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PROGRAM PERFORMANCE

MONITORING AND EVALUATION PLAN

USAID/Morocco

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3. Strategic Objective 3 - Monitoring-Reporting-Evaluation Plan

STRATEGIC OBJECTIVE NO. 3: Improved health of children under five and women of child bearing age

i. Results and Performance Indicators

The results and performance indicators for Strategic Objective No. 3 are summarized in the table below. The Program Outcomes under this objective suggest that the Mission's bilateral and centrally funded activities will help the Ministry of Public Health expand the coverage and improve the quality of key FP/MCH services (particularly in rural areas), shift a greater portion of family planning users to the private sector for services, increase the proportion of family planning users adopting longer term methods of contraception, particularly IUDs and sterilization, and provide a greater mix of family planning methods to appeal to different market niches. In addition, resources will be devoted to improving service sustainability, as donor assistance is shifted from recurrent costs (i.e., provision of vaccines and contraceptives) to expanding newer services, such as prenatal care, diarrheal disease control, and STD/HIV screening. Sustainability activities include support for Ministry of Public Health decentralization of authority to the regional level; improvement of MOPH planning and management; shifting costs to consumers who procure services in the private sector; and continuing discussions with the Ministry over health care financing. The strategic objective working group has identified the specific results, indicators, strategies and activities that support achievement of the results under this strategic objective. See Section 5 - Strategic Objective No. 3 - PPMER Planning Matrix for the specific details.

| STRATEGIC OBJECTIVE NO. 1: Improved Health of Children Under Five and Women of Child Bearing Age | | |
|---|---------------------------------------|--|
| SPECIFIC RESULTS | PERFORMANCE INDICATORS | DATA SETS |
| R1. Women have fewer, healthier pregnancies and safer deliveries | R1 Total Fertility Rate (urban/rural) | Demographic and Health Survey, 1992 and 1997 |
| R2. Fewer children under five develop and die from major preventable diseases and complications of delivery | R2.1 Infant Mortality (urban/rural) | |
| | R2.2 Child mortality (urban/rural) | |

ii. Data Collection Instruments

a. Measurement Techniques

As shown in the Program Performance, Monitoring, Evaluation and Reporting (PPMER) Planning Matrix, the data sets for measuring performance indicators will be acquired from different sources. The two primary data sets are the Demographic and Health Survey (DHS) and MOPH service statistics. At the program outcome level, for each specific result identified, two indicators have often been selected: a primary indicator designed to demonstrate impact but for which data cannot be collected annually and a proxy indicator designed to show momentum and for which data can usually be acquired annually. Nine out of seventeen indicators draw data from Demographic and Health Surveys, one of which was done in 1992 and another of which is scheduled in 1997 at the end of the strategy period. Except in the case of the Strategic Objective results, each indicator drawing data from the DHS is accompanied by a proxy indicator. All three strategic objective results can only be measured by indicators measured through the DHS. There are no adequate proxies at the S.O. level, so program outcome proxy indicators must stand as proxies to measure likely progress toward the S.O results in the intervening years. In a few instances (i.e., vaccination, diarrheal disease), there may be surveys conducted by UNICEF that can be used to confirm the service statistics and private sector wholesaler data used to measure proxy indicators.

Other than the DHS, only one specialized survey appears to be required. This is a survey to measure practice of diarrheal disease prevention techniques. The techniques will be defined when a contract team comes out in a couple of months, and the method of measurement will then be discussed. It may, however, prove to be possible to add relevant questions to the surveys that the MOPH does on different diseases each year. UNICEF may also measure practice in one or two surveys conducted over the strategy period.

b. Budget

The DHS costs approximately \$500,000. Costs for the diarrhea preventive practices survey will need to be estimated when the survey requirements are determined. The principal cost for the remaining indicators is in terms of staff time, acquiring and reviewing service statistics, private sector sales of contraceptives and ORS sachets, and surveys generated by other donors.

iii. Methodological Issues

a. Data Quality

DHS data are the best data available for the indicators selected to measure impact. Those administering the survey this year felt that the quality of the Moroccan data was very high. However,

the DHS still has a sizable sampling error, which could mean that a target is actually reached or even exceeded even though the data do not support such a conclusion. There is no way around this except to compare DHS data with service statistics and private sector sales data to try to determine if the three sources reinforce each other.

