Review of Health and Agriculture Project Monitoring Tools for Title II Funded PVOs

Prepared for Food Aid Management
by Thomas P. Davis Jr., MPH &
Julie Mobley, MSPH

July 2001

Table of Contents

List of Annexes iii
Abbreviations iv
Acknowledgements vi
Dedication vii
Executive Summary viii

I. The Monitoring and Evaluation Framework 1
Monitoring and Evaluation Defined 1
The Role of Monitoring in the M & E Framework 3
Relationship of Monitoring and Evaluation 4
Levels of Information 5
Summary 6

II. Methodology for Review of Monitoring Tools 7

III. Review of Monitoring Tools 9
A. Tools for Monitoring Quality of Service Delivery and Key Processes 9
- #1 Quality Improvement and Verification Checklists (FHI: Ag., Health)..... 10
- #2 Target Coverage Charts (FHI: Health, Agriculture)..... 16
- #3 Verbal Case Review for IMCI Clinical Practices (BASICS: Health)..... 18
- #4 Integrated Health Facility Assessment (BASICS: Health)..... 23
- #5 Food Distribution End Use Monitoring Report (ARC: Food Distribution) . 28
- Other Tools/Methods for Monitoring Quality of Services or Key Processes .. 32

B. Tools for Monitoring Client Satisfaction 35
- Measuring Client Satisfaction using Exit Interviews – an Introduction 36
- #6. Exit Interview Using Negative Response Cases (IPPF: Health, Ag.)..... 40
- #7. Key Informant Interviews (Agriculture; Health) 45
- #8. Focus Groups (Agriculture; Health)..... 49
- Other Tools/Methods for Monitoring Client Satisfaction..... 51

C. Tools for Monitoring Adoption of Practices (Techniques/Behaviors) and Acquisition of Knowledge.....**52**
- #9 Pre/Posttests 53
- #10 Rotating Mini-KPC Surveys (FHI: Health, Agriculture) 57
- #11 MCH Calendar (PCI: Health, Agriculture) 65
- #12 Holistic Community Epidemiology System (SCF: Health, mod. for Ag) . 70
- #13 LQAS with KPC Questions (NGO Networks: Agriculture, Health) 74
- #14 Grain Storage Silos Maintenance Questionnaire (PCI: Ag, mod. for Health) 77
- #15 Growth Monitoring using the Behavior Box (FOCAS/FHI: Health) 80
- Other Tools/Methods for Monitoring Acquisition of Knowledge 84
- Other Tools/Methods for Monitoring Adoption of Practices..... 85

IV. Other General References / Tools for Use in Development of a Monitoring System 90

Annexes:

Annex A: Contributors to the Title II Monitoring Toolbox

Annex B: Verbal Case Review Forms

Annex C: Consultant Training Skills Matrix

Annex D: FHI's Focus Group Training Notes

Annex E: FHI's Training Notes: Using Pre- & Posttests in Trainings

Annex F: Rotating Mini-KPC Data Entry Sheet (MS Excel form)

Annex G: Study on Mothers' Use and Reaction to the MCH Calendar

Annex H: Grain Storage Silos Maintenance Questionnaire

Annex I: ACDI Oral Posttest Questions for Microfinance

Annex J: ACDI/VOCA's Client Adoption of Practices Questionnaire Form

Annex K: Relationship of Monitoring Tools to Title II Generic Indicators

Abbreviations

ADRA	Adventist Development and Relief Agency International
AED	Academy for Educational Development
Ag	Agriculture
ARC	American Red Cross
ARHC	Andean Rural Health Care
ARI	Acute Respiratory Infection
BASICS	Basic Support for Institutionalizing Child Survival
BCC	Behavior Change Communication
BHR	Bureau for Humanitarian Response
CARE	Cooperative for Assistance and Relief Everywhere
CHW	Community Health Worker
C-IMCI	Community Component of IMCI
CORE	Child Survival Collaborations and Resources Group
CRS	Catholic Relief Services
CSTS	Child Survival Technical Support Group
DAP	Development Activity Proposal
EPI	Expanded Program of Immunization
FAM	Food Aid Management
FANTA	Food and Nutrition Technical Assistance Project
FFP	Food for Peace
FHI	Food for the Hungry International
FOCAS	Foundation of Compassionate American Samaritans
FSRC	FAM Food Security Resource Center
HFA	Health Facility Assessment
HH	Household
IMCI	Integrated Management of Childhood Illnesses
IPM	Integrated Pest Management
IPPF	International Planned Parenthood Federation
IRC	International Red Cross
JHU	Johns Hopkins University
KPC	Knowledge Practices and Coverage
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MOH	Ministry of Health
NRC	Negative Response Cases
NRM	Natural Resources Management
OICI	Opportunities Industrialization Centers International, Inc.
ORS	Oral Rehydration Solution
PCI	Project Concern International
PVC	Office of Private and Voluntary Cooperation
PVO	Private Voluntary Organization
QAP	Quality Assurance Project

