results in line with the needs and priorities of beneficiaries and the community? • To what extent are the project objectives consistent with national needs, government policies and priorities, and IPPF's mandate? • Does the target population consider the project objectives useful? • Are the project objectives complementary to other interventions in the area? 	<ul style="list-style-type: none"> • review of needs assessments and situation analyses, government policies, IPPF policies, Demographic and Health Survey reports • interviews with stakeholders, partners • interviews with project personnel
Effectiveness	<ul style="list-style-type: none"> • To what extent have project results been achieved? • Do the data collected provide adequate evidence regarding achievements? • What are the reasons for the achievement and non-achievement of project results? 	<ul style="list-style-type: none"> • review of service statistics • review of project reports • interviews with project personnel • focus group discussions with beneficiaries
Efficiency	<ul style="list-style-type: none"> • Did actual results justify the costs incurred? • Have resources been spent as economically as possible? • Did project activities overlap and duplicate other similar interventions? • Were there more efficient ways and means of delivering more and better results with the available inputs? • What has been the quality of day to day project management? 	<ul style="list-style-type: none"> • review of financial records • review of project results • key informant interviews with local implementing partners, local health authorities • literature review (comparison with similar interventions of other organizations)
Sustainability	<ul style="list-style-type: none"> • Is it likely that project activities will be sustained after the withdrawal of current support? • What is the degree of ownership of communities, beneficiaries and stakeholders? • To what extent is the project embedded in institutional/organizational structures? • Have project activities been integrated into the current practices of your and/or other organizations (government, NGOs, INGOs etc)? • Have resources been allocated by the counterparts to continue project activities? 	<ul style="list-style-type: none"> • community asset mapping • key informant interviews • review of Ministry of Health and other ministries, local authorities and non-governmental organizations
Design	<ul style="list-style-type: none"> • Are project strategies realistic, appropriate and adequate to achieve the results? • Are project results consistent with project objectives? • Are project indicators specific, practical and adequate? • Have external risk factors been identified? • Have execution, implementation, and monitoring and evaluation responsibilities been clearly identified? • Does the design address the prevailing gender situation? • Does the project include strategies for national capacity building? • Does the design establish linkages among project components? • Does the design ensure learning? 	<ul style="list-style-type: none"> • review of project documentation, log frame and reports

Table 2.5 Key questions and data collection methodology¹⁰ (continued from previous page)

Evaluation objective	Key questions	Data collection methodology
Delivery process	<ul style="list-style-type: none"> • How were activities implemented? • Were the planned outputs achieved? With adequate quality? Within the planned timeframe? • Was project management being executed in a cost effective and cost efficient way? Were financial, human and material resources being managed efficiently and responsibly? Were sound financial and equipment management procedures being practised? • Was the technical assistance provided appropriate and of good quality? • Did project information and monitoring data provide adequate information about the project? Were they used contribute to effective decision making during project implementation? 	<ul style="list-style-type: none"> • direct observation • key informant interviews: project coordinators; Ministry of Health and other involved ministries; local health authorities/local implementing partners; IPPF Member Association staff • focus group discussions with community representatives • review of documents and records • review of project monitoring and evaluation tools; midterm review reports
Causality	<ul style="list-style-type: none"> • What factors or events have affected project results? Were they internal or external? Were they expected or unexpected? • To what extent is it possible to establish a causal link between the project and its effects? 	<ul style="list-style-type: none"> • document search/project documentation • key informant interviews: project coordinators, project managers, implementing partners
Long term effects	<ul style="list-style-type: none"> • To what extent have the project goal and objectives been achieved? • What are the documented changes between the baseline and the endline data? • What have been the longer term effects (positive and negative, intended and unintended) of the project? • What change has the project made to the lives of beneficiaries? 	<ul style="list-style-type: none"> • baseline and endline survey reports • case studies • focus group discussions with beneficiaries • Demographic and Health Surveys and other population surveys, government surveys • interviews with key informants

Where do we get the data from?

A survey that includes each and every member of the study population is a census. It is the best way to learn all about a group but is impractical, time consuming and expensive. A common practice in evaluation, therefore, is to select a number of items or individuals from the entire group. These few individuals make up the 'sample' that is considered to represent the total study population and from which data will be drawn. The process of selecting the sample is referred to as sampling.

There are two major types of sampling, random and non-random sampling, and a number of sub-types within each group.

Random sampling¹¹

This is where all items or individuals have the same chance to be selected. It is systematic and rules out any bias of selecting a particular member of the population. The most common type of random sampling is simple random

sampling where each member in a population is allotted an identification number. The required number of samples is picked up manually or by consulting a random number generator (a book, calculator or computer) to provide a list of selected individuals. This method is recommended for small populations but gets very complicated to use in large populations where every person or item has to be listed before the random numbers can be drawn.

Other random sampling methods include systematic sampling where after the first item is selected at random as a starting point, subsequent samples are chosen with a uniform gap between each, for example every 15 minutes, every fifth head of household or every tenth person entering a community hall. Another random sampling method is stratified sampling which involves selecting samples from each 'strata' or group such as age, sex, marital status, etc.

Non-random sampling

This is where all items or individuals do not have the same chance to be included in the sample, and subjectivity plays a role in selection. Non-random sampling is often used in small scale monitoring and evaluation processes and is less time consuming. The most common types of non-random sampling include convenience sampling, where respondents are chosen arbitrarily and in an unstructured manner based on easy availability and/or accessibility; snowball sampling, which is a type of convenience sampling where existing study subjects refer others to be included; and purposive sampling, where the evaluator handpicks subjects 'on purpose' based on the information needs of the survey.

Sample size

Sample size refers to the number of items or individuals selected from the population. The two major considerations for selecting a sample size are quantity and quality. Quantity is important as the sample must be large enough to be representative of the study population and yet small enough for data to be collected and analyzed in a time efficient manner. The quality of the sample is also important as it needs to demonstrate all characteristics of the study population.

Key points to consider when deciding on sample size are:¹²

- methodology selected
- degree of accuracy required
- extent of variation in the population with regard to the study requirements
- time and money available

How do we ensure good quality data?

To ensure that the collected data are reliable and valid, a common method used is triangulation. The term is derived from an ancient sailing metaphor where sailors used several location points, mostly on the basis of the relative positions of the sun, moon and stars, to determine their positions and to navigate through uncharted waters. In the context of data collection, triangulation refers to the use of multiple methods. This increases confidence in the findings as the limitations of one approach can be compensated by the strengths of another, and because multiple and complementary data sets are more likely to lead to an increased understanding of complex situations.

Data analysis

Once data have been collected, the next step is to conduct an analysis to meet the needs of monitoring, evaluation and learning. Progress in technology and an increased availability of computer packages designed to analyze data have made analysis, particularly for voluminous data, much easier. There is a variety of off-the-shelf software available,

free of charge or at a competitive price. It should also be noted that, depending on the type of data available, analysis does not always have to be computer-based. What is most important is that data are analyzed in a way that provides answers to key monitoring and evaluation questions that are then used to increase performance, and not just to satisfy externally imposed reporting requirements.

Reporting monitoring and evaluation findings

It is vital that data collection and analysis result in reflection and learning, and that the findings are shared in an open and transparent manner with all the major stakeholders in the project.

An organization's culture, protocols, practices and available resources will influence the way that evaluation results are reported and to whom. Here we discuss the most common methods of reporting and the strengths and weaknesses of each.

Debriefing meetings

Debriefing meetings are utilized to present the findings and recommendations to various groups involved in the project. It is an effective way to get instant feedback from beneficiaries, project staff and/or funding agency representatives. Debriefing meetings need to be facilitated well and conducted in local languages, so that all participants get to put forward their views and the discussions are constructive.

Written reports

Written reports are the most common means of reporting. These usually have an executive summary, information on the background and context of the project, purpose, scope and focus of the project as well as the evaluation mission, methodology, findings, conclusions, lessons and recommendations (including an action plan for implementing the recommendations).

The risk with written evaluation reports is that they end up on a shelf with few stakeholders reading beyond the executive summary. Without a fully participative approach to the evaluation process and in the reporting stage, the risk is that the recommendations will not be followed up. This is particularly common with externally commissioned evaluations. For project beneficiaries and others who are unable to attend debriefing meetings, it is critical that they also get the chance to see the key findings from any evaluation and provide feedback. This will probably mean translating at least the summary report and recommendations into a local language(s), and ensuring that any technical jargon is limited.

In any report, it is recommended that the findings are presented in a variety of forms combining both text and graphics, and that the length of the report is limited to avoid unnecessary information overload. Simple bar and

pie charts are often easier to understand than long tables with numbers. We provide a suggested outline of a final evaluation report in Table 2.6 as a sample.

Table 2.6 A sample table of contents page for a written report of a final evaluation

Title	Page number
Acknowledgements	
Map of the project area	
Executive summary	
Main findings and recommendations	
1 Introduction	
1.1 Background and context	
1.2 Terms of reference	
2 Project relevance and innovation	
2.1 Relevance of project design	
2.2 Relevance of project objectives	
2.3 Innovation	
3 Achievement of project objectives and targets	
4 Gender and rights issues	
5 Management and use of knowledge information systems	
6 Monitoring, evaluation, documentation and learning approaches	
7 Management	
8 Governance	
9 Financial issues	
9.1 Expenditure against approved budget with details	
9.2 Personnel costs	
9.3 Project income	
9.4 Cost effectiveness	
9.5 Financial analysis	
9.6 Financial procedures	
9.7 Reporting	
10 Sustainability potential	
11 Lessons learned	
12 Recommendations and action plan	
Appendices	
Acronyms	

Videos

Audio-visuals can be used effectively to provide evidence of change, to demonstrate how beneficiaries feel about a project and to initiate further discussion in other groups. Videos are often more engaging, accessible and convincing than a written report.

Point to remember:

Using a variety of different reporting methods suited to each audience works best in most situations.

Table 2.7 illustrates the strengths and weaknesses of each of the above reporting methods and issues to consider when using the different methods.

Utilizing evaluation information

IPPF's Monitoring and Evaluation Policy stresses the importance of monitoring, evaluation and learning for organizational effectiveness, ongoing reflection on how to strengthen our performance, and for high quality reporting to those we serve (our clients) and to those who support our work (our donors). IPPF also has an Organizational Learning strategy which emphasizes the importance of learning at individual, programme and organizational levels (Appendix 4).

For Member Associations, monitoring and evaluation information is valuable when it is recognized and used by project staff and decision makers to improve performance of projects. For this to happen, the use of monitoring and evaluation information needs careful consideration at the planning stage, for example when developing a monitoring and evaluation plan, and in collaboration with all potential users. This increases the chances of collecting and then using the information to make key decisions, implementing recommendations made and informing project design in the future.

Table 2.7 Reporting evaluation findings – strengths and weaknesses

Methods	Strengths	Weaknesses	Things to consider
Debriefing meetings	<ul style="list-style-type: none"> participants can clarify questions, raise issues and comment on things they do not agree with do not depend on literacy level of audience 	<ul style="list-style-type: none"> if not facilitated well, all participants may not get a chance to contribute getting people together is time consuming for face to face meetings, logistics need to be organized might be expensive may need more than one meeting to reach all groups involved/interested 	<ul style="list-style-type: none"> facilitation visual presentation adequate time for discussion
Written reports	<ul style="list-style-type: none"> can be read in own time can be referred back to at any point in time for information can be used to follow up recommendations or to quote from 	<ul style="list-style-type: none"> only accessible to literate people no immediate way for readers to clarify difficult words/terminologies usually written in only one language translation is expensive 	<ul style="list-style-type: none"> length of the report flow of the contents language – in more than one language, as well as simplicity and clarity use of charts, diagrams and tables
Videos	<ul style="list-style-type: none"> easily engaging more convincing can be utilized to demonstrate change 	<ul style="list-style-type: none"> expensive to prepare need some technical knowledge/expertise to record/edit consent and ethical issues might lead to conflict 	<ul style="list-style-type: none"> appropriate language cultural sensitivity on certain issues people with required skills

To draw up an effective utilization plan, the following questions need to be addressed.

- Who is likely to use the evaluation information? For what purpose?
- What decisions, if any, are the evaluation findings expected to influence?
- How much influence do you expect the evaluation to have – realistically?
- How will we know afterwards if the evaluation was used as intended? (In effect, how can use be measured?)

In the context of learning organizations, accountability focuses not simply on the findings themselves and sharing them with both internal and external audiences, but on the decisions that are made as a result of the findings.¹³

There are four main steps in utilizing evaluation information, as follows:

reflect: relate the findings back to the project objectives and try to assess what worked, what did not work so well and what could have been improved/done differently

follow up: on recommendations made and monitor progress

apply: recommendations and learning to future projects

share: as widely as possible – not only the evaluation findings but the applications and reflections as well

Data use in advocacy and resource mobilization

Reliable data contribute to strong evidence-based advocacy. This includes all levels of advocacy – community, national, regional and global. Reliable data are also a source of information on which to base project planning and identify future funding needs. Available data from previous evaluations should be referred to, as much as possible, when developing project proposals.

Participation of stakeholders in evaluation

Project stakeholders include any people who are affected by or involved in a project. These may include members of the community, project staff, programme managers, donors, government workers and, of course, service users and other project beneficiaries.

The active involvement of multiple stakeholders in monitoring and evaluation can be of significant benefit to both the participants themselves, as well as in increased effectiveness and performance of the project. Involving project beneficiaries provides insight into the project's outcomes from their own perspectives and ensures that any evaluation information is relevant in the local context. It also contributes to a feeling of ownership of results from all stakeholders and promotes the use of information to improve decision making and support change. Involving stakeholders in monitoring and evaluation can range from a minimal role as interviewees, to an extensive role where stakeholders are active members in the evaluation team.

Table 2.8 illustrates some of the key differences between conventional and participatory monitoring and evaluation.¹⁴

Table 2.8 Differences between conventional and participatory monitoring and evaluation

Conventional monitoring and evaluation	Participatory monitoring and evaluation
<ul style="list-style-type: none"> • aim to make a judgement on the project for accountability purposes • strive for 'scientific objectivity' of monitoring and evaluation findings, thereby distancing the external evaluators from the stakeholders • emphasize the needs for information of project funders and policy makers • focus on measurement of success according to predetermined indicators 	<ul style="list-style-type: none"> • aim to empower stakeholders • a process of individual and collective learning and capacity building of stakeholders • emphasize the needs of information for the project implementers and people affected by the project • a flexible process, continuously evolving and adapting to the project's specific circumstances and needs

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- 1 Adapted from: International Federation of Red Cross and Red Crescent Societies (2002) *Handbook for Monitoring and Evaluation*. Geneva. 1st Edition.
 - 2 Feuerstein, MT (1986) *Partners in evaluation: Evaluating development and community programmes with participants*. Macmillan: London.
 - 3 MDG Monitor, Tracking the Millennium Development Goals. Available at: <http://www.mdgmonitor.org/goal5.cfm> (Date accessed 26/11/08)
 - 4 Adapted from: UNESCO (2004) Session notes, session 8: Understanding and using indicators, Asia-Pacific regional training workshop on cultural mapping and cultural diversity programming lens to safeguard tangible and intangible cultural expressions and protect cultural diversity. Bangkok. Available at: www.unescobbkk.org/fileadmin/user_upload/culture/Cultural_lens/Introduction_to_Indicators.doc (Date accessed 26/11/08).
 - 5 Adapted from: Warburg, A (2006) *Toolkits: A practical guide to planning, monitoring, evaluation and impact assessment*, Save the Children UK.
 - 6 Adapted from: AusAID (2005) *AusGuide – A guide to program management*. Australia. Available at: <http://www.ausaid.gov.au/ausguide/default.cfm> (Date accessed 26/11/08).
 - 7 Adapted from Snap Surveys. Qualitative vs Quantitative Research. Available at: www.snapsurveys.com/techadvqualquant.shtml (Date accessed 26/11/08).
 - 8 Adapted from: Data gathering methods: an overview: Available at www.ceecis.org/remf/Service3/unicef_eng/module5/docs/5-1-2_overview-data-gathering-methods.doc (Date accessed 26/11/08).
 - 9 Frechtling, J and Sharp, L (eds) (1997) *User-friendly handbook for mixed method evaluations*. Division of research, evaluation and communication: National Science Foundation. U.S.
 - 10 Definitions adapted from: Australian Bureau of Statistics. Available at: http://www.abs.gov.au/WEBSITE/DBS/D3310116.NSF/A91A469056624A32CA256EB000026CA7/116E0F93F17283EB4A2567AC00213517!OPEN_DOCUMENT (Date accessed 26/11/08).
 - 11 International Finance Cooperation (2006) *IFC against AIDS: A practical guide to monitoring and evaluating corporate HIV/AIDS programs*, pp. 17. World Bank Group. Available at: [http://www.ifc.org/ifcext/aids.nsf/AttachmentsByTitle/Practical_Guide_to_Monitoring_and_Evaluating_Coporate_HIV_Programs/\\$FILE/Practical_Guide_to_Monitoring_and_Evaluating_Coporate_HIV_programs.pdf](http://www.ifc.org/ifcext/aids.nsf/AttachmentsByTitle/Practical_Guide_to_Monitoring_and_Evaluating_Coporate_HIV_Programs/$FILE/Practical_Guide_to_Monitoring_and_Evaluating_Coporate_HIV_programs.pdf) (Date accessed 26/11/08).
 - 12 Adapted from: UNFPA (2004) *Programme manager's planning, monitoring and evaluation toolkit: Tool Number 5: Planning and Managing an Evaluation, Part II: Defining Evaluation Questions and Measurement Standard*. New York. Available at: www.unfpa.org/monitoring/toolkit/tool5_2.doc (Date accessed 26/11/08).
 - 13 Patton, MQ (1999) Evaluation training lectures delivered to the Inaugural Conference of the African Evaluation Association, 13–17 September 1999. Nairobi.
 - 14 Adapted from: World Bank (2001) Tool number 4: Stakeholder participation in monitoring and evaluation. The programme managers monitoring and evaluation toolkit, pp. 2. Available at: http://gametlibrary.worldbank.org/FILES/463_Guidelines%20for%20Stakeholder%20participation%20in%20M&E.pdf (Date accessed 26/11/08).