USAID has invested considerable resources over the years in improving the quality of MOPH FP/MCH service statistics. These are now felt to be of reasonable quality but efforts to track and reconcile problems in the reporting continue. Decentralization of some decision-making authority could improve local statistics because those responsible for assembling the data would be using the data to make decisions and therefore might have a heightened concern for accuracy. The exact impact of service statistics on the results that USAID would like to achieve is in most cases not clear. The Evaluation Project of R&D/Pop/P&E may undertake research to try to explore the link between service statistics for certain services and the actual impact sought.

Private sector wholesaler to retailer sales data for ORS, condoms and pills are judged to be reliable but sales data to retailers may not be entirely consistent with retailer sales to individuals and use by individuals. There will be some wastage or loss at the pharmacy and user stages. At least in the case of condoms, the large number of condoms used to indicate one couple year of protection allows for wastage.

b. Attribution and Linkage Issues

There appear to be no serious issues of attribution or linkage. AID is the major donor in family planning, HIV/STD screening, and will be a major donor for diarrheal disease control. While not the major donor for safe motherhood, AID efforts to expand private and public FP/MCH services, which are integrated in the public sector, and substantial support for IE&C messages aimed at achieving healthier pregnancies and deliveries, will make an important contribution to maternal health.

iv. Baseline and Performance Targets

The baseline and performance targets for each indicator under the strategic objective and program outcomes are summarized in Table 7 which follows.

a. Baseline Data

For most of those indicators for which data are provided by the 1992 DHS, the baseline is available. For a few indicators (i.e., contraceptive use effectiveness rate), the rates have not yet been calculated but will be available by early spring. The baseline year for MOPH service statistics and private sector sales statistics is 1991, and the data are readily available. By late spring, the only indicator for which a baseline may not

be determined is the one that measures practice of diarrheal prevention techniques, but the process for determining it should be underway.

b. Performance Targets

Good historical data are available for setting targets for most indicators. In some instances, AID targets are the same as those of the Ministry of Public Health; in other cases (particularly vis-a-vis contraceptive prevalence), staff felt more comfortable with estimates that are slightly more conservative than those of the MOPH.

TABLE 1. Strategic Objective No.3 - Baseline and Performance Targets

| STRATEGIC OBJECTIVE, PROGRAM OUTCOMES/SPECIFIC RESULTS | INDICATORS | BASELINE§ | ACTUAL 1992 | PERFORMANCE TARGETS | | | | | | |
|---|------------|----------------------|--------------------------------------|--------------------------------------|------|------|------|------|------|-----|
| | | | | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | |
| Strategic Objective No. 3: Improved health of children under five and women of child bearing age Specific Results Sought: R1. Women have fewer, healthier pregnancies and safer deliveries R2. Fewer children under five develop and die from major preventable diseases and complications of delivery | R1 | Total Fertility Rate | 4.2 | 4.2 | | | | | | 3.7 |
| | | urban | 2.8 | 2.8 | | | | | | 2.5 |
| | | rural | 5.7 | 5.7 | | | | | | 4.9 |
| | R2.1 | Infant Mortality | 57 | 57 | | | | | | 50 |
| | | urban | 44 | 44 | | | | | | 39 |
| | | rural | 65 | 65 | | | | | | 61 |
| | R2.2 | Child mortality | 20 | 20 | | | | | | 17 |
| | | urban | to be obtained from final DHS report | to be obtained from final DHS report | | | | | | TBD |
| | | rural | to be obtained from final DHS report | to be obtained from final DHS report | | | | | | TBD |