QIVC	Quality Improvement and Verification Checklist
SARA	Support for Analysis and Research in Africa
SCF	Save the Children Foundation
SWC	Soil and Water Conservation
TCC	Target Coverage Charts
USAID	United States Agency for International Development
VCR	Verbal Case Review
WHO	World Health Organization
WV	World Vision

Acknowledgements

The authors wish to thank the many individuals within the Title II and Child Survival communities who contributed their time, technical knowledge and assistance in developing this report. In particular, the authors extend special thanks to the group of people who helped manage and coordinate this assignment, including Mara Russell, Coordinator of Food Aid Management (FAM), David Ameyaw, Chair of the FAM Working Group on Monitoring and Evaluation, and Anne Swindale, Deputy Director, Food and Nutrition Technical Assistance Project (FANTA). Members of the FAM Working Group on Monitoring and Evaluation whose organizations implement Title II health and nutrition development programs supplied project documents, participated in long e-mail dialogues on the details of their monitoring tools, met with one of the authors, participated in conference calls, and/or reviewed the survey instruments and this report. Trish Schmirler, with the FAM Food Security Resource Center (FSRC), helped in getting documents and tools posted to FAM's website. These individuals, along with others from Title II private voluntary organizations (PVOs) and partner organizations who provided input, are listed in Annex A.

Dedication

To our courageous colleagues everywhere who have committed their lives to the elimination of world hunger.

> This is the true joy in life, the being used for a purpose recognized by yourself as a mighty one; the being a force of nature instead of a feverish, selfish little clod of ailments and grievances complaining that the world will not devote itself to making you happy. ... Life is no "brief candle" for me. It is a sort of splendid torch which I have got hold of for the moment, and I want to make it burn as brightly as possible before handing it on to future generations.
>
> -- George Bernard Shaw

Executive Summary

As more and more effective development methods are created and disseminated (e.g., the Hearth methodology), and new, rapidly-spreading problems emerge (e.g., AIDS), the potential for both positive and negative rapid changes in communities in developing countries increases. These changes lead to increasing need among PVOs and their NGO and governmental counterparts to measure changes more frequently during the life of a project, which in turn requires improved monitoring systems. As new interventions are added to an organization's repertoire, new monitoring tools must be found to measure the outputs and outcomes of these interventions (e.g., changes in sexual practices). Also, as organizations seek to improve the effectiveness and sustainability of their projects, it is clear that more must be done to monitor and improve the *quality* of development work.

This document was written to provide organizations and agencies with a compendium of monitoring tools that can be used in Title II funded and other health and agriculture development projects. Section I provides a framework for monitoring and evaluation in order to help the reader to:

- define important elements of a strong monitoring and evaluation system,
- distinguish between monitoring and evaluation functions,
- define what a monitoring system should help an organization to do,
- understand the relationship between monitoring and evaluation, and
- understand the levels of monitoring data that should exist in a development strategy.

In order to collect information on useful tools, the authors queried Food Aid Management (FAM) member organizations and other agencies (e.g., BASICS, QAP[1]) on monitoring tools that they have used for monitoring:

- the quality of service delivery,
- client satisfaction,
- acquisition of knowledge, and
- adoption of practices (behavior change).

Given the paucity of tools for separately monitoring acquisition of knowledge, and the overlap of tools that were used to monitor concurrently adoption of practices and acquisition of knowledge, the last two tool categories were combined into the category, "Tools for Monitoring Adoption of Practices (Techniques/Behaviors) and Acquisition of Knowledge." Other tools were added from the health and agricultural literature to those identified by Title II funded PVOs.