Section 3

IPPF's global indicators programme

Introduction

IPPF's 30 global indicators are used by the Federation to monitor progress in implementing its Strategic Framework 2005–2015, and to identify areas where investment needs to be focused in future years in the pursuit of the Federation's strategic goals and objectives. The 30 global indicators are divided into the Five 'A's: adolescents, HIV and AIDS, abortion, access and advocacy.

IPPF's global indicators were approved by the Senior Management Team in January 2004. An online survey was then developed to collect data for the indicators, and piloted in 10 Member Associations. Feedback on the design of the survey was collected through a questionnaire completed by Member Associations as well as further discussions with IPPF colleagues.

Baseline data for the global indicators were collected in 2005, and the results from each subsequent year can be compared with these baseline data. Throughout this section, we provide examples of how the global indicators data can be graphically presented, at Member Association, regional and global levels.

Global indicators data collection and analysis

Global indicators data are collected annually from all IPPF Member Associations, both grant receivers and non-grant receivers. The collection of these data involves a major collaborative effort for Member Associations, Regional Offices and Central Office. All Member Associations are asked to complete an online survey, and those Member Associations that provide sexual and reproductive health services are also asked to complete the service statistics module. Both of these tools are located on IPPF's electronic Integrated Management System (eIMS).

Once submitted, the data are reviewed and cleaned by staff in the Regional Offices in consultation with each Member Association. Data cleaning guidelines are followed to ensure consistency and quality of the data submitted (Appendix 5). Once signed off by Regional Offices, a final check then takes place at Central Office before data analysis begins (Appendix 6).

Analysis of the service statistics data is aided by a number of system-generated reports available on the eIMS (Appendix 7). These reports permit analysis of service data at Member Association, regional, sub-regional and global levels, and by anyone working or volunteering for IPPF with access to the eIMS. Essentially, this means that at the click of a button, the reports provide information on, for example, the numbers and type of sexual and reproductive health services provided, couple years of protection, new users and service delivery points.

Data on services also allow IPPF to conduct a variety of interesting and useful analyses, including the proportion of contraceptive and non-contraceptive sexual and reproductive health services provided (Figure 3.1) and trends over time (Figure 3.2), service provision to young and adult clients, services provided by different types of service delivery points (clinical and non-clinical) and the estimated proportion of vulnerable clients served by Member Associations against their respective UNDP Human Development Index rankings¹ (Figure 3.3).

Figure 3.1 Percentage of contraceptive and non-contraceptive sexual and reproductive health (SRH) services provided, in year X

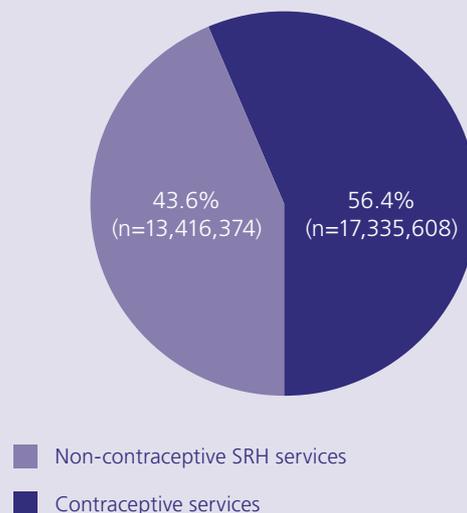


Figure 3.2 Number of contraceptive and non-contraceptive sexual and reproductive health (SRH) services provided, year X to year Z

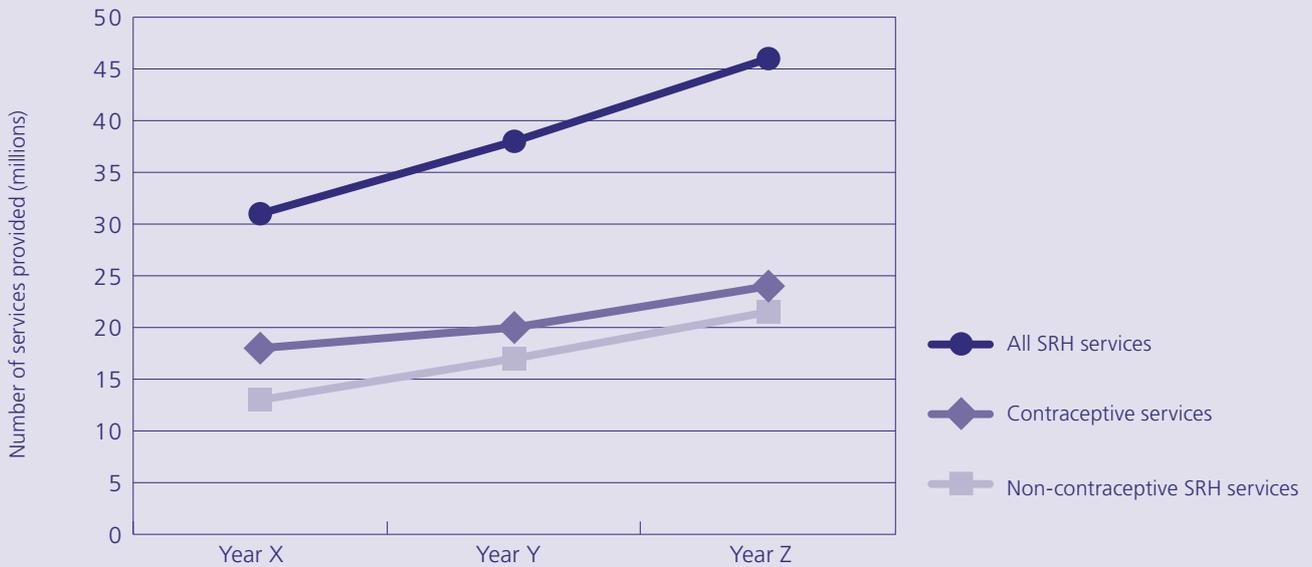
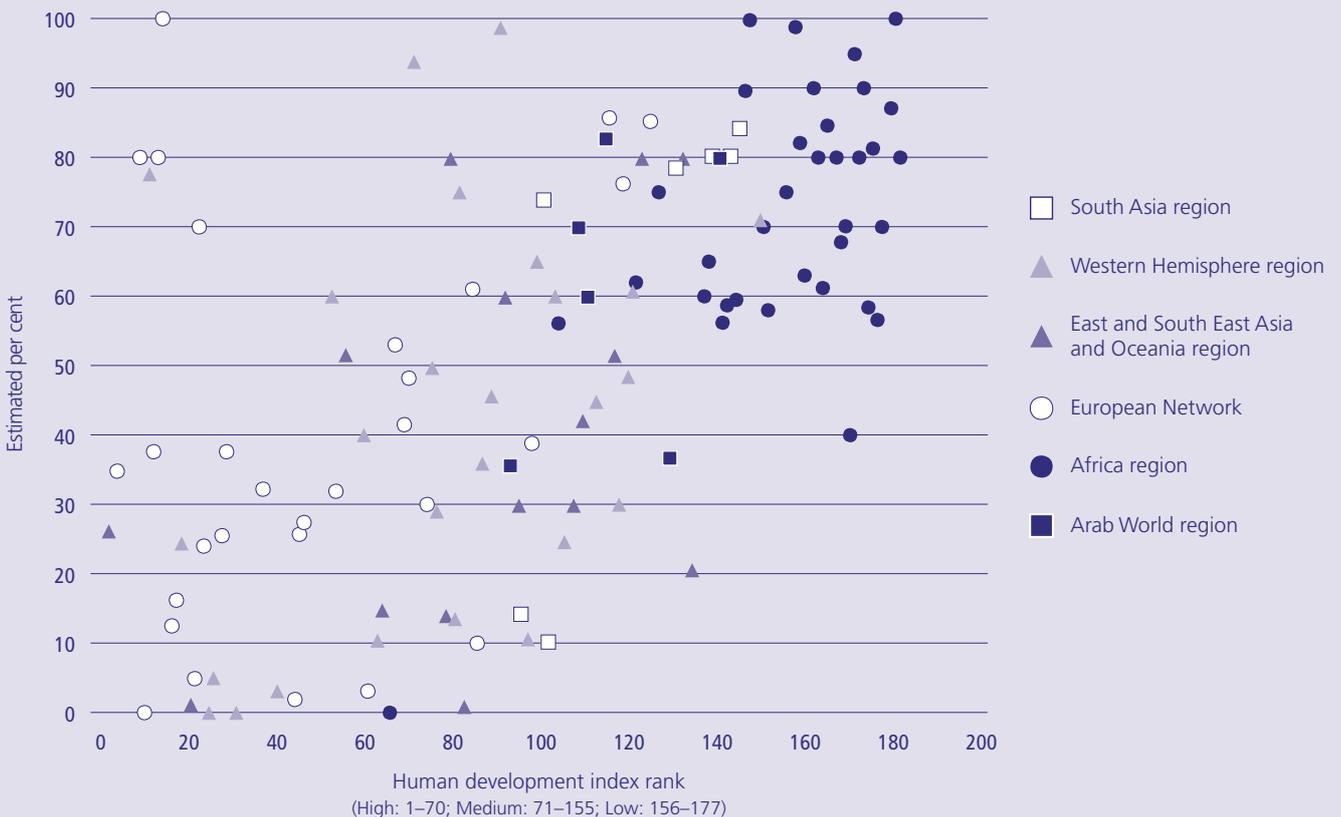


Figure 3.3 Estimated percentage of Member Association clients who are poor, marginalized, socially-excluded and/or under-served, by human development index rank



When designing the global indicators programme, we have been careful to make sure that all the data collected are used for a variety of different purposes and at different levels of the Federation. This ensures that Member Associations are not overburdened with reporting requirements that do not serve a function somewhere within IPPF.

Global indicators data reporting and utilization

IPPF's global indicators are reported on an annual basis in a number of key publications, including the Annual Performance Report, IPPF At a glance, various donor reports, and other regional reports such as regional annual reports.

The global indicators provide information to monitor the implementation of IPPF's Strategic Framework 2005–2015 at the global level, as well as monitoring progress in the implementation of strategic plans at regional and Member Association levels. Results are presented each year to IPPF's key decision makers on our Governing Council and on each of our six Regional Executive Committees to enable IPPF's volunteers to monitor progress, allocate budgets and make informed decisions.

Regional Offices use the global indicators data to prioritize and target activities, to identify where technical support needs are required in upcoming years and to make appropriate planning decisions to provide this support. Regional Offices also use global indicators data, alongside data on need, capacity and performance, to make decisions on allocating resources to Member Associations.

For each Member Association, global indicators data are used to inform decision making by governance and staff to improve programmes and performance. The survey and service data provide Member Associations with the opportunity to review their progress on an annual basis, view their own performance in comparison to others in the Federation, and to judge effectiveness and efficiency. Member Associations use the data to support resource mobilization and advocacy activities by sharing global indicators results and trends in performance over time with donors and other stakeholders. Results are also included in annual reports and proposals and this can make a significant difference in a Member Association's ability to raise resources at the local and national levels.

What global indicators do and what they don't do...

The majority of IPPF's global indicators are process indicators providing information on what IPPF Member Associations are doing in the Five 'A's. The indicators on

services are output indicators measuring the provision of sexual and reproductive health services provided by Member Associations, and another output indicator measures the estimated proportion of clients served by Member Associations that are poor, marginalized, underserved and/or socially-excluded. There is one outcome indicator which monitors the number of successful policy initiatives and/or positive legislative change in support of sexual and reproductive health and rights to which the Member Association's advocacy efforts have contributed.

This means that our global indicators do not provide information on the quality of all the services we provide, nor the long term effect (or impact) of the services on sexual and reproductive health. In addition, the indicators do not provide in-depth information or qualitative data on the projects implemented by Member Associations. This type of information is collected in project reports, annual reports, midterm reviews, evaluations and special studies, and is used to complement global indicators results.

For service provision indicators, trends analysis at the regional and global levels is challenging as the Member Associations reporting their data can differ slightly from year to year, making any one year's data set different from another. However, response rates being achieved are consistently high and, at the regional and global levels, trends analysis is now becoming less problematic than in the past.

Meaningful global, regional and trend interpretation and analysis of the data collected are also challenging as Member Associations operate in very different contexts, and it is important to recognize that global indicators data are most easily interpreted when analyzed in the local context.

Despite the challenges, the global indicators data offer IPPF an important opportunity to review progress on an annual basis, to conduct more extensive country-level analyses, and to offer a sign post showing where the most useful in-depth, qualitative research is needed.

Understanding our global indicators

Our 30 global indicators are divided across IPPF's five priority areas of adolescents, HIV and AIDS, abortion, access and advocacy. This section describes each of the global indicators. A more detailed explanation of how each indicator is calculated is provided in Appendix 8.

Adolescents

Indicator 1: Proportion of Member Associations with 20 per cent or more young people under 25 years of age on their governing board, by sex

This indicator monitors the extent to which Member Associations provide young people with the opportunity to participate in the governance of the Member Association. IPPF's policy on youth (approved May 2001) strongly recommends that at least 20 per cent of Member Association governing board members should be under the age of 25.

Data on the sex of young board members are also collected and recorded.

Indicator 2: Percentage of Member Association staff who are under 25 years of age, by sex

This indicator monitors the extent to which Member Associations involve young people in the day to day work of the organization. Member Association staff include all full time, part time, permanent and temporary staff employed by the Member Association at all levels and all sites (the headquarters, branches, project sites, clinical and non-clinical service delivery points) and who are paid a salary or are included on the payroll. This does not include young volunteers. The results of this indicator help Member Associations to reflect on the age composition of their staff and on whether young people are able to contribute to a Member Association's work programme, in a capacity other than as a volunteer.

Data on the sex of the youth staff members are also collected and recorded.

Indicator 3: Proportion of Member Associations providing sexuality information and education to young people

This indicator requires the Association to provide both sexuality information and sexuality education to young people. In IPPF, we differentiate these two terms as follows.

- Sexuality information involves generating and disseminating general and technical information, facts and issues to create awareness and knowledge on sexuality.
- Sexuality education seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality, physically and emotionally, individually and in relationships. Sexuality education recognizes that information on sexuality alone is not enough.

To qualify for this indicator, Member Associations are required to provide both sexuality information and sexuality education to young people. We record data on

the target groups reached by sexuality information and sexuality education programmes, as well as the different methodologies employed by Member Associations in providing sexuality education.

Indicator 4: Proportion of Member Associations providing sexual and reproductive health services to young people

This indicator requires the Member Association to provide at least one type of sexual and reproductive health service to young people. These services include provision of emergency contraception and other methods of contraception, abortion-related services, condom distribution, gynaecological services, sexually transmitted infection and HIV-related services (treatment, counselling and care), and various other types of counselling related to sexual and reproductive health.

These data provide us with information on the range of services provided to young people by Member Associations. Additional information is collected on the different client groups that access services, on whether young clients' perceptions on service provision are taken into account in all service delivery points, and on the training given to providers to ensure they can offer high quality youth friendly services.

Indicator 5: Proportion of Member Associations advocating for improved access to services for young people

This indicator requires the Member Association to conduct advocacy activities to increase access by young people to sexual and reproductive health services with at least one target group. The target groups for advocacy activities include young people, government/decision makers, community/religious leaders, lawyers/legal bodies, media, teachers/parents and youth organizations.

The results of this indicator illustrate the extent to which our Member Associations advocate for young people's rights to access sexual and reproductive health services and on which specific target groups they focus their advocacy.

Indicator 6: Number of sexual and reproductive health services (including contraception) provided to young people

These data are collected from the service records of each Member Association and are categorized by type of sexual and reproductive health service provided to young people.

The data can also be analyzed to show which service delivery points provide services to youth (static and mobile/outreach clinics, community-based distribution or other service delivery points) (Figure 3.4).