§ Baseline data represent an annual average for the years 1987-1992 for the three S.O. indicators.

| STRATEGIC OBJECTIVE, PROGRAM OUTCOMES/SPECIFIC RESULTS | INDICATORS | BASELINE§ | ACTUAL 1992 | PERFORMANCE TARGETS | | | | | | |
|---|---|--|---------------------------------|---------------------------------|------|--------------------|--------------------|--------------------|--------------------|--------------------|
| | | | | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | |
| Program Outcome No. 3.1: Increased use of effective MCH/FP services | R1.1 | Contraceptive Prevalence rate | 42 | 42 | | 42 | 44 | 46 | 47 | 48 |
| | | urban | 55 | 55 | | 55 | 56 | 56 | 57 | 57 |
| | | rural | 32 | 32 | | 33 34 | 35 36 | 36 35 | 38 40 | 39 42 |
| Specific Results sought: | | | | | | | | | | |
| R1. | More women use longer term contraception and use all modern methods correctly and over a longer period of time. | long-term short-term | 6 30 | 6 30 | | 7 30 | 8 30 31 | 9 31 32 | 10 31 33 | 11 31 34 |
| R2. | More women receive prenatal care. | R1.1.1 Couple Years of Protection provided by the public sector | 1991 = | 1991 = | | | | | | |
| | | long-term short-term | 207,396 733,357 | 207,396 733,357 | | 244,099 736,792 | 265,576 738,510 | 287,054 740,228 | 308,531 741,945 | 330,008 743,663 |
| R3. | More men and women use improved STD/HIV services. | R1.1.2 Couple years of protection provided by private sector (short-term methods) | 1991 = | 1991 = | | 289,901 | 303,352 | 316,803 | 330,253 | 343,704 |
| R4. | More women practicing diarrheal disease prevention and rehydration techniques | R1.2 Contraceptive Use Effectiveness Rate | available from DHS final report | available from DHS final report | | | | | | |
| | | R2 Percentage of pregnant women receiving qualified pre-natal care | 30 32 | 32 | | 36 | 41 | 46 | 50 | 54 |
| | | R3 Number of clients using public HIV/STD screening services male female | TBD | TBD | | TBD | | | | |
| | | R4.1 Percent of diarrheal disease cases provided with ORS | 15 | 15 | | 16 | 18 | 20 | 20 | 23 |
| | | R4.1.1 Number of new diarrhea cases provided with ORS rehydration therapy at MOPH facility | TBD | TBD | | | | | | |

2000
54
60
48
12
38

Leaf...

25

§ Baseline data for DHS indicators represent an annual average for the years 1987-1992.

Program Performance Monitoring, Evaluation and Reporting Planning Matrix

| Monitoring, Evaluation Reporting (MER) Issues | STRATEGIC OBJECTIVE No. 3 Improved health of children and women of child-bearing age | PROG. OUTCOME No. 3.1 Increased Use of Effective FP/MCH Services | PROG. OUTCOME No. 3.2 Increased sustainability of FP/MCH services |
|---|---|--|--|
| 1. What are the specific results sought? Specify the results sought by recipients of A.I.D. assistance as applicable. | <u>SPECIFIC RESULTS:</u> R1. Women have fewer, healthier pregnancies and safer deliveries R2. Fewer children under five develop and die from major preventable diseases and complications of delivery | <u>SPECIFIC RESULTS:</u> R1. More women use longer term contraception and use all modern methods correctly and over a longer period of time. R2. More women receive prenatal care. R3. More men and women use improved STD/HIV services. R4. More women practicing diarrheal disease prevention and rehydration techniques | <u>SPECIFIC RESULTS:</u> R1. FP/MCH services continue to expand with increased efficiency as donor support for recurrent costs is scaled down. R2. Private sector share of FP/MCH services increases R3. Maintain current levels of vaccination |
| 2. What critical assumption are made when specifying these results? | <u>CRITICAL ASSUMPTIONS:</u> 1. GOM proceeds with social sector development. 2. GOM implements planned health sector reforms. 3. Socio-political environment remains favorable toward family planning. 4. Economic conditions continue to improve. 5. There are no major epidemics or natural disasters. | <u>CRITICAL ASSUMPTIONS:</u> 1. No major reorganization of the MOPH (including decentralization) disrupts services | <u>CRITICAL ASSUMPTIONS:</u> 1. Government will continue to support private sector provision of services. 2. Effective officials in place and turnover is low. 3. GOM continues to buy vaccines. |