This document also presents specific, detailed information on how each tool can be used by an organization, which was collected through correspondence with PVOs and other agencies. In Section II, a matrix (preceding each group of tools) shows the attributes of each tool so that the user can compare tools in terms of:

- the time and personnel needed for training staff and using the tool,
- the information provided by the tool,
- the level at which stakeholders can participate in the modification and use of the tool, and
- the ease of interpretation of the data collected with the tool.

---

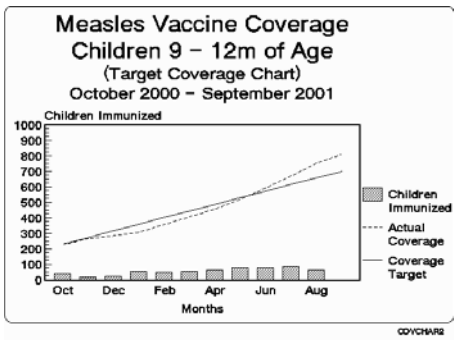
[1] BASICS = Basic Support for Institutionalizing Child Survival; QAP = Quality Assurance Project

Many of the Title II organizations contacted use *forms* to track information on project inputs, activities, and outputs. These forms are usually geared to a particular project's indicators, as they should be. However, these forms used alone should not be considered *tools*, at least not the type of tools that are useful to disseminate to other organizations. In this paper, a monitoring tool is defined as a *set of instruments and instructions that can be used and adapted by different organizations to monitor the quality of service delivery, client satisfaction, acquisition of knowledge, or adoption of practi*ces. In this compendium, the authors have tried to include only monitoring tools that present innovative ways of collecting monitoring data in the aforementioned categories – tools that can be used successfully by different organizations with varied project indicators. Preference was given to tools that can be easily adapted for use in both health and agricultural projects. A brief description of each of the fifteen tools chosen for this compendium is given below.

Tools for Monitoring Quality of Service Delivery:

1. **Quality Improvement and Verification Checklists (QIVCs): QIVCs provide information on the quality of project staff and/or volunteers performance of key processes performed by an organization in a particular context in agriculture, health, administration, and other areas, and on how the quality changes over time**. These tools have been evaluated on a small scale in several countries and shown to rapidly increase the quality of development workers' performance of key tasks. When using the tool, supervisory-level staff members observe project staff and/or volunteers carrying out processes that can be observed in one day or less, are key to project success, and are often repeated. The checklists are very detailed so that supervisors can build a worker's self-confidence by making many more positive than negative comments on the person's performance, since low perceived self-efficacy may be one of the reasons for poor performance by development workers. Other successful methods for changing behavior from the behavior change communcation (BCC) literature (e.g., asking the person evaluated to point out their own errors, asking him or her to commit to making certain changes) are incorporated into the instructions for giving feedback with this tool. These tools are being used in seven or more countries presently (e.g, by Food for the Hungry, Int. [FHI], Curamericas). Training notes for using QIVCs have been developed in English, Spanish, and Haitian Creole, while QIVCs have been developed for 16 different processes in five different languages so far.

2. **Target Coverage Charts (TCCs):** A Target Coverage Chart is a **simple tool that provides managers and other staff with a monthly or quarterly, graphical representation of cumulative progress in achieving coverage levels** (e.g., percent of farmers trained on a topic, percent of children receiving vitamin A). They are useful for monitoring the level of coverage of a particular service during a given period. In general, they are not based on the *proportion* of beneficiaries who have received a particular service (i.e., coverage), but on the *number* of beneficiaries provided with a service (i.e., output). To use the tool, after setting target coverage levels for a given year, the number of beneficiaries covered with a service is added to the number covered in the



previous month, and a point is plotted representing this new coverage level. A line is drawn connecting the points representing coverage month-to-month. (A bar graph can also be superimposed on the chart to indicate the actual number of beneficiaries covered in a given month.) When the coverage line is consistently below the target line, the coverage target will most likely not be met. When the coverage line follows or is higher than the target line then the coverage target will most likely be met. This tool has been used by Latin American ministries of health for many years.