Figure 3.4 Number of contraceptive services provided to young people, by type of service delivery point

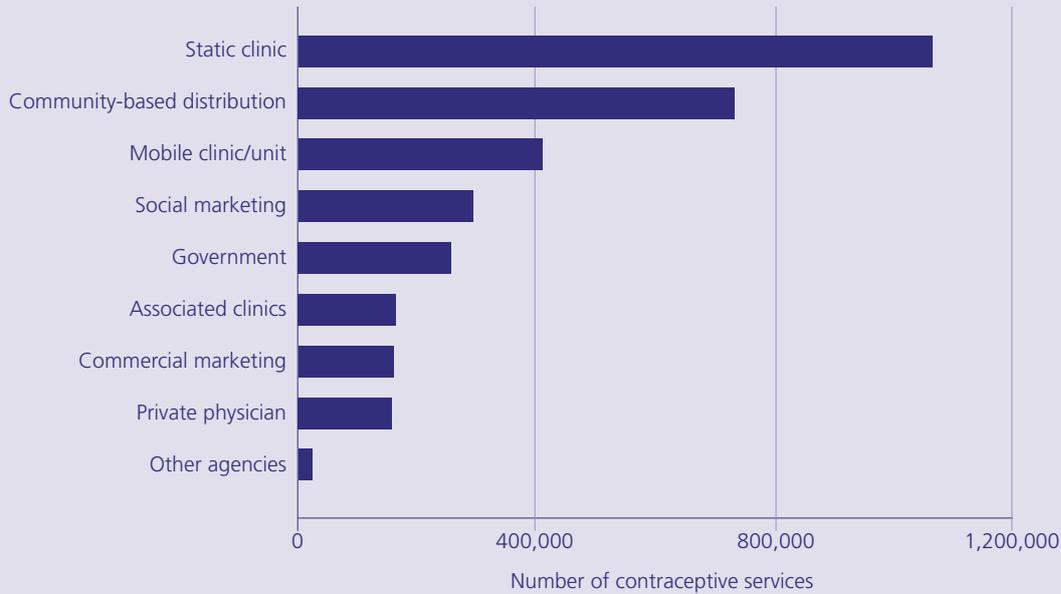
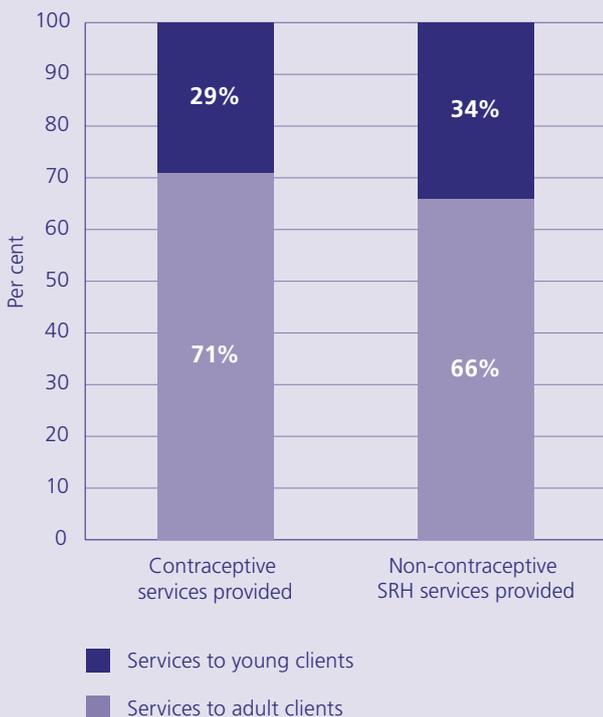


Figure 3.5 Percentage of sexual and reproductive health (SRH) services provided to young and adult clients



By recording the number of services provided to young people, we can also compare the numbers of sexual and reproductive health services that IPPF provides to young and to adult clients (Figure 3.5).

Point to remember:

For IPPF’s global indicators programme, we record the number of services provided to a client and not the number of clients or client visits. This is a more accurate way to measure IPPF’s performance, because by recording client numbers only we would get a significant underestimate of IPPF service provision as a client may be provided with several services during one visit. For example, during one visit, a client may receive the following services: a pregnancy test, pre-abortion counselling and a supply of condoms. This is recorded as three services provided, rather than one client or one visit.

HIV and AIDS

Indicator 7: Proportion of Member Associations with a written HIV and AIDS workplace policy

This indicator requires the Member Association to have a written HIV and AIDS workplace policy in place. The contents of the individual Member Associations’ policies are reviewed by the HIV and AIDS teams based in the Regional and Central Offices of IPPF.

Indicator 8: Proportion of Member Associations providing HIV-related services along the prevention to care continuum

This indicator requires the Member Association to provide at least six of the following nine HIV and AIDS services: information, education and communication/behaviour change communication; condom distribution; management of sexually transmitted infections; voluntary counselling and testing services; psychosocial support and counselling; prevention of mother to child transmission; treatment of opportunistic infections; antiretroviral treatment; and palliative care.

Requiring at least six of the nine services to qualify for this indicator ensures that Member Associations provide a mix of both prevention and care service elements that are essential in a comprehensive approach to HIV and AIDS.

Indicator 9: Proportion of Member Associations advocating for increased access to HIV and AIDS prevention, treatment and care, and reduced discriminatory policies and practices for those affected by HIV and AIDS

To score for this indicator, the Member Association is required to conduct both advocacy to increase access to prevention, treatment and care, and advocacy to reduce discriminatory policies and practices for those affected by HIV and AIDS. Information is also collected on the target groups of these advocacy activities including government/decision makers, lawyers, media, community leaders and religious leaders.

Indicator 10: Proportion of Member Associations with strategies to reach people particularly vulnerable to HIV infection

This indicator requires the Member Association to implement strategies to reach groups vulnerable to HIV infection including people living with HIV, sex workers, men who have sex with men, gay and bisexual men, injecting drug users, migrants and internally displaced people.

Additional information is collected on the details of the strategies and the services provided to these vulnerable groups.

Indicator 11: Proportion of Member Associations conducting behaviour change communication activities to reduce stigma and promote health-seeking behaviour

This indicator requires the Member Association to conduct behaviour change communication to reduce stigma associated with HIV and AIDS, and also to promote health-seeking behaviour among groups that are vulnerable to and affected by HIV and AIDS.

Additional information is collected on the details of the target groups as well as the behaviour change

communication strategies used to reduce stigma or promote health-seeking behaviour.

Indicator 12: Number of HIV-related services provided

These data are collected from the service records of the Member Association, and are categorized according to the different types of HIV-related services including sexually transmitted infection services, HIV prevention counselling, HIV voluntary counselling (pre- and post-test), HIV serostatus lab tests, opportunistic infection treatment, HIV psychosocial support and post-exposure prophylaxis, antiretroviral treatment, and AIDS home care treatment.

The data can be analyzed to show which service delivery points provide HIV-related services (static and mobile/outreach clinics, community-based distribution or other service delivery points).

Indicator 13: Number of condoms distributed

These data are collected from the service records of the Member Association. Data are available on the numbers of both male and female condoms that are distributed by Member Associations.

Abortion

Indicator 14: Proportion of Member Associations advocating for reduced restrictions and/or increased access to safe legal abortion

This indicator requires the Member Association to advocate for national policy and legislative change on abortion.

Information is also collected on the target groups of these advocacy activities, including government/decision makers, community/religious leaders, the general public, media, women's associations, health professionals and lawyers, as well as details on the strategic partnerships that Member Associations are involved in to advocate on abortion.

Indicator 15: Proportion of Member Associations conducting information, education and communication activities on (un)safe abortion, the legal status of abortion and the availability of legal abortion services

This indicator requires the Member Association to conduct information, education and communication activities on the three categories of: (un)safe abortion; legal status of abortion; and the availability of legal abortion services.

Information is collected on the target groups of the information, education and communication activities which include young people, female clients, men, women's groups, community groups, parents, community leaders and health professionals.

Indicator 16: Proportion of Member Associations providing abortion-related services

This indicator requires the Member Association to provide at least one of the abortion-related services, which include pre-abortion counselling, surgical abortion - dilation and curettage (D&C) or dilation and evacuation (D&E), surgical abortion (vacuum aspiration), medical abortion, post-abortion care, management of complications and incomplete abortion, and referrals to external abortion services.

Indicator 17: Number of abortion-related services provided

These data are collected from the service records of the Member Association, and are categorized as pre-abortion counselling, post-abortion counselling, induced surgical abortion, medical abortion, referrals to external abortion services and post-abortion care.

The data can be analyzed to show which service delivery points provide abortion-related services (static and mobile/outreach clinics, community-based distribution or other service delivery points).

Access**Indicator 18: Proportion of Member Associations conducting programmes aimed at increased access to sexual and reproductive health services by poor, marginalized, socially-excluded and/or under-served groups**

This indicator requires the Member Association to both implement programmes to increase access to sexual and reproductive health services by the poor, marginalized, socially-excluded and/or under-served groups and to advocate for the sexual and reproductive health and rights of the poor, marginalized, socially-excluded and/or under-served groups (Box 3.6). Information is collected on the different vulnerable groups targeted by projects, as well as the different types of initiatives undertaken, including subsidized services, specially adapted fee structures, community-based services, and outreach and mobile services.

Box 3.6 Definitions of poor, marginalized, socially-excluded and under-served groups

Poor: people living on less than US\$2 per day

Marginalized: people who for reasons of poverty, geographical inaccessibility, culture, language, religion, gender, migrant status or other disadvantage, have not benefited from health, education and employment opportunities, and whose sexual and reproductive health needs remain largely unsatisfied

Socially-excluded: people who are wholly or partially excluded from full participation in the society in which they live

Under-served: people who are not normally or well-served by established sexual and reproductive health service delivery programmes due to a lack of capacity and/or political will; for example, people living in rural/remote areas, young people, people with a low socio-economic status, unmarried people, etc

Indicator 19: Estimated percentage of Member Association clients who are poor, marginalized, socially-excluded and/or under-served

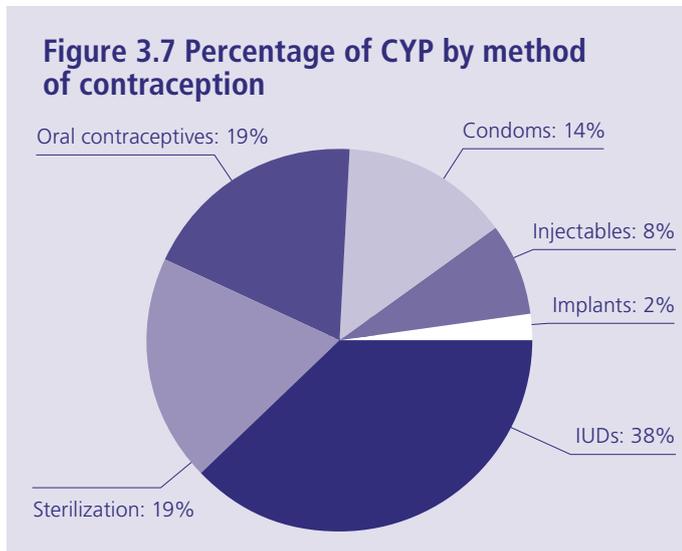
This indicator requires the estimated total number of clients served and the estimated number of clients served who are poor, marginalized, socially-excluded and/or under-served.

Member Associations are advised to be guided by the definitions of these categories but to bear in mind that the accurate collection of the data is challenging for two reasons. Firstly, in the different national and local contexts in which Member Associations work, there will be a variety of alternative ways of identifying clients who are vulnerable according to these four categories, and they may not be mutually exclusive. For example, in the majority of countries, sex workers will be both socially-excluded and under-served; all mobile health units will be providing services to marginalized groups who will also be under-served by established health service delivery programmes; and women, who make up the majority of the poorest of the poor, also remain marginalized in many parts of the world, as their gender alone acts as a barrier to health, education and/or employment opportunities.

Secondly, data collection on numbers of clients is challenging as IPPF's centralized data collection system does not currently require, nor support, the recording of numbers of clients. For this reason, we can only ask that Member Associations provide an estimate for this indicator.

Indicator 20: Number of couple years of protection, by method

These data are collected from the service records of the Member Association. Couple years of protection refers to the total number of years of contraceptive protection provided to a couple, and is reported by method of contraception from data on the numbers of items of contraception distributed (Figure 3.7). Couple years of protection (CYP) is calculated using internationally recognized conversion factors for each method of contraception (see Appendix 9 for conversion factors used).



Indicator 21: Number of contraceptive services provided, by type

These data are collected from the service records of the Member Association and are broken down by different types of contraceptive services provided. These include condoms, oral contraceptives, IUDs, emergency contraception, implants, injectables, sterilization, other hormonal and barrier methods, and contraceptive counselling (Figure 3.8).

The data can be used to highlight which service delivery points provide contraceptive services (static and mobile/outreach clinics, community-based distribution or other service delivery points).

Indicator 22: Number of non-contraceptive sexual and reproductive health services provided, by type

These data are collected from the service records of the Member Association and are categorized by the different types of non-contraceptive sexual and reproductive health services provided. The main categories include gynaecological services, maternal and child health services, sexually transmitted infection/reproductive tract infection services, HIV-related services, abortion-related services, urological and infertility services (Figure 3.9).

The data can be used to highlight which service delivery points provide non-contraceptive sexual and reproductive health services (static and mobile/outreach clinics, community-based distribution or other service delivery points) (Figure 3.10).

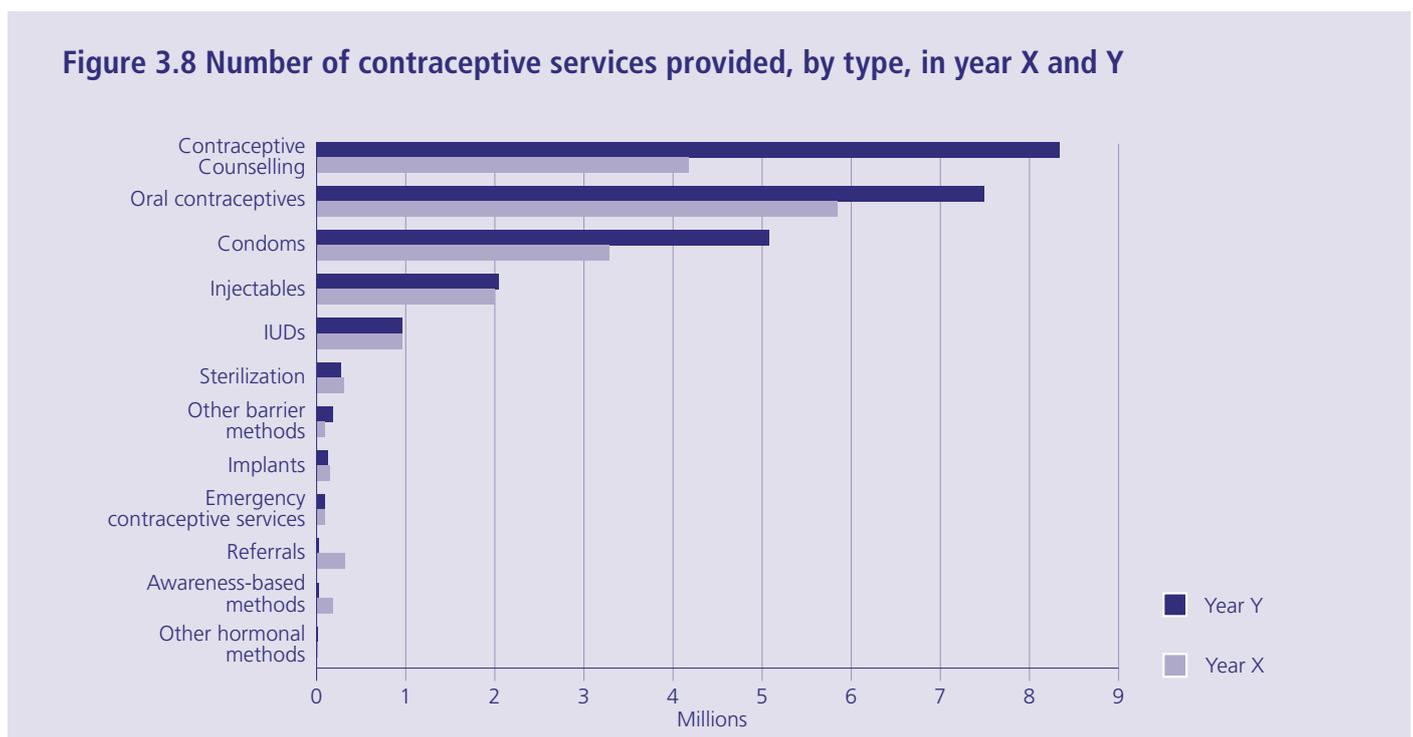


Figure 3.9 Number of non-contraceptive sexual and reproductive health (SRH) services provided, by type, in year X and Y