Program Performance Monitoring, Evaluation and Reporting Planning Matrix

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| <p>2. What critical assumption are made when specifying these results?</p> | <p><u>CRITICAL ASSUMPTIONS:</u> 1. GOM proceeds with social sector development. 2. GOM implements planned health sector reforms. 3. Socio-political environment remains favorable toward family planning. 4. Economic conditions continue to improve. 5. There are no major epidemics or natural disasters.</p> | <p><u>CRITICAL ASSUMPTIONS:</u> 1. No major reorganization of the MOPH (including decentralization) disrupts services</p> | <p><u>CRITICAL ASSUMPTIONS:</u> 1. Government will continue to support private sector provision of services. 2. Effective officials in place and turnover is low. 3. GOM continues to buy vaccines.</p> |
| <p>3. Which project and non-project activities produce these results?</p> <p>3.1 What specific program strategies is employed to generate each result?</p> | <p><u>ACTIVITIES/PROJECTS:</u> Result 1: Family Planning and Child Survival IV, central resources, and private sector FP project (to be designed) Result 2: FP/CS IV, central resources</p> <p><u>Result one strategy:</u> via social marketing and training for private practitioners, turn some of the burden for providing FP and delivery services to the private sector; segment the market for different contraceptive products and train practitioners in delivery of longer term methods; IE&C to increase awareness and understanding of correct use of FP</p> | <p><u>ACTIVITIES/PROJECTS:</u></p> | <p><u>ACTIVITIES/PROJECTS:</u></p> |

Program Performance Monitoring, Evaluation and Reporting Planning Matrix

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| | <p>methods; dev. of STD/HIV screening to slow infection and ensure that IUDs not inserted in women w/ STDs; IE&C and service expansion for safe motherhood</p> <p><u>Result two strategy:</u> Test alternative approaches to outreach, support increased coverage for existing services and expand new services (rehydration for diarrheal disease); IE&C for control of diarrheal disease control and immunization</p> <p><u>Both results:</u> improve services for rural women, particularly in order in increase contraceptive prevalence; management training, improved evaluation and research, improved health educ. curricula, improved MIS, decentralization</p> | | |
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Program Performance Monitoring, Evaluation and Reporting Planning Matrix

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| <p>4. What specific program outcome results generate specific strategic objective result? (use Table 1)</p> <p>4.1 What specific project outputs (i.e, number trained, etc.) generate specific program outcome results?</p> <p>4.2 How are these linkages/correlations determined?</p> | <p><u>LINKAGE ANALYSIS</u></p> <p>See Table 1</p> | <p><u>LINKAGE ANALYSIS</u></p> | <p><u>LINKAGE ANALYSIS</u></p> |
| <p>5. Which donors are working towards the achievement of these results?</p> <p>5.1 Which of these donors collaborate with A.I.D.?</p> | <p><u>COLLABORATORS:</u></p> <p><u>Result one:</u> UNFPA & EEC (safe motherhood); EEC (FP); UNICEF (immunization)</p> <p><u>Result two:</u> UNICEF (diarrheal disease, immunization)</p> | <p><u>COLLABORATORS:</u></p> | <p><u>COLLABORATORS:</u></p> |