3. **Verbal Case Review for Integrated Management of Childhood Illnesess (IMCI) Clinical Practices**: The Verbal Case Review (VCR) is a **household-based survey for assessing the quality of clinical care of sick children provided by healthcare providers, the care-seeking behavior of the parents of sick children, and assessment of the adequacy and effectiveness of care being provided to sick children in the home**. Information on the quality of care and nutritional counseling provided to parents of sick children, particularly with regard to care being provided by private practitioners, is of immediate interest and use to program managers and health providers in government, NGOs and donor agencies. Data from this tool have stimulated higher-level decision makers to devote additional resources to private practitioners, rather than concentrating solely on the government health system. The principle of the tool – a delayed exit interview – may be readily adapted to other aspects of quality of care (e.g. quality of agricultural extension, quality of counseling during growth monitoring/promotion). Data from the VCR have been presented to healthcare providers in an intervention target area to stimulate participation in the intervention. This same type of activity could be applied in Title II fields in order to stimulate interest in involvement in Title II interventions.

4. **Integrated Health Facility Assessment** (HFA): The Integrated Health Facility Assessment is designed for use by health programs that are planning to integrate child health care services at the district level. The implementation of integrated management of childhood illnesses (IMCI) protocols generally leads to health professionals doing a better job of screening for malnutrition and counseling of mothers on breastfeeding and other feeding practices (including feeding during illnesses). In that way, implementation of IMCI contributes to Title II and other health program indicators by improving food utilization. While mainly used in child survival programs presently, the HFA would be **useful to Title II health program managers who wish to upgrade the quality of local health services by giving them a better idea of what improvements need to be made in local health services**. During the assessment, information is collected on the case management of all important causes of infant and childhood morbidity and mortality in developing countries and on the program elements that are required to allow integrated practice. This information is collected through inspection of facilities, observation of the management of illnesses by health workers, exit interviews with patients, and interviews with staff members. As part of the HFA process, indicators are chosen, and are then used in an ongoing system of monitoring (using parts of the HFA methodology in an ongoing manner).

5. **Food Distribution End Use Monitoring Report:** This tool includes three main parts: a *beneficiary exit interview,* a *market survey,* and a *district level summary*. While this tool is principally used to collect information on commodity usage (which is generally beyond the scope of this toolkit), some of the elements of this tool **can be adapted for use in monitoring the quality of other services and client satisfaction**. All organizations conducting distribution programs (whether development or emergency programs) should do end-use monitoring to meet standard accountability requirements (to verify that targeted beneficiaries receive their rations). By using this tool, the distributing agency can also learn about customer satisfaction while conducting their end-use survey.

Tools for Monitoring Client Satisfaction:

6. **Exit Interview Using Negative Response Cases**: With this tool, users of a given facility (e.g., a tree nursery, health facility) or set of facilities are interviewed following provision of services. Exit interviews are used to **prioritize opportunities for improvement of services, to enable dialogue between clients and service providers about service quality and access, and to eventually increase sustainability by making services more client-oriented**. During the exit interview, a trained interviewer questions the client concerning access to services, interpersonal relations with staff, physical aspects of the facility, wait time for services, perceived technical competence of the staff, effectiveness and efficiency of services, the lag time in getting information from the service, and the cost of services.

   This tool provides a practical way to get service providers to give attention to even low levels of dissatisfaction with certain areas of service, despite overall low levels of dissatisfaction. It is designed to diminish the problem of courtesy bias by focusing on areas for improvement rather than absolute levels of satisfaction. Following the interviews, staff identify "areas for improvement" as those items in the questionnaire about which at least 5% of respondents expressed dissatisfaction. These items are called "negative response cases" (NRCs). The threshold of 5% for identifying dissatisfaction is based on observed results of earlier surveys, and is meant to flag a manageable number of areas for improvement with each survey. This tool has mainly been used by non-Title II family planning programs.

7. **Key Informant Interviews:** Key informant interviews are used to obtain client **satisfaction and other types of information from a community member who is in a position to know the community as a whole, or the particular portion of a community in which one is interested**. Informants are selected who not only understand the situation that is the focus of the interviews, but who have reflected on it, as well. Project staff members (and community volunteers, if they are used) develop a sampling scheme to help insure that the interviews (taken as a group) provide a high degree of representation of community members' perceptions of problems. Project staff work with stakeholders to come up with a question guide, a general list of questions to be used by all key informant interviewers. Interviewers are then assigned to key informants whom they will interview. After potential interviewees are selected, interviewers carry out a basic, semi-structured interview with the key informant (using

good qualitative interviewing skills) in order to determine the perceived quality of the service being offered by the organization and how it could be improved. As with many qualitative methods, analysis of the data can be difficult.