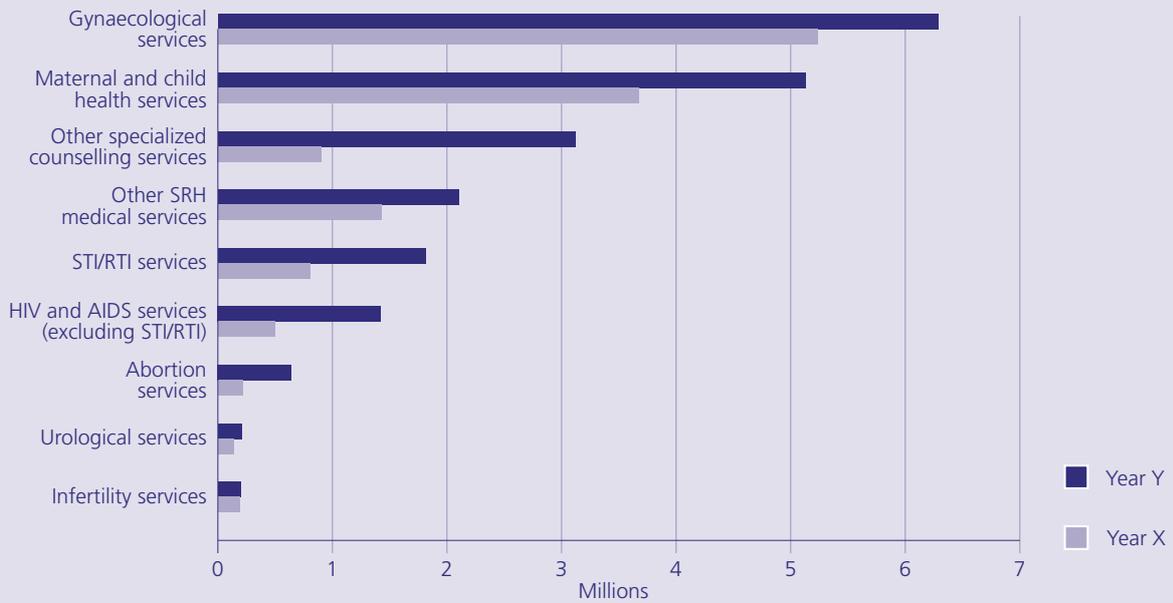
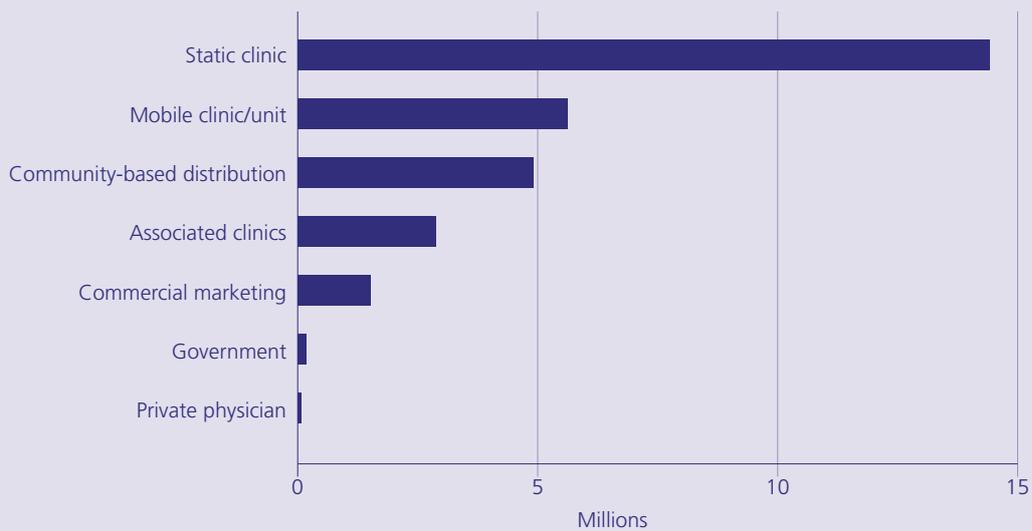


Figure 3.10 Number of non-contraceptive sexual and reproductive health services provided, by type of service delivery point



Indicator 23: Number of service delivery points by type

These data are collected from the service records of the Member Association that provide sexual and reproductive health services. The categories include clinic-based service delivery points (static and mobile clinics) and non-clinic-based service delivery points (community-based volunteers, social marketing outlets, private physicians, pharmacies, government clinics and other agencies).

Indicator 24: Proportion of Member Associations with gender-focused policies and programmes

This indicator requires the Member Association to have both a gender equity policy in place and to implement at least one type of gender-focused programme. These include women's empowerment, participation, women's rights in clinics, men's needs, men's role in gender equality, gender-based violence, gender capacity building, and monitoring and evaluation of gender programmes.

According to IPPF policy, each governing board should be made up of at least 50 per cent women, and additional information is collected by the global indicators survey on the gender of the Member Association's board. Data are also recorded on the proportion of female staff in management positions with supervisory and budgetary decision making responsibilities.

Indicator 25: Proportion of Member Associations with quality of care assurance systems, using a rights-based approach

For those Member Associations that provide clinical services, this indicator requires compliance with quality of care standards in all their clinics in the six categories as follows:

- adhere to written standards consistent with IPPF's 'Medical and Service Delivery Guidelines for Sexual and Reproductive Health Services'²
- have procedures to ensure clients' perceptions on service provision are taken into account (exit interviews, satisfaction surveys and mechanisms to implement recommendations)
- provide orientation/ongoing training to staff in all service delivery points (training on contraceptive technology, treatment for sexually transmitted infections, infection prevention and control, client rights)
- have mechanisms in place to assess technical competence of service providers
- implement strategies to assess the quality of care provided
- have the right conditions to deliver sexual and reproductive health services (adequate privacy and comfort, essential supplies, cleanliness, running water, electricity, accessibility)

Advocacy**Indicator 26: Proportion of Member Associations involved in influencing public opinion on sexual and reproductive health and rights**

This indicator requires the Member Association to have both a communications strategy to influence public opinion on sexual and reproductive health and rights, and to conduct initiatives to influence public opinion on sexual and reproductive health and rights to support favourable policies and legislation.

Information is collected on the types of initiatives employed to influence public opinion including television, radio, newspapers, magazines, web-based media, community outreach, and working with religious and community leaders.

Indicator 27: Proportion of Member Associations involved in advancing national policy and legislation on sexual and reproductive health and rights

This indicator requires the Member Association to conduct advocacy activities to advance national policy and legislation on sexual and reproductive health and rights.

Additional information is collected on the types of activities undertaken to advance national policy and legislation such as direct lobbying, working with the media and public education, as well as on the groups targeted by these activities including government, religious and community leaders, the general public and the media. Finally, as this type of work requires strong partnerships with other organizations, information is collected on the partners working with Member Associations including other non-governmental organizations, governments, international organizations and the media.

Indicator 28: Number of successful policy initiatives and/or positive legislative change in support of sexual and reproductive health and rights to which the Member Association's advocacy efforts have contributed

This indicator requires the change in national policy or legislation to have taken place in the previous year (January to December). Information is collected on the situation before and after the change, and the Member Association's specific advocacy role (Box 3.11).

This indicator can also be positive if the 'change' involves a proposal to change a policy or law that would be harmful to sexual and reproductive health and rights, if that proposal was blocked through the advocacy efforts of the Member Association and its partners.

Box 3.11 Examples of successful policy initiatives and/or positive legislative change in support of sexual and reproductive health and rights to which the Member Association's advocacy efforts have contributed³

Following a long period during which the IPPF Member Association in **Portugal** advocated for changes in the abortion laws, in February 2007 a referendum to allow all women to seek abortion services on demand until the tenth week of pregnancy was held. The result was a majority vote in favour of changing the existing law.

In **Colombia**, the National Council on Health Safety now includes hormonal contraceptives and male condoms in the Compulsory Health Plan and the Subsidized Health Plan. The IPPF Member Association in Colombia provided technical assistance to the Council.

The **Gambian** Member Association successfully lobbied with government to include contraceptives in the list of essential drugs. The act was passed in parliament in 2007, and contraceptives are now formally recognized as essential drugs for the first time in the country.

In **Vanuatu**, there was no national policy on HIV and AIDS before 2007. The Vanuatu Member Association lobbied for the introduction of a policy and was invited to participate in the drafting committee. The policy was finally launched on World AIDS Day 2007.

Indicator 30: Proportion of Member Associations advocating for national governments to commit more financial resources to sexual and reproductive health and rights

This indicator requires the Member Association to provide information on at least one campaign that focuses on advocating for national governments to commit more financial resources to sexual and reproductive health and rights, within their national budget lines and/or in meeting their commitments to international agreements such as Cairo and Beijing.

Additional information is collected on key advocacy activities that Member Associations participate in, for example national development plans, poverty reduction strategy papers, sector-wide approaches and country coordinating mechanisms.

Using global indicators to monitor progress in IPPF's Strategic Framework

The global indicators are used to help IPPF monitor progress in implementing our Strategic Framework 2005–2015, and Table 3.12 illustrates the direct links between the global indicators and the Framework's 22 strategic objectives.

- 1 UNDP *Human Development Indices: A statistical update 2008*. Available at: <http://hdr.undp.org/en/statistics/> (Date accessed 26/11/08).
- 2 IPPF (2004) *Medical and service delivery guidelines for sexual and reproductive health services*. London. Available at: www.ippf.org/NR/rdonlyres/DD4055C9-8125-474A-9EC9-C16571DD72F5/0/medservdelivery04.pdf (Date accessed 26/11/08).
- 3 IPPF *Annual Performance Report 2007–2008*. Available at: www.ippf.org/en/Resources/Reports-reviews/Annual+Performance+Report+2007-8.htm (Date accessed 22/12/08).

Indicator 29: Proportion of Member Associations involved in counteracting opposition to sexual and reproductive health and rights

This indicator requires the Member Association to provide information on at least one opposition strategy that it is counteracting.

Information is collected on the different types of opposition strategies including misinformation of sexual and reproductive health and rights, undermining existing policy, blocking new policy supporting sexual and reproductive health, and defunding of sexual and reproductive health programmes.

Table 3.12 Linking IPPF's Strategic Framework objectives with global indicators

Strategic Framework objective	Corresponding global indicator
Adolescents	
Objective 1: To strengthen commitment to and support for the sexual and reproductive health, rights and needs of adolescents/young people	Indicator 5: Proportion of Member Associations advocating for improved access to services for young people
Objective 2: To promote participation of adolescents/young people in governance and in the identification, development and management of programmes that affect them	Indicator 1: Proportion of Member Associations with 20 per cent or more young people aged under 25 on their governing board, by sex
	Indicator 2: Percentage of Member Association staff who are under 25 years of age, by sex
Objective 3: To increase access to comprehensive, youth friendly, gender-sensitive sexuality education	Indicator 3: Proportion of Member Associations providing sexuality information and education to young people
Objective 4: To increase access to a broad range of youth friendly services	Indicator 4: Proportion of Member Associations providing sexual and reproductive health services to young people
	Indicator 6: Number of sexual and reproductive health services (including contraception) provided to young people
Objective 5: To reduce gender-related barriers and practices which affect the sexual and reproductive health and rights of young women	Indicator 2: Percentage of Member Association staff who are under 25 years of age, by sex
HIV and AIDS	
Objective 1: To reduce social, religious, cultural, economic, legal and political barriers that make people vulnerable to HIV and AIDS	Indicator 9: Proportion of Member Associations advocating for increased access to HIV and AIDS prevention, treatment and care, and reduced discriminatory policies and practices for those affected by HIV and AIDS
	Indicator 11: Proportion of Member Associations conducting behaviour change communication activities to reduce stigma and promote health-seeking behaviour
Objective 2: To increase access to interventions for the prevention of sexually transmitted infections and HIV and AIDS through integrated, gender-sensitive sexual and reproductive health programmes	Indicator 7: Proportion of Member Associations with a written HIV and AIDS workplace policy
	Indicator 10: Proportion of Member Associations with strategies to reach people particularly vulnerable to HIV infection
	Indicator 13: Number of condoms distributed

Table 3.12 Linking IPPF's Strategic Framework objectives with global indicators (continued)

Strategic Framework objective	Corresponding global indicator
HIV and AIDS (continued)	
Objective 3: To increase access to care, support and treatment for people infected by HIV and support for those affected by HIV/AIDS	Indicator 12: Number of HIV-related services provided
Objective 4: To strengthen the programmatic and policy linkages between sexual and reproductive health and HIV and AIDS	Indicator 8: Proportion of Member Associations providing HIV-related services along the prevention to care continuum Indicator 13: Number of condoms distributed Indicator 21: Number of contraceptive services provided, by type
Abortion	
Objective 1: To strengthen public and political commitment for the right to choose and to have access to safe abortion	Indicator 15: Proportion of Member Associations conducting information, education and communication activities on the nature of (un)safe abortion, the legal status of abortion and the availability of abortion services
Objective 2: To increase access to safe abortion	Indicator 14: Proportion of Member Associations advocating for reduced restrictions and/or increased access to safe legal abortion
Objective 3: To expand the provision of abortion-related services as an integral part of sexual and reproductive health services	Indicator 16: Proportion of Member Associations providing abortion-related services Indicator 17: Number of abortion-related services provided
Objective 4: To raise awareness among the general public, policy makers and key professional groups on the public health and social justice impact of unsafe abortion	Indicator 14: Proportion of Member Associations advocating for reduced restrictions and/or increased access to safe legal abortion Indicator 15: Proportion of Member Associations conducting information, education and communication activities on the nature of (un)safe abortion, the legal status of abortion and the availability of abortion services
Access	
Objective 1: To reduce socio-economic, cultural, religious, political and legal barriers to accessing sexual and reproductive health information, education and services	Indicator 18: Proportion of Member Associations conducting programmes aimed at increased access to sexual and reproductive health services by poor, marginalized, socially-excluded and/or under-served groups Indicator 24: Proportion of Member Associations with gender-focused policies and programmes

Table 3.12 Linking IPPF’s Strategic Framework objectives with global indicators (continued)

Strategic Framework objective	Corresponding global indicator
Access (continued)	
Objective 2: To strengthen political commitment and support for reproductive health programmes	Indicator 27: Proportion of Member Associations involved in advancing national policy and legislation on sexual and reproductive health and rights
	Indicator 28: Number of successful national policy initiatives and/or positive legislative change in support of sexual and reproductive health and rights to which the Member Association’s advocacy efforts have contributed
	Indicator 29: Proportion of Member Associations involved in counteracting opposition to sexual and reproductive health and rights
	Indicator 30: Proportion of Member Associations advocating for national governments to commit more financial resources to sexual and reproductive health and rights
Objective 3: To empower women to exercise their choices and rights in regard to their sexual and reproductive lives	Indicator 24: Proportion of Member Associations with gender-focused policies and programmes
Objective 4: To increase male commitment to sexual and reproductive health	There is no global indicator for this objective, although IPPF does implement programmes to increase male commitment to sexual and reproductive health.
Objective 5: To improve access to sexual and reproductive health information and sexuality education using a rights-based approach	Indicator 3: Proportion of Member Associations providing sexuality information and education to young people
	Indicator 19: Estimated percentage of Member Association clients who are poor, marginalized, socially excluded and/or under-served
	Indicator 21: Number of contraceptive services provided, by type
	Indicator 22: Number of non-contraceptive sexual and reproductive health services provided, by type

Table 3.12 Linking IPPF's Strategic Framework objectives with global indicators (continued)

Strategic Framework objective	Corresponding global indicator
Access (continued)	
Objective 6: To improve access to high quality sexual and reproductive health services using a rights-based approach	Indicator 19: Estimated percentage of Member Association clients who are poor, marginalized, socially excluded and/or under-served
	Indicator 20: Number of couple years of protection, by method
	Indicator 21: Number of contraceptive services provided, by type
	Indicator 22: Number of non-contraceptive sexual and reproductive health services provided, by type
	Indicator 23: Number of service delivery points, by type
	Indicator 25: Proportion of Member Associations with quality of care assurance systems, using a rights-based approach
Advocacy	
Objective 1: To strengthen recognition of sexual and reproductive health and rights, including policy and legislation which promotes, respects, protects and fulfils these rights	Indicator 27: Proportion of Member Associations involved in advancing national policy and legislation on sexual and reproductive health and rights
	Indicator 28: Number of successful national policy initiatives and/or positive legislative change in support of sexual and reproductive health and rights to which the Member Association's advocacy efforts have contributed
	Indicator 29: Proportion of Member Associations involved in counteracting opposition to sexual and reproductive health and rights
Objective 2: To achieve greater public support for government commitment and accountability for sexual and reproductive health and rights	Indicator 26: Proportion of Member Associations involved in influencing public opinion on sexual and reproductive health and rights
	Indicator 30: Proportion of Member Associations advocating for national governments to commit more financial resources to sexual and reproductive health and rights
Objective 3: To raise the priority of sexual and reproductive health and rights on the development agenda resulting in an increase in resources	Indicator 30: Proportion of Member Associations advocating for national governments to commit more financial resources to sexual and reproductive health and rights

Appendix 1

Monitoring, evaluation and learning checklist: a guide to assess capacity

IPPF's 'Monitoring, evaluation and learning checklist' is a guide for Member Associations to assess their capacity in monitoring, evaluation and learning and to identify areas that need strengthening. The checklist uses IPPF's Monitoring and Evaluation Policy as its key reference, and complements the membership standards and checks in IPPF's Accreditation System.

The checklist should be completed by a small group of Member Association staff involved in monitoring and evaluation. The results should be shared with

other key stakeholders including volunteers and senior management from the Association. A format for an action plan is provided to assist in building capacity in areas of monitoring, evaluation and learning identified as needing strengthening.