Program Performance Monitoring, Evaluation and Reporting Planning Matrix

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| <p>6. How much funding is each donors, HG entities and USAID providing for achieving each result? (Use Table 2)</p> <p>6.1 How much funding is provided by collaborating donors?</p> | <p><u>PROGRAM FUNDING:</u></p> <p>AID is providing roughly \$39 million through the strategy period. AID is the largest donor for family planning and AIDS/STD; UNFPA for safe motherhood; and UNICEF for diarrheal disease control and immunization.</p> | <p><u>PROGRAM FUNDING:</u></p> | <p><u>PROGRAM FUNDING:</u></p> |
| <p>7. What % is A.I.D. funding relative to the total funding? (use Table 2)</p> <p>7.1 What % of its total portfolio funding is A.I.D. allocating for achieving each result? (use Table 3 for budget analysis)</p> | | | |
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Program Performance Monitoring, Evaluation and Reporting Planning Matrix

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| <p>8. What specific performance indicators are used to measure progress towards achieving the results sought?</p> <p>8.1 What is the scope of each indicator (i.e., program outcome population, geographic area, gender, etc)</p> | <p>INDICATORS:</p> <p>R1 Total Fertility Rate (urban/rural)</p> <p>R2.1 Infant Mortality (urban/rural)</p> <p>R2.2 Child mortality (urban/rural)</p> | <p>INDICATORS:</p> <p>R1.1 Contraceptive Prevalence rate (urban vs. rural; long-term vs. short-term methods)</p> <p>R1.1.1 Couple Years of Protection provided by the public sector (long-term vs. short-term methods)</p> <p>R1.1.2 Couple years of protection provided by private sector (short-term methods)</p> <p>R1.2 Contraceptive Use Effectiveness Rate</p> <p>R2 Percentage of pregnant women receiving qualified pre-natal care</p> <p>R3 Number of clients using twelve HIV/STD screening services (male/female)</p> <p>R4.1 Percent of diarrheal disease cases provided with ORS</p> <p>R4.1.1 Number of new diarrhea cases provided with ORS rehydration therapy at MOPH facility</p> <p>R4.1.2 Number of ORS packets distributed to retail outlets</p> <p>R4.2 Percent of women practicing diarrhea prevention techniques</p> | <p>INDICATORS:</p> <p>R1 Number of FP/MCH visits per donor dollar</p> <p>R2 Percentage of FP users getting contraceptives in the private sector</p> <p>R2.1 Private sector share of the condom and oral contraceptive markets</p> <p>R3 Percent of target population completely vaccinated by MOPH</p> |
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Program Performance Monitoring, Evaluation and Reporting Planning Matrix

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| <p>9. How are each of these indicators measured?</p> <p>9.1 What specific data sets are required for measuring these indicators?</p> <p>9.2 What are the measurement units of each data set?</p> <p>9.3 How reliable are the data sets</p> | <p>R1 Total lifetime fertility of the average Moroccan woman (DHS)</p> <p>R2 Annual number of deaths of infants under the age of one per thousand live births (DHS)</p> <p>R2.3 Deaths of children aged one through four years per total population of the same age (DHS)</p> <p>Demographic & Health Surveys (DHS) have a substantial margin of error but provide the only data available for many of these indicators.</p> | <p>R1.1 Percent of married women of child bearing age (15 - 49) currently using contraceptives, disaggregated by rural/urban and long term/short term methods (DHS)</p> <p>R1.1.1 Measured using MOPH services statistics, converting long-term/short-term products distributed to CYP: Long-term - sterilization = 10 CYP; 1 Norplant = 3.5 CYP; 1 IUD = 3.5 CYP Short-term - 15 cycles pills = 1 CYP; 150 condoms = 1 CYP</p> <p>R1.1.2 Measured as in R1.1.1, for pills and condoms only sold by wholesalers to retailers, using sales statistics (International Marketing Services (IMS) data available through SOMARC)</p> <p>R1.2 One minus the probability that a woman would get pregnant while using contraceptives (DHS)</p> | <p>R1 Number of FP/MCH visits to MOPH facilities for pregnancy and delivery, FP, diarrheal disease, nutrition surveillance, and immunization services divided by the number of major donor dollars (AID, UNICEF, EEC, UNFPA). Donor dollars per annum will be calculated by averaging grant divided by number of years of the grant)</p> <p>R2 FP users getting contraceptives in the private market as a percentage of total users</p> <p>R2.1 Ratio of commercially distributed pills and condoms to MOPH provided pills and condoms, translated into CYP</p> <p>R3 Percent of target population completely vaccinated with 3 DPT; 1 Measles; 1 Polio; 1 BCG</p> <p>With respect to R3, DHS data could differ from MOPH percentages based on service statistics. Therefore, for the years DHS data are available, MOPH percentages will be used as well.</p> |
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Program Performance Monitoring, Evaluation and Reporting Planning Matrix