8. **Focus Groups**: Focus Groups are used to **obtain client satisfaction and other types of information from groups of people who share common traits** that affect their satisfaction with services and who generally have a common life situation or worldview. (That is, the respondents share characteristics that most likely influence attitudes towards the focus group topic.) This information is collected during a group interview whereby a group of about 6-15 people have a conversation about a given topic, guided by a moderator or facilitator who uses broad, open-ended, qualitative questions, followed by more narrowly-focused questions (probes). Focus groups generally last between 30 and 120 minutes.

Tools for Monitoring Adoption of Practices and Acquisition of Knowledge:

9. **Pre/Posttests**: Pre/posttests are useful **in measuring principles, facts and techniques that were understood and absorbed by participants during a training or educational session**. The purpose of pretests/posttests is to measure the amount of knowledge that has been acquired and retained following an educational or training session. Pre/posttests can be conducted using standard written (pencil-and-paper type) or verbal tests, or using simulations of on-the-job situations where workers apply skills and knowledge learned during a training.

10. **Rotating Mini-KPC Survey**: Rotating Mini-KPC (knowledge, practice, and coverage) surveys are used **to monitor changes in knowledge, practice and coverage of program participants**. Every three to six months, a sample of program participants is used by randomly selecting one of the *Care Groups*[2] with which each development worker works (or a sample of each of those groups). Teams of three to four interviewers and one supervisor carry out interviews. Communities are visited on a pre-arranged day and time. The indicator levels found through these interviews are compared to baseline and to the preceding three- to six-month monitoring period. Volunteers at the community level receive a flipchart which graphically presents the coverage levels of mothers (as a point prevalence) in the district in which they live so that they can share results with the community. Indicator levels are also plotted on individual line graphs and the graphs are posted at the projects' offices. (This report, of course, becomes the bulk of what is included in the CSR4 report.) The system also allows for pairing up of community-level educators so that the less effective volunteers (i.e., those for whom fewer changes are seen in those whom they educate) are paired with stronger educators in order to improve their education and counseling methods (as World Relief has done in Mozambique).

---

[2] Care Groups are groups of volunteer mothers who educate 10 mothers each in their neighborhood as part of a multiplier model.

11. **Maternal and Child Health (MCH) Calendar**: The purpose of this tool is to **track events and trends important to a development project – with the help of community members -- at the household level**. In its application by Project Concern International (PCI), the calendar is used to monitor child and family health and morbidity by tracking health behaviors and events (e.g., exclusive breastfeeding, illnesses, and service delivery) that occur each month in each household. While useful with community IMCI (i.e., in conducting and facilitating verbal case reviews), this tool also lends itself to monitoring of **agricultural** and other practices. The tool also helps to prompt the development worker as to questions that should be used with the beneficiary, and to facilitate selection of topics that should be discussed during home visits in order to promote behavior change.

    Development workers (e.g., Community Health Workers [CHWs] or Extensionists) give the calendar to program participants during a home visit. Each monthly page has a traditional western calendar with a row of seven icons at the top indicating the common problems in the project area (e.g., diarrhea, white fly), and services sought and received (e.g., immunizations, training in integrated pest management [IPM]). The program participant is asked to mark an X over any of the icons at the top of the calendar that represent a problem encountered, or service received during the given month. Each numbered square representing one day on the calendar has a small box at the bottom where additional, daily information on adopted practices can be included (e.g., if a child was given oral serum on a given day, if a farmer weeded on a given day). When the development worker visits the program participant, s/he asks the person about the events recorded on the calendar, using questions to see if the person has properly managed the problem encountered and filled out the calendar correctly. Counsel is given. After assuring that the data are complete, the monthly sheet is taken from the program participant by the development worker. The development worker tabulates the data from the calendars each month manually in order to analyze each community's results. Trends are then monitored for a given community or data are aggregated to look at larger areas.