Instructions

Assess your Association's capacity in monitoring, evaluation and learning by answering 'yes', 'no' or 'partially' in the following checklist:

Monitoring and evaluation systems		yes	no	partially
1	Are sufficient financial resources allocated to monitoring and evaluation activities?			
2	Are monitoring and evaluation responsibilities included in the job descriptions of one or more members of staff?			
3	Do programme and monitoring and evaluation staff receive training/ refresher training on monitoring, evaluation and learning?			
4	Are project beneficiaries and stakeholders actively involved in the design and development of monitoring and evaluation plans, and the evaluation of projects?			
5	Do projects have monitoring and evaluation plans with indicators that measure project performance?			
Data management processes: capture, quality control and analysis		yes	no	partially
6	Is there a manual or computerized system(s) to assist in data collection, analysis and review?			
7	Are systems in place and checks regularly made to ensure quality control of data?			
8	Are systems in place to assess cost effectiveness?			
9	Are baseline surveys conducted before and endline surveys conducted after every project to provide evidence of change?			
10	Are data disaggregated by age and gender?			
Data utilization, learning and accountability		yes	no	partially
11	Does a needs assessment, which includes applying lessons learned from previous projects, take place before every new project?			
12	Are analyses of both performance and needs used to make programme and resource allocation decisions?			
13	Does the governing board use evidence, including monitoring and evaluation findings and global indicators, to monitor achievements and challenges, and to inform policy making?			
14	Are evaluation findings shared with volunteers, staff, external stakeholders and beneficiaries in appropriate and accessible formats (for example, debriefing meetings, donor reports, summary reports, etc)?			
15	Are your Member Association's global indicators results, including service provision data, disseminated widely to both volunteers and staff?			

Action plan format

On the basis of the results of the self-assessment, you may have ideas to implement certain activities to strengthen your Member Association's capacity in monitoring, evaluation and learning. Here is an action plan format to assist you.

Expected results	Major activities	Strategies	Resources	Timeframe	Person responsible
What do we want to achieve with regard to monitoring, evaluation and learning?	What do we need to do?	How do we do it?	What kind of support do we need to implement the activities?	When will we do it?	Who will ensure that it happens?

Appendix 2

A sample monitoring and evaluation plan

Title of project: Positive Vibes¹

Goal	To reduce HIV, sexually transmitted infections and unwanted pregnancy rates among Haitian youth aged 10 to 24 through a participatory street theatre approach focusing on positive sexuality messages, which will inform and empower youth to make informed decisions about, and act out, a healthy sexuality.			
Objective 1	By the end of the project period, increase awareness among in- and out-of-school Haitian youth (aged 10–24) in Jacmel, Port-au-Prince and Port-de-Paix of the availability of PROFAMIL's youth friendly services and of positive sexuality (including gender equity and decision making in relationships, and preventing HIV, unwanted pregnancy, unsafe abortion, etc) through participatory youth street theatre and a peer education network.			
Key activities	Indicators	Means of verification	Frequency of data collection	Person responsible
1.1 Provide upgraded training to peer educators in key areas of adolescent sexual and reproductive health, focusing on a sex-positive approach and provision of referrals 1.2 Involve all peer educators in supporting roles for street theatre production and in providing referrals to PROFAMIL services 1.3 Develop and implement promotional strategy for PROFAMIL street theatre 1.4 Peer educators conduct post-event qualitative interviews with youth audience to gather input on and assess effect of street theatre initiative	Results			
	Changes in young people's attitudes towards youth sexuality/their own sexuality through participation in street theatre or peer education	Post-test results	At each performance, analyzed quarterly	Peer educators and evaluation consultant
	Number of youth (approximately) in audience of performances, by site, by month	Project records	At each performance	Youth officers
	Percentage of youth respondents to street theatre who express absorption of positive sexuality messages ² and report knowing of PROFAMIL youth services post-test, by site, by month	Post-test results	At each performance, compiled quarterly	Youth officers
	Changes in peer educator attitudes towards youth sexuality and the effectiveness of their work as agents of change	Focus group results	End of project	Evaluation consultant
	Process			
	Number of performances, and approximate number of youth attending, by site	Project records	Quarterly	
	Number of peer educators retrained in key adolescent sexual and reproductive health topics, positive sexuality, and effective referral, by site, by topic	Training records (sign in sheet, etc)	Quarterly	Youth officers
	Number of referrals provided by peer educators to PROFAMIL youth services, by site, by month	Peer educator tracking sheet	Collected by peer educators throughout month, compiled monthly	Data clerk
	Promotional strategy developed and documented	Project records	Quarterly	Project coordinator

Objective 2	By the end of the project period, increase access to PROFAMIL's youth friendly sexual and reproductive health services (especially HIV prevention and condom promotion) in Jacmel, Port-au-Prince and Port-de-Paix and (including mobile health services) through adopting a sex-positive approach and a strong referral system linked with youth street theatre.			
Key activities	Indicators	Means of verification	Frequency of data collection	Person responsible
1.5 Recruit staff for all PROFAMIL Youth Clinics	Results			
1.6 Identify trainer to provide training/sensitization for providers/health promoters to ensure readiness and positive sexuality approach	Number of clinical sexual and reproductive health services provided to youth, by age, gender, site, type	Service statistics	Monthly	Data clerk
1.7 Hire social worker to provide counselling services at all three sites and to inform drama scenarios	Number of counselling services provided to youth, by site, by month, by topic/type	Counselling service statistics/records	Monthly	Data clerk
1.8 Research potential partners and create functioning referral network with other youth agencies (all three sites)	Number of contraceptives distributed to youth, by site, type of contraceptive, month (specify if distributed by clinic or by peer educators)	Service statistics	Monthly	Data clerk
1.9 Monitor effectiveness of referral systems (both with partner agencies and from peer educators), modify as necessary	Changes in adult staff attitudes towards the sexuality of young people	Focus groups	End of project	Evaluation consultant
1.10 Distribute condoms at street theatre and peer education events	Process			
	Number of providers trained in adolescent sexual and reproductive health topics and positive sexuality, by site, by topic	Project/training records	Quarterly	Youth officers
	Number of potential partners (youth-serving agencies) identified and contacted (related to referral)	Project records	Quarterly	Clinic Director
	Number of referrals to external youth-serving agencies provided to youth clients, by site, by month	Service statistics	Monthly	Data clerk

Objective 3	By the end of the project period, strengthen resource mobilization efforts to ensure the sustainability of PROFAMIL's youth programme and services by expanding efforts to reach new donors, particularly among the Haitian diaspora in the United States.			
Key activities	Indicators	Means of verification	Frequency of data collection	Person responsible
1.11 Train PROFAMIL staff in proposal development (training will be conducted by consultants)	Results			
	Overall funds raised to support PROFAMIL's youth programme and this project	Member Association financial records	Annual	IPPF/Western Hemisphere Region
1.12 Collaborate with IPPF to develop proposals and market PROFAMIL youth programme	Funds raised by 'Friends of PROFAMIL' to support youth programme and this project	Member Association financial records	Annual	IPPF/Western Hemisphere Region
	Process			
1.13 Test and promote fundraising aimed at generating financial support for PROFAMIL's youth programmes from the large middle class Haitian immigrant population in South Florida ('Friends of PROFAMIL')	Number of PROFAMIL staff trained in proposal development	Project records	Annual	Management team
	Number of proposals submitted to donors for continued project funding (written by trained PROFAMIL staff in collaboration with IPPF)	Project records	Annual	Management team

- 1 Association pour la Promotion de la Famille Haitienne (PROFAMIL) (2008) Positive Vibes: Innovation Fund/Adolescent Project. IPPF, Haiti
- 2 Expressing learning at least one of the following through viewing the street theatre: gender equity and decision making in relationships, and preventing HIV, unwanted pregnancy and unsafe abortion.

Appendix 3

A sample terms of reference

Terms of Reference (TOR) for a final evaluation of a sexual and reproductive health project

Background

'The Sexual and Reproductive Health Project' has been designed to improve the capacity of **[insert Member Association name]** to deliver a comprehensive package of sexual and reproductive health services. The project covers **[insert project sites]**. The project focuses on maternal mortality, sexually transmitted infections, HIV and AIDS.

The project objectives are in line with **[insert relevant global development framework, such as, ICPD and Beijing commitments, the UNFPA Strategic Direction and Multi-Year Funding Framework (MYFF) or other national policy frameworks like Health Sector Reforms, SWAPs, PRSPs]**. The Project's expected results are **[insert details from project proposal]**. The project started in **[insert month and year]** with **[insert approved total budget and currency]** for a **[insert number]** year(s) period of implementation.

Evaluation purpose

The evaluation will assess the relevance, efficiency, effectiveness, performance and sustainability of the project. The evaluation will also assess whether the project has resulted in positive changes in the sexual and reproductive health and rights of the service users. Lessons will be identified and the findings will be used to improve future programming.

Evaluation objectives

The objectives of the evaluation are:

- 1 to assess the relevance of the project with regard to priorities and policies of the national government, Member Association, IPPF Secretariat and funding agencies, and the needs of target groups
- 2 to assess the effectiveness of the project
- 3 to assess the progress according to the project objectives comparing actual and expected results as measured by the project's indicators (reference to the project logframe) and changes since the baseline study
- 4 to identify and document the factors for success (good practices) or failure and the reasons behind those
- 5 to assess the qualitative effects of the project on the target populations (for example, change in health seeking behaviour, attitudes, gender issues) and the community
- 6 to assess the efficiency of the implementation processes and strategies of the project
- 7 to assess the management of the project and its contribution to achieving the desired results
- 8 to assess project sustainability potential or the likelihood to continue project activities after the funding has been withdrawn (continuation, replication, adaptation, scaling up/down, ownership, community participation, decentralization, integration of project into health district plans, other source of funding, collaboration/handover with other non-governmental organizations, etc)
- 9 to draw lessons learned from the project to apply these lessons to future related projects and policy development
- 10 to make recommendations for future actions

Methodology

The evaluation will combine both qualitative and quantitative methods to gather relevant information. Desk reviews of existing reference documents, performance indicators as per project logframes, key informant interviews and focus group discussions with project staff, beneficiaries and other stakeholders will be used as data collection methods (list others you plan to use).

Point to remember:

Ensure that the methodology is participatory and helps to get views and perceptions from staff, beneficiaries, stakeholders and partners including frank discussion of problems and what did not work well. The evaluation methodology should capture not just what happened but also why and how.

Evaluation steps

- preparatory activities: review of project reports and documents, trip reports, statistics, collation and analysis of performance data
- evaluation activities: analysis of project performance data, review of implementation of recommendations from the midterm review, discussion/interview with project personnel, visits to project sites, observation of activities, meetings with partners and community representatives, focus group discussions with beneficiaries
- post-evaluation activities: preparation and dissemination of the final evaluation report, sharing of lessons learned and good practices

Timing and duration

The final evaluation of the project will be conducted during the last quarter of project implementation **[insert dates]**. It will last up to **[insert number]** working days (alter depending on the size and complexity of the project to be evaluated).

Team composition

The evaluation will be conducted by a joint team composed of staff from the relevant Member Association and **[insert other team members]**

Expected outputs

A debriefing meeting with the project staff and volunteers as appropriate and a final evaluation report in electronic format and hard copy in the agreed outline including a short and succinct Executive Summary, and recommendations. **[List any other expected outputs.]**

Attachments (examples):

- conceptual framework/project logical framework
- map of project sites
- list of projects/sites to be evaluated
- evaluation mission schedule
- lists of persons to be interviewed
- terms of reference for evaluators
- project statistics

Appendix 4

IPPF's Organizational Learning Strategy: 'Be brave, angry and smart' (2006)

"Organizational learning occurs when an organization becomes collectively more knowledgeable and skilful in pursuing a set of goals."¹

1. Introduction

To achieve the goals and objectives of IPPF's Strategic Framework 2005–2015, the Federation recognizes the importance of learning from its own experience and that of others, and of using its knowledge to increase organizational effectiveness. In 2006, a recognized expert in organizational learning was commissioned to carry out a consultation with IPPF's Secretariat (Central and Regional Offices). The subsequent report, 'Raising the profile of organizational learning in IPPF: Review findings and proposals' (2006), analyzed the Federation's current approaches to organizational learning and knowledge management and provided a series of proposals on how IPPF can build on its considerable strengths, address weaknesses and more fully realize the potential for organizational learning.

The organizational learning strategy presented here, '**Be brave, angry and smart**', builds on this work, and represents a 'global level' strategy for the Federation.² It is hoped that the new strategy will inspire all levels of the Federation to promote a strong learning culture.

2. What is organizational learning?

Organizational learning is the intentional use of collective and individual learning processes to continuously improve the organization's ability to achieve its mission and to increasingly satisfy its clients and those who support its work.

3. What does an organization need to do to learn?

Effective organizational learning requires a number of key functions to be undertaken by the organization.³ The following section describes the 'eight function model' used to analyze the Federation's current approaches to organizational learning, and provides examples of how IPPF is currently implementing many of these key functions.

Gathering internal experience

A process of gathering experience to enable the organization to be aware of what it does and the effects it has: mechanisms include strategic planning, documentation,

case studies, annual reports, evaluation and research reports, policy documents, meetings, workshops, trip and meeting reports, and informal contacts/exchanges.

Examples from IPPF

- twinning arrangements between Member Associations in western and eastern Europe
- end of project meetings to identify and share lessons learned
- focal point meetings on accreditation, evaluation, electronic Integrated Management System, finance, communication, etc
- technical advisers from Central and Regional Offices providing technical support to Member Associations on specialist areas
- prioritized focus countries for specific capacity building to provide models for scaling up

Accessing external learning

A process of sharing experience with and learning from others outside the organization, and subsequently bringing what has been learned back into the organization by sharing with other colleagues: mechanisms include networking, attending conferences and workshops, actively seeking opportunities for learning through joint initiatives, exchanges and secondments with other organizations.

Examples from IPPF

- contributing to international initiatives/partnerships
- shaping international and national sexual and reproductive health agendas
- participating in international networks and e-groups, conferences and workshops with coherent strategies and clear aims, messages and mechanisms for reporting back

Developing an organizational memory

Process by which an organization's accumulated knowledge and expertise is readily available to those who need it, when they need it: mechanisms include documentation, intranets and extranets, websites, teamwork, networking, and connecting people who have knowledge and expertise and are willing to share.

Examples from IPPF

- IPPF publications/documentation, news updates
- focal point groups

- email, e-groups, team working
- annual work planning and budgeting on the electronic Integrated Management System

Using communications systems to connect people and exchange information

The infrastructure that connects people and enables them to exchange information and knowledge: mechanisms include document sharing, email, newsletters, websites, face to face communication, meetings, online video conferences, podcasting.

Examples from IPPF

- newsletters, e-learning, websites, Skype
- SharePoint to provide different teams with shared space to work collaboratively
- open plan office, communal areas

Drawing conclusions

The process by which people convert information into useable knowledge by reflection, reviewing consequences, making comparisons and discussing with others: mechanisms include 'before, during and after' action reviews, thematic reviews and specially commissioned studies, evaluations and trip reports.

Examples from IPPF

- end of project meetings and publications
- trip reports, project documentation, programme reviews and themed reports, final evaluations, IPPF's Annual Performance Report
- study tours, exchange visits

Integrating learning into strategy and policy

Developing strategies, policies and resource allocation systems that draw on the knowledge and expertise within the organization: mechanisms include participatory learning and collaboration that can increase the commitment needed to implement.

Examples from IPPF

- exchange of knowledge and experience during the process of building IPPF's Strategic Framework 2005–2015
- IPPF policies on monitoring and evaluation, child protection and others
- provision of key information to IPPF's governing bodies as a basis for decision making
- joint participation and decision making by the Secretariat (Central and Regional Offices) in various initiatives (for example, the Innovation Fund, Quality of Care programme, global indicators programme)

Having a supportive culture for learning

A supportive culture that supports learning as a legitimate and valued activity and requires a positive attitude to learning from everyone: mechanisms include opportunity (time, space), recognition and reward for learning, open sharing of information, willingness to tackle difficult problems and challenges in an environment where innovation and creativity are valued and supported by senior management.

Examples from IPPF

- informal learning sessions, learning events
- human resource initiatives that recognize the importance of learning in annual performance appraisals, personal objectives and development plans etc
- divisional and cross-divisional sharing of expertise, collaboration, brainstorming

Applying learning

An organization systematically applies its learning, knowledge and expertise to both its own practices and policies, and to those of other organizations: mechanisms include implementing a strategy for scaling up which reflects learning about what has worked, using new knowledge and insight to improve effectiveness, innovation based on learning, pooling of experience to develop new programmes, dissemination of publications.

Examples from IPPF

- development and implementation of IPPF's accreditation system, review of project proposals (for example, the Innovation Fund), Member Association Analysis Process (Western Hemisphere Region)
- dissemination of publications
- divisional and cross-divisional sharing of expertise, collaboration, brainstorming to develop new initiatives
- feedback loops to ensure that the global indicators and evaluation results are drivers of planning and capacity building

4. Why is organizational learning important for IPPF?

Intellectual capital is an important asset for IPPF, and strengthening organizational learning in a more systematic way will have many benefits for the Federation. Without a learning culture, opportunities to identify and utilize learning to improve the effectiveness, efficiency and performance of IPPF's work will be missed.