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| | <p>R2 Percentage of women seeing MD, nurse or midwife at least once for prenatal care and receiving one tetanus toxoid injection (DHS)</p> <p>R3 MOPH service statistics for all patients screened at 12 facilities (6 FP reference centers and 6 STD centers)</p> <p>R4.1 Percent of children under five who had diarrhea in the previous 2 weeks and who were treated w/ ORS sachet or home solution</p> <p>R4.1.1 MOPH service statistics defining number of new diarrheal disease cases provided w/ ORS</p> <p>R4.1.2 Wholesaler to retailer sales statistics acquired from IMS through Population Services International</p> <p>R4.2 Prevention techniques to be defined in next couple of months</p> | |
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Program Performance Monitoring, Evaluation and Reporting Planning Matrix

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| <p>10. How are data sets aggregated across projects and program outcomes to measure performance at the strategic objective level? (Use Table 4)</p> | | <p>AID has invested considerable sums in improving MCH/FP service statistics and data are judged to be relatively reliable. In some cases, service statistics conform with DHS data. For R4.1, incidence of diarrhea rises in certain seasons and the DHS may not reflect true incidence. IMS data for private sector contraceptive and ORS sachet sales to retailers are reliable.</p> | |
| <p>11. What data collection instruments (i.e., data sources) are used for gathering the required data sets?</p> <p>11.1 What is the estimated cost of data collection & analysis for each type of data collection instrument? (use Table 5 - Data Collection & Analysis Budget)</p> | <p><u>INSTRUMENTS:</u></p> <p>R1, R2.1, R2.2 DHS</p> | <p><u>INSTRUMENTS:</u></p> <p>R1.1, R1.2, R2, R4.1: DHS (two years)</p> <p>R1.1.1, R3, R4.1.1: Service statistics of MOPH - MIS of Sante Maternale Infantile/Planification Familial and STD statistics</p> <p>R1.1.2: IMS through SOMARC project</p> <p>R4.1.2: IMS through Population Services Int. (PSI)</p> <p>R4.2: Survey (TBD)</p> | <p><u>INSTRUMENTS:</u></p> <p>R1 MOPH service statistics; donor assistance for FP/MCH</p> <p>R2 DHS (2 years)</p> <p>R2.1 IMS data through SOMARC, MOPH service statistics</p> <p>R3 MOPH service statistics, DHS (2 years); UNICEF survey (one or two years)</p> |