Organizational learning is particularly important for IPPF in order to:

- increase organizational effectiveness (understanding what works in what circumstances requires the ability and willingness to learn from experience)
- develop organizational capacity (strengthening organizational capacity also requires the ability to reflect and learn from the organization's experience)
- make best use of limited resources
- strengthen partnerships that are built on transparent decision making, mutual respect and positive experiences of cooperation
- use information from monitoring and evaluation for future planning
- create a healthy organization (which is more effective and adaptable, and where people want to stay longer and contribute more)

5. IPPF's Organizational Learning Strategy

The Federation's approach to organizational learning emphasizes the role of learning by individuals, and in programme and organizational development; acknowledges the importance of both planned learning and learning that occurs unexpectedly; and recognizes the importance of Member Associations as the main source of the Federation's knowledge. These principles guide IPPF's organizational learning strategy, as follows:

Goal

IPPF has a culture and infrastructure that gains knowledge through controlled experimentation, observation, analysis, sharing and a willingness to examine both successes and failures, and that uses its knowledge to achieve the Strategic Framework 2005–2015.

Objectives

- 1 To empower IPPF volunteers and staff by creating a supportive culture for learning that provides encouragement, recognition, support, resources and time.
- 2 To strengthen systematic approaches, planning and processes that capture IPPF's institutional memory and good practices and that enable evidence-based decision making.
- 3 To increase the availability, access, quality and use of tools and systems that facilitate capture, storage, dissemination and use of information throughout the Federation.

6. Programme strategies

Objective 1: To empower IPPF volunteers and staff by creating a supportive culture for learning that provides encouragement, recognition, support, resources and time and, specifically, to:

- promote a climate of openness and trust where individuals are encouraged to speak out, develop and challenge ideas, and where learning from mistakes is valued as much as learning from success
- develop performance measures that reward and encourage investment in learning
- strengthen IPPF's commitment to learning and personal development to ensure there is time for staff to think and learn regularly
- conduct exit interviews that are designed to avoid institutional memory loss
- provide strong induction to new employees that emphasizes the importance of and responsibility of all IPPF staff in learning, and highlights the opportunities for learning provided by the organization

Objective 2: To strengthen systematic approaches, planning and processes that capture IPPF's institutional memory and good practices and that enable evidence-based decision making and, specifically, to:

- ensure all new and revised IPPF policies benefit from the Federation's knowledge and expertise
- ensure that learning is applied during all proposal development, strategic planning, and annual programme and budgeting processes
- conduct maintenance and regular review of IPPF's electronic Integrated Management System to ensure continuity and renewal of the approaches and processes
- ensure unprocessed information is transformed into organizational knowledge and available on the electronic Integrated Management System

Objective 3: To increase the availability, access, quality and use of tools and systems that facilitate capture, storage, dissemination and use of information throughout the Federation and, specifically, to:

- identify where different knowledge and expertise resides in Member Associations
- establish mechanisms for sharing knowledge and expertise laterally – across Regional Offices, across Member Associations and between Regional Offices and Member Associations – both within and across regions
- explore other avenues of 'connecting': collaboration and connection through staff profile pages, e-forums, list serves, team pages, podcasts, blogs, internal wiki pages, etc

- increase use of IPPF's electronic Integrated Management System by providing up to date relevant information and regular training, by improving the user friendliness of the system, and by strengthening current, and implementing new functionalities, in response to feedback from users, Regional Office focal points and the Central Office advisory board
- increase integration between the Federation-wide extranet and the Secretariat-wide new SharePoint-based intranet allowing different access points to upload, share and access information; this integration can extend towards the website to allow public sharing of knowledge
- establish and participate in partnerships with external organizations to learn from joint initiatives on organizational learning, knowledge management, and knowledge information systems and tools

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- 1 Britton, B (2006) *Raising the profile of organizational learning in IPPF: Review findings and proposals*, pp. 5. IPPF. London.
 - 2 This strategy was developed in 2007 and shared with the Swedish International Development Cooperation Agency (SIDA) in May 2007.
 - 3 Britton, B (1998) *The learning NGO*, INTRAC. Oxford.

Appendix 5

Guidelines for consistency checks of the global indicators online survey data

These guidelines provide a series of consistency checks that can be used by Member Associations before submitting data on the global indicators survey.

These checks have been highlighted specifically as it is in these areas of the survey that most inconsistencies are found. If followed, the checks listed below will guide the Member Associations to complete the online survey successfully, and ensure that the global indicators data are of good quality year on year.

- the number of governing board members should not be zero and should be the same when asked for in both the adolescent and access sections
- the number of **young** governing board members should not be more than the total number of governing board members
- the number of **female and male** governing board members should add up to the total number of governing board members
- if the Member Association employs young staff, their role(s) should be explained and numbers should be specified
- the total number of staff should not be zero and should be more than the total number of **young** staff
- the total number of staff should be more than the total number of staff in management positions
- a Member Association either has a written work place policy on the non-discrimination of people with HIV and AIDS, or they do not and are conducting internal advocacy to create one. The response should be yes to one of these options, and cannot be yes to both.
- the estimated number of Member Association's clients should not be zero (except for those who do not provide any clinical services; for IPPF, counselling is a clinical service) and counselling clients should be included in the total estimated number of clients
- the percentage of poor, marginalized, socially-excluded and/or under-served clients should be less than or equal to the total number of estimated clients. Use the definitions of these terms to guide you and do not just consider the financially poor clients but also those who are marginalized, socially- excluded and/or under-served
- the estimated number of Member Association's clients should not be more than the number of services provided (as reported in the service statistics module)
- if the Member Association reports providing a particular service in the survey (such as HIV and AIDS treatment, post-abortion counselling, pap smear tests, etc), there should be some corresponding data reported in the service statistics module indicating the number of those services provided
- make sure the services provided by a Member Association are reported consistently in the survey; for example, if a Member Association responds 'yes' to the provision of STI diagnosis and STI treatment in the adolescents section of the survey, there should be a corresponding 'yes' in the HIV and AIDS section of the survey
- any question which says '**If yes, please provide details**' should be filled in if the response is 'yes'
- if the Member Association reports contributing to any successful policy initiatives and/or positive legislative changes, **all** the following aspects should be explained in the text box:
 - the situation before the policy or legislative change
 - the policy initiative or legislative change which took effect and the role played by the Member Association to bring about the change

If this information is not provided, the Member Association does not receive a score for this indicator.

Point to remember:

- read the survey as a whole document to ensure responses across the Five 'A's are consistent
- read the definitions and explanations provided for the questions in the survey; if unsure, do not hesitate to ask your Regional Office contact on global indicators
- compare your survey responses with the your service statistics data
- compare your survey responses and your service statistics data with those of previous years to check for trends and consistency

Appendix 6

Annual reporting schedule for IPPF's global indicators programme

Responsibility	Activity	January	February	March	April	May	June	July
Regional Offices	Send letter requesting the submission of the online survey and the service statistics to the Member Associations (including the relevant deadlines)							
Central Office	Activate the online survey and the service statistics module for all Member Associations to access							
Central Office	Send reminder to Regional Offices							
Regional Offices	Send reminder to Member Associations							
Member Associations	Complete the online survey and enter service statistics data in the online module							
Central Office	Close the online survey and service statistics modules for Member Association data entry (end March)							
Regional Offices	Review the data and make changes as needed							
Central Office	Close the online survey and the service statistics modules for all Regional Offices (end April)							
Regional Offices	Analyze regional data							
Central Office	Review and analyze global data							
Central Office	Prepare June Donors' Report							
Regional Offices	Thank Member Associations and share the global indicators results							

Appendix 7

List of service statistics and global indicators reports available on eIMS

A variety of reports is available on the eIMS (electronic Integrated Management System) which can be used by volunteers and staff at all levels of the Federation for various monitoring and evaluation purposes.

To access these reports, go to the 'Reports' section on the eIMS, as shown in Figure A7.1, and click on 'Statistics' or 'GI Survey Reports' as appropriate.

Service statistics reports

MA Multi-Year Service Statistic Matrix: presents a matrix for all services provided, new users and items provided by a Member Association over a five-year period. This report also shows, in graphic format, the proportion of couple years of protection (CYP) by method, the CYP trend and the number of new users over the years for the Member Association.

Regional Multi-Year Service Statistic Matrix: presents a matrix for all services provided, new users and items provided by an IPPF region over a five-year period. This report also shows, in graphic format, the proportion of CYP by method, the CYP trend and the number of new users over the years for the region.

Service Stats Sub Continent Summary: presents a matrix for all services provided, new users and items provided by a sub-set of Member Associations belonging to a sub-continent within a region. This report also shows, in graphic format, the proportion of couple years of protection (CYP) by method, the CYP trend and the number of new users over the years for the sub-set of Associations.

Service Stats Channels of Distribution: presents details of all sexual and reproductive health and non-sexual and reproductive health medical services provided, new users, items provided or referrals (as selected) by channels of distribution. This report can be run for a region or a Member Association for a particular year or for a number of years as required.

Service Stats by Units of Measure: presents details of all sexual and reproductive health and non-sexual and reproductive health medical services provided by the chosen unit of measure (services provided, new users, items provided or referrals).

Service Statistics by Service Type: presents a matrix for all services provided, new users and items provided by country, region or globally.

Service Outlets by Channel & Location: presents the number of service delivery points by type and location.

Service Statistics Regional Overview: a summary report of regional service statistics presented in a tabular format. It presents data on numbers of all sexual and reproductive health services provided, new users, items provided and referrals. This report also presents details of sexual and reproductive health services provided to young people, CYP and number of service delivery points by type.

Service Statistics Global Overview: a summary report of global service statistics presented in a tabular format. It presents data on numbers of all sexual and reproductive health services provided, new users, items provided and referrals. Also presents details of sexual and reproductive health services provided to young people, CYP and number of service delivery points by type.

Service Statistics MA Overview: a summary report of Member Association service statistics presented in a tabular format. Presents data on numbers of all sexual and reproductive health services provided, new users, items provided and referrals. Also presents details of sexual and reproductive health services provided to young people, CYP and number of service delivery points by type.

Service Statistics Template: this template lists all the categories of services provided on which data are collected. The template can be run by default categories (categories of services for which annual data collection is mandatory), or non-default categories (categories of services for which data collection is optional).

Service Statistics Row Data: a detailed report with all the data entered by Member Associations by service type, items provided, new users, referrals and by age group. The report can be run for a selection of multiple countries, for example, those participating in a specific programme, as well as by region and globally.

This report also provides summary data for the following four categories: contraceptive services, non-contraceptive SRH services, non-SRH medical services, and non-SRH and non-medical services.

Figure A7.1 Accessing service statistics reports

The screenshot shows the IPPF Extranet interface. The top navigation bar includes the IPPF Extranet logo and the text 'Reports/ Statistics'. A left-hand navigation menu lists various sections: Extranet Home, Linked Projects, Medical Info, Schedule, IPPF Survey, IPPF Service Statistics, New Accreditation, Commodities, Data Entry, Search, Reports, APB | HYR | AR, Financial, Multi-Entity, Programmatic, Statistics, Staff Allocation, GI Survey Reports, Cubes, Risk Register, and Inventory Status. The 'Reports' section is expanded, showing a list of reports with 'View' buttons next to each:

MA Multi-Year Service Statistic Matrix	View
Regional Multi-Year Service Statistic Matrix	View
Service Stats Sub Continent Summary	View
Service Stats Channels of Distribution	View
Service Stats by Units of Measure	View
Service Statistics by Service Type	View
Service Outlets by Channel & Location	View
Service Statistics Regional Overview	View
Service Statistics Global Overview	View
Service Statistics MA Overview	View
Service Statistics Template	View
Service Statistics Row Data	View
Relative volume of services provided, by MA	View
Service Statistics Trends Graphs	View

Relative volume of services provided, by MA: a summary report which ranks Member Associations by the number of sexual and reproductive health services provided. It can be altered to show services by the most or the least number of services provided, services provided to people under or over 25 years of age, or by clinic-based or non-clinic based service delivery point. It can be seen by individual regions or by all regions, and by transaction year.

Service Statistics Trends Graphs: a report which generates 16 different multi-year line graphs and pie charts showing trends over years for a variety of services including HIV and abortion-related services provided, condom distribution, contraceptive services and services provided to young people. The report can be generated by region, country and over a number of years.

Global indicators survey reports

Global Indicators Survey Template: this is the global indicators online survey questionnaire which Member Associations are required to complete on an annual basis. The survey is divided into five sections according to IPPF's Five 'A's. As some questions have changed since the survey began in 2005, this report must be run according to the relevant year.

Global Indicator Survey Question Count: provides a quick list of Member Associations and the number of survey questions they have responded to (for a particular year) with their entity numbers and full names. This report is very useful for the regional evaluation focal points to monitor the Member Associations' progress in completing the survey.

Global Indicator Survey Questions Not Answered Completely: provides a list of Member Associations by region and question numbers (from the survey questionnaire) which were not completely answered. This is also another quick monitoring tool to identify the questions needing attention.

Global Indicator Survey Row Data: presents a matrix showing all the responses for all Member Associations within a region (or all regions) by question numbers.

Appendix 8

Global indicators for the Five 'A's: calculations and explanations

In this Appendix, we explain the calculations used to transform the data submitted by Member Associations into IPPF's overall global indicators results. The same analysis can be conducted for regional or sub-regional results.

The data are collected from the online survey and the service statistics module. Unless specified otherwise, the denominator is the total number of responding Member Associations in a particular year.

Indicator 1: Proportion of Member Associations with 20 per cent or more young people under 25 years of age on their governing board, by sex:

- calculate 20 per cent of (total number of governing board members in your Member Association) = X
- round up or down X to the nearest whole number to get Y
- if (number of females < 25 years of age on governing board + number of males < 25 years of age on governing board) \geq Y, 'Yes' for indicator
- calculate total number of Member Associations scoring 'Yes' for indicator = Z

To get the indicator value:

- divide Z by the total number of responding Member Associations
- multiply the proportion by 100 to get the percentage value of the indicator
- data presentation requires calculation by sex

Indicator 2: Percentage of Member Association staff who are under 25 years of age, by sex:

- number of female staff below 25 years of age for all Member Associations = X
- number of male staff below 25 years of age for all Member Associations = Y
- total number of staff (male and female, young and adult for all Member Associations) = Z
- data presentation requires calculation by sex

To get the indicator value:

- calculate $[(X + Y)/Z] * 100$

Indicator 3: Proportion of Member Associations providing sexuality information and education to young people

- calculate total number of Member Associations that answered 'Yes' to both sexuality education and information = X

To get the indicator value:

- divide X by the total number of responding Member Associations
- multiply the proportion by 100 to get the percentage value of the indicator
- data presentation requires bar chart by target group

Indicator 4: Proportion of Member Associations providing sexual and reproductive health services to young people

- calculate total number of Member Associations that answered 'Yes' to at least one category in the question 'Please provide information on the types of sexual and reproductive health services provided to young people under 25 years' = X

To get the indicator value:

- divide X by the total number of responding Member Associations
- multiply the proportion by 100 to get the percentage value of the indicator
- data presentation requires bar chart by type of service provided and by target group

Indicator 5: Proportion of Member Associations advocating for improved access to services for young people

- calculate total number of Member Associations that answered 'Yes' to at least one category in the question 'Please state with which target groups your Member Association conducts advocacy activities to increase access of young people to sexual and reproductive health services' = X

Key:

\geq means greater than or equal to * means multiply / means divide

To get the indicator value:

- divide X by the total number of responding Member Associations
- multiply the proportion by 100 to get the percentage value of the indicator
- data presentation requires bar chart by target group

Indicator 6: Number of sexual and reproductive health services provided to young people under 25 years of age

To get the indicator value:

- calculate total number of services provided (by all Member Associations) to young people under 25 years of age from the online service statistics report (global overview report on the eIMS)
- remember to add the services and referrals to get the indicator value

Indicator 7: Proportion of Member Associations with a written HIV and AIDS workplace policy

- calculate total number of Member Associations that answered 'Yes' in response to the question 'Does your Member Association have a written workplace policy on non-discrimination of people with HIV and AIDS?' = X

To get the indicator value:

- divide X by the total number of responding Member Associations
- multiply the proportion by 100 to get the percentage value of the indicator

Indicator 8: Proportion of Member Associations providing HIV-related services along the prevention to care continuum

- calculate total number of Member Associations that answered 'Yes' to at least six out of nine categories in the question 'Does your Member Association provide the HIV-related services listed?' = X

To get the indicator value:

- divide X by the total number of responding Member Associations
- multiply the proportion by 100 to get the percentage value of the indicator
- data presentation requires bar chart on proportion of Member Associations providing HIV/AIDS-related services, by type of service

Indicator 9: Proportion of Member Associations advocating for increased access to HIV and AIDS prevention, treatment and care, and reduced discriminatory policies and practices for those affected by HIV and AIDS
Responses from two questions are combined for indicator as follows:

- calculate total number of Member Associations that answered 'Yes' to both the questions 'Does your Member Association conduct advocacy activities for increased access to prevention, treatment and care?' and 'Does your Member Association conduct campaigns for reduced discriminatory policies and practices for those affected by HIV and AIDS?' = X

To get the indicator value:

- divide X by the total number of responding Member Associations
- multiply the proportion by 100 to get the percentage value of the indicator

Indicator 10: Proportion of Member Associations with strategies to reach people particularly vulnerable to HIV infection

- calculate total number of Member Associations that answered 'Yes' to at least one category in response to the question 'Does your Member Association implement strategies to reach out to, and provide services to, groups that are particularly vulnerable to HIV infections?' = X

To get the indicator value:

- divide X by the total number of responding Member Associations
- multiply the proportion by 100 to get the percentage value of the indicator
- data presentation requires bar chart by group targeted by strategies

Indicator 11: Proportion of Member Associations conducting behaviour change communication activities to reduce stigma and promote health-seeking behaviour.
Responses from two questions are combined for indicator as follows:

- calculate total number of Member Associations that answered 'Yes' to the question 'Does your Member Association conduct behaviour change communication activities to reduce stigma associated with HIV and AIDS?' and also answered 'Yes' for at least one category of the question 'Does your Member Association conduct behaviour change communication activities to promote health-seeking behaviour among groups that are vulnerable to and affected by HIV and AIDS?' = X

To get the indicator value:

- divide X by the total number of responding Member Associations
- multiply the proportion by 100 to get the percentage value of the indicator
- data presentation requires bar chart by target groups

Indicator 12: Number of HIV-related services provided

To get the indicator value:

- calculate total number of HIV-related services provided (by all Member Associations) from the online service statistics report (global overview report)
- remember to add the services and referrals to get the indicator value
- data presentation requires bar chart by type of service provided

Indicator 13: Number of condoms distributed

To get the indicator value:

- calculate total number of condoms distributed (by all Member Associations) from the 'items provided' column of the online service statistics report (global overview report)

Indicator 14: Proportion of Member Associations advocating for reduced restrictions and/or increased access to safe legal abortion

- calculate total number of Member Associations that answered 'Yes' in response to the question 'Does your Member Association conduct advocacy activities for national policy or legislative change on abortion?' = X

To get the indicator value:

- divide X by the total number of responding Member Associations
- multiply the proportion by 100 to get the percentage value of the indicator
- data presentation requires bar chart for target groups

Indicator 15: Proportion of Member Associations conducting information, education and communication activities on (un)safe abortion, the legal status of abortion and the availability of legal abortion services

Responses from three questions are combined for indicator as follows:

- calculate total number of Member Associations that answered 'Yes' to at least one category in each of following three questions: 'Does your Member Association conduct information, education and communication activities on unsafe/safe abortion

with the target groups listed?', 'Does your Member Association conduct information, education and communication activities on the legal status of abortion with the target groups listed?' and 'Does your Member Association conduct information, education and communication activities on the availability of safe legal abortion services with the target groups listed?' = X

To get the indicator value:

- divide X by the total number of responding Member Associations
- multiply the proportion by 100 to get the percentage value of the indicator

Indicator 16: Proportion of Member Associations providing abortion-related services

- calculate total number of Member Associations that answered 'Yes' to at least one category in response to the question 'Does your Member Association provide the following abortion-related services?' = X

To get the indicator value:

- divide X by the total number of responding Member Associations
- multiply the proportion by 100 to get the percentage value of the indicator
- data presentation requires bar chart for service type
- additional analysis requires proportions of Member Associations providing surgical and/or medical abortion services

Indicator 17: Number of abortion-related services provided

To get the indicator value:

- calculate total number of abortion-related services provided (by all Member Associations) from the online service statistics report (global overview report). Remember to add the services and referrals to get the indicator value
- data presentation requires bar chart by type of abortion-related service provided

Indicator 18: Proportion of Member Associations conducting programmes aimed at increased access to sexual and reproductive health services by poor, marginalized, socially-excluded and/or under-served groups

Responses from two questions are combined for indicator as follows:

- calculate total number of Member Associations that answered 'Yes' to the question 'Does your Member Association implement programmes to increase access to sexual and reproductive health services by the poor,

marginalized, socially-excluded and/or under-served?' and also responded 'Yes' to at least one category of the question 'Which type of programmes/initiatives does your Member Association implement to increase access to sexual and reproductive health services by the poor, marginalized, socially-excluded and/or under-served?' = X

To get the indicator value:

- divide X by the total number of responding Member Associations
- multiply the proportion by 100 to get the percentage value of the indicator

Indicator 19: Estimated percentage of Member Association clients who are poor, marginalized, socially-excluded and/or under-served

To get the indicator value:

- calculate total (estimated) number of Member Association clients who are poor, marginalized, socially excluded and/or under-served = X
- divide X by the total number of clients for all the responding Member Associations
- multiply the proportion by 100 to get the percentage value of the indicator

Indicator 20: Number of couple years of protection, by method

To get the indicator value:

- calculate total number of couple years of protection provided (by all Member Associations) from the online service statistics report (global overview report)
- data presentation requires bar chart by CYP values for different contraceptive methods

Indicator 21: Number of contraceptive services provided, by type

To get the indicator value:

- calculate the total number of contraceptive services provided (by all Member Associations) from the online service statistics report (global overview report)
- remember to add the services and referrals to get the indicator value
- data presentation requires bar chart by type of contraceptive service

Indicator 22: Number of sexual and reproductive health services (excluding contraceptive services) provided, by type

To get the indicator value:

- calculate the total number of non-contraceptive sexual and reproductive health services provided (by all Member Associations) from the online service statistics report (global overview report).
- remember to add the services and referrals to get the indicator value
- data presentation requires bar chart by type of non-contraceptive sexual and reproductive health service

Indicator 23: Number of service delivery points, by type

To get the indicator value:

- calculate the total number of service delivery points (for all Member Associations) from the online service statistics report (global overview report)

Indicator 24: Proportion of Member Associations with gender-focused policies and programmes

- calculate total number of Member Associations that answered 'Yes' to the question 'Does your Member Association have a gender equity policy in place?' and 'Yes' to at least one category in the question 'Does your Member Association implement gender-focused programmes/initiatives?' = X

To get the indicator value:

- divide X by the total number of responding Member Associations = Y
- multiply Y by 100 to get the percentage value of the indicator
- data presentation requires bar chart by type of strategy

Indicator 25: Proportion of Member Associations with quality of care assurance systems, using a rights-based approach

Responses from six questions are combined for indicator as follows:

- calculate total number of Member Associations that answered 'Yes' to at least one category in all six questions:
[In all service delivery points, does your Member Association:
 - adhere to written standards/protocols/norms that are consistent with 'IPPF's Medical and Service Delivery Guidelines for Sexual and Reproductive Health Services' (2004)?
 - have procedures to ensure clients' perceptions on service provision are taken into account in all service delivery points?
 - provide orientation and ongoing training to staff in all its service delivery points on the following topics?

- have mechanisms in place to regularly assess the technical competence of service providers in the delivery of sexual and reproductive health services, infection prevention and client-provider interaction?
- implement strategies/approaches to assess the quality of care provided?
- have the right conditions to deliver sexual and reproductive health services?] = X

To get the indicator value:

- divide X by the total number of responding Member Associations
- multiply the proportion by 100 to get the percentage value of the indicator
- data presentation requires bar chart by type of strategy

Indicator 26: Proportion of Member Associations involved in influencing public opinion on sexual and reproductive health and rights

- calculate total number of Member Associations that answered 'Yes' to the question 'Does your Member Association have a communications strategy to influence public opinion on sexual and reproductive health and rights?' and for at least one category in the question 'What are the main initiatives your Member Association is involved in to influence public opinion on sexual and reproductive health and rights to support favourable policies and legislation?' = X

To get the indicator value:

- divide X by the total number of responding Member Associations = Y
- multiply Y by 100 to get the percentage value of the indicator
- data presentation requires bar chart by group targeted by the strategies and by type of strategy

Indicator 27: Proportion of Member Associations involved in advancing national policy and legislation on sexual and reproductive health and rights

- calculate total number of Member Associations that answered 'Yes' to the question 'Does your Member Association conduct advocacy activities to advance national policy and legislation on sexual and reproductive health and rights?' = X

To get the indicator value:

- divide X by the total number of responding Member Associations
- multiply the proportion by 100 to get the percentage value of the indicator

Indicator 28: Number of successful national policy initiatives and/or positive legislative changes in support of sexual and reproductive health and rights to which the Member Association's advocacy efforts have contributed

- calculate total number of successful national policy initiatives and/or positive legislative changes in support of sexual and reproductive health and rights to which the Member Association's advocacy efforts have contributed as reported by the Member Associations

Indicator 29: Proportion of Member Associations involved in counteracting opposition to sexual and reproductive health and rights

- calculate total number of Member Associations that answered 'Yes' to at least one category in response to the question 'What opposition strategies is your Member Association counteracting?' = X

To get the indicator value:

- divide X by the total number of responding Member Associations = Y
- multiply Y by 100 to get the percentage value of the indicator
- data presentation requires bar chart by source of opposition, and by type of strategy

Indicator 30: Proportion of Member Associations advocating for national governments to commit more financial resources to sexual and reproductive health and rights

- calculate total number of Member Associations that answered 'Yes' to at least one category in response to the question 'On which campaign issue(s) does your Member Association advocate for national governments to commit more financial resources to sexual and reproductive health and rights?' = X

To get the indicator value:

- divide X by the total number of responding Member Associations = Y
- multiply Y by 100 to get the percentage value of the indicator
- data presentation requires bar chart by type of campaign

Appendix 9

Explanatory note on couple years of protection (CYP)

Couple years of protection (CYP) refers to the total number of years of contraceptive protection provided to a couple. The following table illustrates how the CYP values are calculated for different methods of contraception.

Method	CYP factor	Calculation
Condoms (male/female)	120 per CYP	$\text{CYP} = (\text{number of condoms provided})/120$
Oral contraceptive pills (OCP)	15 per CYP	$\text{CYP} = (\text{number of OCPs provided})/15$
IUD	3.5 CYP per IUD	$\text{CYP} = (\text{number of IUDs provided}) * 3.5$
Injectables: Depo-Provera (3 months dose)	4 per CYP	$\text{CYP} = (\text{number of Depo-Provera provided})/4$
Injectables: Noristerat (2 months dose)	6 per CYP	$\text{CYP} = (\text{number of Noristerat provided})/6$
Injectables: monthly injectables	13 per CYP	$\text{CYP} = (\text{number of injectables provided})/13$
Implants	3.5 CYP per device	$\text{CYP} = (\text{number of implants provided}) * 3.5$
Diaphragm	1 CYP per diaphragm	$\text{CYP} = \text{number of diaphragms provided}$
Sterilization (VSC)	10 CYP per sterilization	$\text{CYP} = (\text{number of sterilizations provided}) * 10$

Calculation explained	What does it mean?
For example, if your organization has provided 120,000 condoms in one year, your CYP figure for condoms is 1,000.	By providing 120,000 condoms in one year, your organization has provided contraceptive protection to 1,000 couples.
If your organization has provided 150,000 OCP in one year, your CYP figure for oral contraceptive pills is 10,000.	By providing 150,000 OCP in one year, your organization has provided contraceptive protection to 10,000 couples.
If your organization has provided 1,000 IUDs in one year, your CYP figure for IUDs is 3,500.	By providing 1,000 IUDs in one year, your organization has provided contraceptive protection to 3,500 couples.
If your organization has provided 1,000 Depo-Provera in one year, your CYP figure for injectables (Depo-Provera) is 250.	By providing 1,000 Depo-Provera in one year, your organization has provided contraceptive protection to 250 couples.
If your organization has provided 6,000 Noristerat in one year, your CYP figure for injectables (Noristerat) is 1,000.	By providing 6,000 Noristerat in one year, your organization has provided contraceptive protection to 1,000 couples.
If your organization has provided 3,000 monthly injectables in one year, your CYP figure for monthly injectables is 1,000.	By providing 13,000 monthly injectables in one year, your organization has provided contraceptive protection to 1,000 couples.
If your organization has provided 1,000 implants in one year, your CYP figure for implants is 3,500.	By providing 1,000 implants in one year, your organization has provided contraceptive protection to 3,500 couples.
If your organization has provided 1,000 diaphragms in one year, your CYP figure for diaphragms is 1,000.	By providing 1,000 diaphragms in one year, your organization has provided contraceptive protection to 1,000 couples.
If your organization has provided 1,000 sterilizations in one year, your CYP figure for sterilization is 10,000.	By providing 1,000 sterilizations in one year, your organization has provided contraceptive protection to 10,000 couples.

Glossary

General monitoring and evaluation terminologies¹

Accountability: obligation and responsibility regarding programme implementation and use of resources. This includes evidence of activities undertaken, results and lessons learned.

Analysis: the process of applying logical, statistical and mathematical methods to draw conclusions from data.

Assumption: consideration of probable hypothetical situations for the purpose of planning an action.

Attribution: the act of linking 'cause' to 'happenings' or 'observed actions'.

Auditing: an assessment (of a person, organization, system, process, project or product) to determine the validity, reliability and internal processes in place.

Baseline study: a structured way of collecting factual information before an intervention begins to determine the key indicators against which future results will be compared.

Beneficiaries: people expected to gain positive changes in their lives through the implementation of an intervention.

Conclusion: a set of rational comments on evidence-based findings and facts with regard to a specific situation.

Data: specific quantitative and qualitative information or facts.

Data collection method: the strategy and approach used to gather data.

Data source: the person, document or institution from which the data are collected.

Database: An accumulation of information that has been systematically organized for easy access and analysis.

Effectiveness: a measure of the extent to which a project achieves its planned results.

Efficiency: A measure of how economically or positively inputs (financial, human, technical and material resources) are used to produce outputs.

Evaluation: an assessment of the relevance, efficiency, effectiveness, performance and sustainability of a project. Evaluation verifies whether project objectives have been achieved or not. It is a management tool which can assist in decision making, and which provides valuable lessons learned for implementing organizations and their partners.

Evaluation questions: a set of questions which define the issues the evaluation will investigate.

Evaluation standards: a set of criteria against which the completeness and quality of evaluation work can be assessed. The standards measure the usability, feasibility and accuracy of the evaluation.

Feedback mechanisms: a process by which beneficiaries and other stakeholders are given the means to provide input, voice concerns and opinions regarding a particular project or activity.

Formative evaluation: an assessment of the project activities and processes during implementation to provide information for improvement. A formative evaluation focuses on collecting data on project activities so that needed changes or modifications can be made in the early stages.

Goal: the purpose or the general change desired in the long term. Generally, a project can contribute to achieving the goal, but it cannot accomplish the goal on its own.

Impact: positive and negative, primary and secondary long term effects produced by a development intervention, directly or indirectly, intended or unintended; the difference a development intervention makes to people's sexual and reproductive health, and the ability to demonstrate it.

Indicators: signs of progress and change that result from an initiative, activity, project or programme. Indicators provide guidance about what information should be collected. Indicators act as a yardstick to measure change.

Inputs: the financial, human, material, technological and information resources provided by stakeholders (i.e. donors, programme implementers and beneficiaries) that are used to implement an intervention.

Key informant: a person (or group of persons) who has unique skills or professional background related to the issue/intervention being evaluated, is knowledgeable about the project participants, or has access to other information of interest to the evaluator.

¹ Many of these definitions have been drawn from resources listed in the 'Further reading' section (page 74).

Learning: the process by which knowledge and experience directly influence changes in behaviour. Both monitoring and evaluation will be ineffective if they do not contribute to learning.

Learning organization: an organization that is skilled at creating, acquiring, and transferring knowledge and at modifying its behaviour to reflect new knowledge and insights. A learning organization facilitates the learning of all its members and continuously transforms itself.

Logical framework: is a methodology for conceptualizing projects clearly and understandably on a single matrix. It is best used to set project objectives and link those to indicators, identify key activities, define critical assumptions on which the project is based, identify means of verifying project achievements and define resources required for implementation.

Means of verification (MOV): the specific sources from which the status of each of the indicators can be ascertained.

Monitoring: an ongoing and systematic activity used to track whether activities are carried out according to plan - in terms of content, time and cost. Monitoring provides project managers with important information on progress, or lack of progress, in relation to project objectives.

Objective: a generic term used to express the desired result that a project seeks to achieve.

Outcome: the short and medium term effects of a project's outputs on a target group.

Outputs: the products and services which result from the completion of activities within an intervention.

Participatory approach: a broad term for the involvement of primary and other stakeholders in programme planning, design, implementation, monitoring and evaluation.

Post-test: a test after an intervention that measures the participants' knowledge and skills, which can be compared to what they knew before the intervention.

Pre-test: a test before an intervention that measures the participants' knowledge or skills, which can then be compared to what they know after the intervention.

Project: a time-bound intervention that consists of a set of planned, interrelated activities aimed at achieving defined results.

Proxy indicator: a variable used to stand in for one that is difficult to measure directly.

Quantitative data: numerical information that can be analyzed using statistical methods.

Qualitative data: text-based information that provides descriptive details, often collected from interviews, focus groups or observation.

Recommendation: proposal for action to be taken following monitoring and evaluation, including the people responsible for implementing those actions.

Relevance: the degree to which the outputs, outcomes or goals of a project remain valid and appropriate as originally planned or as subsequently modified.

Reliability: consistency and dependability of data collected. Absolute reliability of evaluation data is hard to obtain. However, checklists and training of evaluators can improve both data reliability and validity.

Results based management (RBM): an approach to management that puts greater emphasis on measuring results (outcomes and impact), using monitoring and evaluation information to continuously improve performance, careful management of financial resources, and using lessons learned when designing any new projects.

Risks: factors that may adversely affect project activities and achievement of results.

Risk analysis: an analysis or assessment of factors that affect or are likely to affect the achievement of results.

Sample: a select number from the entire population.

Stakeholders: people, groups or entities outside the immediate project staff that have a role and interest in the aims and implementation of a project.