Program Performance Monitoring, Evaluation and Reporting Planning Matrix

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| <p>15. How is each performance indicator evaluated to assess progress towards achieving results?</p> <p>15.1 What algorithm, statistical and econometric methods are used to evaluate each indicator and result?</p> <p>15.2 What is the relevance of the indicator to determining achievement of the result?</p> | <p><u>EVALUATION METHOD:</u> R1 - proxy for maternal mortality, for which reliable data do not exist</p> | <p><u>EVALUATION METHOD:</u> DHS indicators which are the primary indicators for measuring impact can only be reported upon in 1992 and 1997. In the intervening years, the Mission will use proxy indicators (usually targeting public and private sectors in order to form a composite picture) to gauge progress. For most proxy indicators, data can be collected annually.</p> <p>R1.1.1 and R 1.1.2 If CYP is increasing, more women should be practicing family planning and/or they are doing so for longer periods. If CYP is going up more rapidly in the private sector, then this would be a sign that the private sector is beginning to pick up a larger share of the service burden.</p> | <p><u>EVALUATION METHOD:</u> R1 The MOPH does not organize its budget by program, so it is not possible to track the MCH/FP budget or portions thereof to determine if the MOPH is replacing donor funds that being shifted from recurrent costs to other interventions. It is possible to count the number of FP/MCH visits, which should increase, and to divide this by the number of visits per donor \$ to express the efficiency in use of donor funding. This assumes that donor funding remains relatively stable.</p> <p>R3 Donor support is being withdrawn from immunization, and the MOPH being assisted to develop a vaccine capitalization fund in order to buy vaccines from their own resources. If current high levels of vaccination are maintained, this is a sign that the Ministry has sustained its vaccination program.</p> |
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Program Performance Monitoring, Evaluation and Reporting Planning Matrix

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| <p>16. What are the baseline data for each indicator? (use Table 7 for baseline and projected performance program outcomes)</p> <p>16.1 What time period /year does the baseline data reflect (i.e., a point in time, a business cycle, etc.)?</p> <p>16.2 What program outcome population does the baseline data cover?</p> <p>16.3 How is each baseline data determined?</p> | <p><u>BASELINE DATA:</u></p> <p>DHS data are annual averages for the previous five years. They are national in scope.</p> | <p><u>BASELINE DATA:</u></p> <p>MOPH data are reported annually, on a calendar year basis.</p> | <p><u>BASELINE DATA:</u></p> |
|---|--|---|-------------------------------------|

Program Performance Monitoring, Evaluation and Reporting Planning Matrix

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| <p>17. What are the annual projected performance targets for each performance indicator by year? (use Table 7)</p> <p>17.1 How are these performance targets determined?</p> <p>17.2 What critical assumptions are made when determining these performance targets?</p> | <p><u>EXPECTED RESULTS:</u></p> <p>1992 =</p> <p>1993 =</p> <p>1994 =</p> <p>1995 =</p> <p>1996 =</p> <p>1997 =</p> | <p><u>EXPECTED RESULTS:</u></p> <p>1992 =</p> <p>1993 =</p> <p>1994 =</p> <p>1995 =</p> <p>1996 =</p> <p>1997 =</p> | <p><u>EXPECTED RESULTS:</u></p> <p>1992 =</p> <p>1993 =</p> <p>1994 =</p> <p>1995 =</p> <p>1996 =</p> <p>1997 =</p> |
| <p>18. What specific management and technical question does the analysis uncover?</p> <p>18.1 Are there internal inconsistencies?</p> <p>18.2 Overall, is the data accurate, timely and relevant?</p> | | | |

Program Performance Monitoring, Evaluation and Reporting Planning Matrix

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| <p>19. What external factors significantly influenced results?</p> <p>19.1 How and to what extent were the results helped by these external factors?</p> <p>19.2 How and to what extent were the results negatively impacted by these external factors?</p> | | | |
| <p>20. How frequently are data sets analyzed, evaluated and reported? (use Table 6 for Implementation Schedule)</p> <p>20.1 What management reports are produced and how frequently?</p> | | | |
| <p>21. Who is responsible for the analysis and reporting of performance indicators and results?</p> | | | |

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|--|--|--|--|
| <p>made as a result of the MER information?</p> <p>24.1 What corresponding data collection and analysis changes were made?</p> | | | |
| <p>25. How did prior management decisions affect results?</p> | | | |