Summative evaluation: an assessment of the overall effectiveness of a project.

Target group: the specific group of individuals that a project is trying to affect, influence or serve.

Thematic evaluation: an assessment of selected aspects or cross-cutting issues in different types of projects.

Validity: the extent to which methodologies and instruments measure what they are supposed to measure. A data collection method is reliable and valid to the extent that it produces the same results repeatedly.

Service statistics definitions

Age of clients: age at the time of service provision

Clarifications:

- Data on age of clients is only required for reporting services provided and new users in clinic-based service delivery points (SDPs) (static, mobile, outreach or associated).
- Data on age of clients are optional for items provided.
- Data on age of clients are not collected for referrals.
- If a client comes to a Member Association service delivery point for a service before and then after his/her 25th birthday, the first will be recorded as a service provided to a young person, the second will not.

Associated clinic: a regular, permanent location belonging to private individuals, organizations or the public sector providing sexual and reproductive health services by trained doctors, clinicians and/or professional counsellors. An associated clinic is NOT managed by the Member Association and services are provided by the associated clinic staff, NOT by Member Association staff. Member Associations have an agreement to provide significant technical support, monitoring, quality of care and oversight. Member Associations provide contraceptives and other sexual and reproductive health commodities to the associated clinic for their clients.

Clinic-based service delivery point: a regular, permanent location providing sexual and reproductive health services by trained doctors, clinicians and/or professional counsellors.

Commercial marketing (under non-clinic based service delivery points): channels of distribution that sell contraceptives and other sexual and reproductive health commodities at retail prices. These contraceptives and other sexual and reproductive health commodities are provided by the Member Association.

Clarifications:

- Other than contraceptives, no other sexual and reproductive health services are provided through commercial marketing.
- The purpose of commercial marketing is to recover cost and generate profit to subsidize other programmes of the Member Association.

- These channels include pharmacies, retail establishments, drug stores and wholesalers, which may or may not be owned by the Member Association.
- A drug store or a pharmacy that is part of a Member Association static clinic is a commercial marketing service delivery point.
- Only some IPPF products that have supplier authorization can be sold through commercial marketing channels. (Please check with your Regional Office if in doubt).

Community-based distribution and services (CBD/CBS) (under non-clinic based service delivery points):

These outlets are managed by Member Associations and distribute contraceptives and other sexual and reproductive health commodities, directly or indirectly, to clients through community-based workers/volunteers.

Clarifications:

- Community-based workers/volunteers include sexual and reproductive health promoters, educators and health workers.
- They may or may not have a physical space.
- No clinical services are provided.

Government channels of distribution (under non-clinic based service delivery points): national government agencies (e.g. ministries – health, youth, women, social services, army, social security) that procure contraceptives and other sexual and reproductive health commodities from the Member Association. The Member Association is not involved in the provision of services to the clients.

Items provided: total number of contraceptives given to a client directly or indirectly from a Member Association's service delivery points.

Clarifications:

- This includes contraceptives provided to other individuals on behalf of the client, and to other agencies that receive contraceptives from the Member Association for distribution to their clients.
- Data on items provided are collected primarily for CYP calculations; data on the number of non-contraceptive items provided are NOT required.

Mobile clinic and clinical outreach team: a regular, permanent but offsite location providing sexual and reproductive health services by trained doctors, clinicians and/or professional counsellors. A mobile clinic and/or outreach team is managed by the Member Association and run by full and/or part-time Member Association staff. Services are provided through health posts, equipped vehicles, and other premises. Contraceptive and/or other

sexual and reproductive health services are provided by Member Association staff.

Clarifications:

- Each mobile clinic or clinical outreach team is counted as one service delivery point.
- Do NOT count individuals in the team or the numbers of communities reached.

New user: a client who accepts at least one modern method of contraception from the Member Association for the first time.

Clarifications:

- New user data are collected for contraceptive services only.
- Currently, emergency contraception is not listed as a modern method of contraception, and therefore clients accepting emergency contraception are not recorded as new users.
- New user data are required for Member Association clinic clients only. This includes static clinics, mobile clinics, clinical outreach teams and associated clinics.
- Clients who previously obtained contraceptives from a Member Association non-clinic based service delivery point should be recorded as new users when first accepting contraceptive services at a Member Association clinic-based service delivery point.
- A new user may have used contraception in the past, obtained from a non-Member Association service delivery point.
- If an existing client at the service delivery point switches to a new method, that person should not be recorded as a new user. For example, if a client has an IUD removed and begins using injectables, she would not be recorded as a new user.
- All acceptors of male or female sterilization are considered new users, even if they have previously received temporary contraceptive methods from the Member Association clinic.
- A client coming to the Member Association for the first time but referred to another organization for contraceptive services should not be recorded as a new user.
- A client who has been using non-contraceptive services provided by the Member Association service delivery point, and who subsequently receives contraceptives for the first time from this service delivery point should be recorded as a new user.
- The earlier terminology 'new acceptor' remains conceptually the same as 'new user'.

- If two methods are received by a new user at the same time, the more effective method (the one with the higher CYP conversion factor) is counted as the new user method.
- A client can be a new user with a Member Association only once, unless they change to a permanent method.

Non-clinic based service delivery points: a channel of distribution that does NOT provide clinic-based sexual and reproductive health services. (see definition of clinic-based sexual and reproductive health services) However, they do distribute contraceptives provided by the Member Association. Some also provide IEC services.

Other agencies (under non-clinic based service delivery points): NGOs or organizations that are supplied with contraceptives and other sexual and reproductive health commodities by the Member Association. The Member Association is not involved in the provision of services to the clients.

Peri-urban service delivery points: a location to provide services in a peripheral area of a city or a town, either inside a city or town's outer rim, or just outside its official boundaries.

Private physicians (under non-clinic based service delivery points): doctors/clinicians who are supplied with contraceptives and other sexual and reproductive health commodities by the Member Association. The Member Association is not involved in provision of services to the clients.

Referrals (to other organizations): number of services for which clients are formally sent by the Member Association to an external (non-Member Association) service delivery point.

Clarifications:

- Referrals for contraceptive services are not included in the calculation of CYP because no items are provided by the Member Association at the time of referral.
- If contraceptives were distributed by the Member Association to a particular service delivery point where the client was referred to, this would already be included in the CYP calculation, as contraceptives provided by the Member Associations to other service delivery points and organizations are used to calculate CYP.
- If a client is referred for two or more different services to external service delivery points, two or more referrals should be recorded.

- At the global level, the number of referrals is included in the total number of services provided. However, some regions do not include referrals in their data on the total number of services provided.
- Only external referrals to non-Member Association service delivery points are recorded. We do not record internal referrals (those occurring between Member Association service delivery points).

Rural service delivery points: a location to provide services in an area away from the influence of large cities. These are villages, farms or other isolated houses with a much lower population density than that of urban and peri-urban areas.

Service delivery points (channels of distribution/outlets): a location to provide clinic-based or non-clinic based sexual and reproductive health services and commodities.

Services provided: number of services provided to a client by a Member Association service delivery point. If a client is provided with two or more services during one visit, the number of services should be recorded as two or more. Sometimes the terms 'visits' and 'services' are confused. We no longer use the term 'visits'; a client can receive more than one service per visit, and the total number of services provided should be recorded.

Static clinic: a regular, permanent location providing sexual and reproductive health services by trained doctors, clinicians and/or professional counsellors. A static clinic operates from fixed premises, managed by the Member Association and run by full and/or part time Member Association staff.

Social marketing (under non-clinic based service delivery points): a non-clinic based outlet selling contraceptives and other sexual and reproductive health commodities provided by a Member Association social marketing programme at prices that permit cost recovery.

Clarifications:

- Social marketing is regarded as a sustainability model for contraceptive distribution. Contraceptives are sold at a reduced price compared to commercial outlets but the pricing permits recovery of procurement costs and distribution expenses.
- Social marketing service delivery points do not provide counselling.
- Social marketing CANNOT occur in commercial pharmaceutical facilities.

Urban service delivery points: a location to provide services in a city, town or other densely populated area (in comparison to the areas surrounding it). It varies from country to country, but generally the minimum density requirement is 400 persons per square kilometre.

Other IPPF global indicators definitions and explanations

Advertising: involves posters, billboards, flyers etc to influence public opinion on sexual and reproductive health and rights issues and NOT to educate or influence individuals' behaviour, nor to advertise the existence of a Member Association or the services it provides.

Advocacy: is a campaign or strategy to build support for a cause or issue. Advocacy is directed towards creating a favourable environment, by trying to gain people's support and by trying to influence or change legislation.

Availability of safe abortion services: refers to how and where a safe abortion can be obtained.

Behaviour change communication (BCC): involves using communication approaches and tools to encourage positive behaviour change. BCC strategies are designed to accommodate the stage of behaviour adoption of an individual and to impart knowledge and skills and provide psychosocial support that is needed to initiate and sustain change. Before individuals and communities can reduce their level of risk or change their behaviours, they must first understand basic facts about HIV and AIDS, adopt key attitudes, learn a set of skills and be given access to appropriate products and services. They must also perceive their environment as supporting behaviour change and appropriate treatment for prevention, care and support.

Clinical services: The term clinical services refers to counselling and other sexual and reproductive health services provided by the Member Associations through clinic-based or non-clinic based service delivery points.

Direct lobbying: involves working with legislators, decision makers or opinion makers to educate them on sexual and reproductive health and rights issues, proposing specific legislative changes through introducing norms, bills and protocol that advance access to and promote sexual and reproductive health and rights.

Education: whether formal or non-formal, is a process of facilitated learning to enable those learning to make rational and informed decisions.

Governing Board: The term Governing Board means the decision making body of the Member Association that is elected by the total volunteer members of that Member Association.

Health seeking behaviour: refers to what people do to maintain health or return to health, including what influences people to behave differently in relation to their health and what facilitates the use of services.

HIV vulnerability: is both regional and country specific. Groups particularly vulnerable to HIV infection may include people living with HIV, sex workers, men who have sex with men, gay, lesbian and bisexual youth, injecting drug users, newly married women, migrants and internally displaced populations.

HIV-related stigma: can be described as a 'process of devaluation' of people either living with or affected by HIV and AIDS. Stigma relates to people's attitudes. Discrimination is the action that results from this attitude and may include rejection, avoidance and violence against people living with HIV and those associated with the epidemic. HIV-related stigma is unique, as unlike other forms of stigma, it not only arises from a person having (or being associated with) HIV, but is further compounded by the underlying stigmatization of behaviours and attitudes that are frequently connected with the epidemic (such as men having sex with men, sex work and injecting drug use).

IEC (Information, Education and Communication): ensures that clients, or potential clients, of sexual and reproductive health are given the means to make responsible decisions about their sexual and reproductive health.

Improving access to safe abortion: includes the removal of administrative and other barriers to the provision of safe abortion services, the promotion of greater access to affordable and quality services, advocacy with governments and the development of strategic partnerships to expand access.

Information: involves generating and disseminating general and technical information, facts and issues, in order to create awareness and knowledge.

Legal status of abortion: refers to conditions under which abortions are legally permissible

Legislation: is a term referring to laws or the action of legislating. A legislature is a governmental body with the power to adopt laws.

Marginalized: people, who for reasons of poverty, geographical inaccessibility, culture, language, religion gender, migrant status or other disadvantage, have not benefited from health, education and employment opportunities, and whose sexual and reproductive health needs remain largely unsatisfied. Examples include drug users, young people with special needs, street children and sex workers.

Member Association clients: clients provided with sexual and reproductive health services by a Member Association. Sexual and reproductive health services do NOT include IEC activities.

MTCT+ Mother to Child transmission Plus: combines prevention of mother to child transmission (MTCT) programmes with the treatment of the mother and their family members (their partners and children). Service provision includes psychosocial and nutritional counselling, advice on taking medication, peer support and antiretroviral treatment. Mother to child transmission of HIV and AIDS can be reduced by providing treatment in pregnancy, conducting a Caesarean section to deliver the baby, and using formula milk when possible to avoid transmission during breastfeeding.

Nature of abortion: refers to what is meant by abortion (safe and unsafe) and to the different methods which may be used at different stages of pregnancy.

Opposition to sexual and reproductive health and rights: can be from a range of conservative forces including political, religious, cultural and social, aimed at undermining sexual and reproductive health and rights. Opposition strategies include undermining national agreements, de-funding sexual and reproductive health and rights and the organizations that are involved in providing the services, blocking access to sexual and reproductive health and rights through policy, legislative and funding restrictions, spreading misinformation about sexual and reproductive health and rights issues, etc.

Policies: are statements of principles underlying governmental action that can be expressed as national government action such as legislation, resolutions, programmes, regulations, appropriations, administrative practices and/or court decisions.

Poor: people living on less than US\$2 per day.

Public education: involves appearing on media programmes to advance sexual and reproductive health and rights issues, community-based educational campaigns related to a specific sexual and reproductive health and rights issue through posters, billboards, flyers etc and which is designed to sway public opinion to support sexual and reproductive health and rights issues.

Quality of care: is based on IPPF's 'Rights of the Client' and 'Needs of Service Providers' framework. To ensure good quality of care, clients have the right to information, access to services, choice, safety, privacy and confidentiality, dignity and comfort, continuity of services, and opinion. To fulfil these rights, the needs of service providers must be met as well. These include the needs for: training, information, proper infrastructure and supplies, guidance, backup, respect and encouragement, feedback on their performance, and opportunities for self expression. Good quality of care enhances clients' satisfaction and their use of services. It increases job satisfaction and motivation among service providers, and leads to greater sustainability of services.

Restrictions (related to abortion): include legal, policy, administrative and others restrictions to the right to safe abortion.

Safe abortion: refers to an accessible high-quality service performed by skilled professionals in a suitable environment to terminate an unwanted pregnancy.

Sexuality information: involves generating and disseminating general and technical information, facts and issues, to create awareness and knowledge on sexuality.

Sexuality education: whether formal or informal, is a process of facilitated learning to enable those learning to make rational and informed decisions on sexuality. Sexuality topics include sex education, relationships, attitudes towards sexuality, sexual roles, sexual health, gender relations and the social pressures to be sexually active. Information of sexual and reproductive health services, and training in communication and decision-making skills is also provided.

Socially-excluded: people who are wholly or partially excluded from full participation in the society in which they live.

Staff: Member Association staff includes ALL full time, part time, permanent and temporary staff employed by the Member Association at ALL levels (the headquarters, branches and project sites), at ALL sites, and who are paid a salary or are included on the payroll. This does not include young volunteers.

The reference period for which the staff data should be provided is the last month for which payroll data are available. Each member of staff who is part time should be counted as one (not in fractions).

Staff with management and decision-making responsibilities: staff members who supervise at least one member of staff and have budgetary responsibility.

Under-served: people who are not normally or well-served by established sexual and reproductive health service delivery programmes due to a lack of capacity and/or political will; for example, people living in rural/remote areas, young people, people with a low socioeconomic status, unmarried people, etc.

Working with the media: involves educating journalists on sexual and reproductive health and rights issues, and writing articles and opinion pieces on sexual and reproductive health and rights for local and national newspapers.

Key abbreviations

AIDS	Acquired immune deficiency syndrome
BCC	Behaviour change communication
CBD	Community-based distribution
CBO	Community-based organization
CBS	Community-based services
CCM	Country coordinating mechanism
CYP	Couple years of protection
DHS	Demographic and Health Survey
EC	European Commission
eIMS	electronic Integrated Management System
FGD	Focus group discussion
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development (1994)
IEC	Information, education and communication
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
KIS	Knowledge and information systems
KM	Knowledge management
MA	Member Association
MOH	Ministry of Health
MTR	Midterm review
MYFF	Multi-year funding framework
NGO	Non-governmental organization
OL	Organizational learning
OLE	Organizational learning and evaluation
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission
PRSP	Poverty reduction strategy papers
RTI	Reproductive tract infection
SDP	Service delivery point
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
SWAPs	Sector-wide approaches
TOR	Terms of reference

Further reading

Web resources

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Request for feedback

We would greatly appreciate your feedback on the contents of the handbook, and to hear about your experiences of putting IPPF's Monitoring and Evaluation policy into practice.

Please email your comments to Mahua Sen at msen@ippf.org



Putting the IPPF Monitoring and Evaluation Policy into practice

A handbook on collecting, analyzing and utilizing data for improved performance

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IPPF
4 Newhams Row
London SE1 3UZ
United Kingdom

tel +44 (0)20 7939 8200
fax +44 (0)20 7939 8300

email info@ippf.org
web www.ippf.org

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“We are determined to use this handbook to build a strong culture of monitoring, evaluation and learning in an organization that is more effective in meeting the sexual and reproductive health needs of women, men and young people across the globe”.

Dr Gill Greer, Director-General, IPPF

IPPF's Monitoring and Evaluation Policy was revised in 2006, and reflects a much stronger commitment to monitoring, evaluation and learning throughout the Federation. The policy emphasizes how learning from evaluation contributes to the effective management and improved performance of our programmes. It also stresses the need to demonstrate results to our beneficiaries as well as our donors, and at national, regional and global levels.

For those of us in IPPF that are committed to increasing effectiveness, making decisions based on hard evidence, and improving the Federation's accountability through monitoring and evaluation, this handbook provides the guidance and tools needed to translate the Monitoring and Evaluation Policy into practice.