12. **Holistic Community Epidemiology System**: **Managers can use this tool to receive information on important events, coverage levels, compliance with promoted practices, and status of the program participants** (e.g., nutritional status) **for making program decisions.** This system is used by community-level volunteers (e.g., Lead Farmers or CHWs) who:
    - collect information at the community level monthly or bimonthly;
    - add information from local facilities (e.g., clinics);
    - return information to the community for analysis and discussion; and
    - mobilize the community to take action to prevent and confront problems.

    Community-level volunteers are trained in how to use the methodology, beginning with how to conduct a simple census at the community level. A community map is

sometimes developed, as well. Monthly or bimonthly, the development worker visits each family, and interviews a family member to collect the information listed above.

This information is written on a form and used to prepare the flipcharts which help the community to monitor their situation. A consolidated report is analyzed using these data and a software package developed by Save the Children Foundation (SCF)/Bolivia. This information is sent back to the community using a three-page, cloth flipchart. There is a row of pictures on the bottom of each page of this flipchart representing important, community- and facility-level events (e.g., child deaths), and promoted practices that are being tracked. On the top of each page, there is a space for writing in the number of cases for each event/practice and a blank space where the number is represented graphically by gender. Cutouts of women and men are used to represent the data. The first page of the flipchart is used to report back to the community on maternal data (e.g., pregnancies, clean deliveries). The second page is used to report back to the community on child data (e.g., children pneumonia, children with incomplete immunizations). The third page is a three-colored flag. Cutouts are placed on each stripe of the flag to represent the number of individuals in a good (green), at-risk (yellow), and poor (red) situation for three or more situations (e.g., nutritional status, vaccine coverage, prenatal controls).

Community leaders, women's group members, youth, teachers, health facility personnel, and others are invited to the meetings to analyze the data. Comparisons are drawn to previous months and other communities. Participants discuss why and how the problems occur. This information is used to plan strategies to confront problems, determine who will be responsible for taking action, and to convince authorities that they need to invest resources in the community (advocacy). Communities are also encouraged to evaluate the results of their work.

This tool has been formally evaluated. During that evaluation, it was found that – in communities where the system was being used – 3.38 times more children had completed immunization records, and 2.55 times more children had had their growth monitored more than three times in the past year as compared to control communities.

This simple system for giving results back to community members could be adapted easily for work in agriculture and other development areas. Problems such as rat, bird, and insect infestations, and plant diseases, could be tracked.

13. **Lot Quality Assurance Sampling (LQAS) with KPC Questions**: The purpose of this tool is to **monitor changes in knowledge, practice and coverage of program participants** (in health, agriculture, and other development areas). It is similar to the Rotating KPC methodology in many ways, but a different sampling methodology is used. Lot Quality Assurance Sampling (LQAS) is a sampling methodology that uses simple random samples of 19 respondents in each supervision area (e.g., a district) defined by a project. A KPC-type survey questionnaire can be used with each of these respondents. One benefit of using this tool is that an organization using LQAS is able to speak about the situation (e.g., coverage levels) in each of its supervision areas, as well as the situation in the entire project area.

14. **Grain Storage Silos Maintenance Questionnaire**: The purpose of this tool, developed by PCI, is to **monitor grain storage and silo maintenance practices in order to prevent grain loss, and to enable farmers to troubleshoot problems encountered with grain storage**. Similar methodologies could be developed (based on this model) to monitor the use and maintenance of other facilities maintained by program participants or community-level volunteers (e.g., latrines, health equipment, wells). Technicians carry out interviews and silo inspections with farmers participating in project activities. Farmers are interviewed about:
    - the training they have received in silo maintenance,
    - information on the silo itself (e.g., year built/bought),
    - details on the grain(s) stored in the silo (e.g., type of grain stored, month and year of storage, presence of losses of grain in the silo and reason for loss),
    - activities realized before storage of grain (selection, cleaning, cooling), parts of the silo that were checked, and how the silo was sealed;
    - periodic observation and emptying of the silo; and
    - other information.

    The second activity done as part of this monitoring tool is a visual inspection of the silo. It includes observation of:
    - location of the silo,
    - protection from rain,
    - condition of the silo (e.g., dents, holes, rust)
    - sealing of the silo,
    - grain humidity (> 15% or < 15%, determined using a “salt test”) and the condition of the grain.

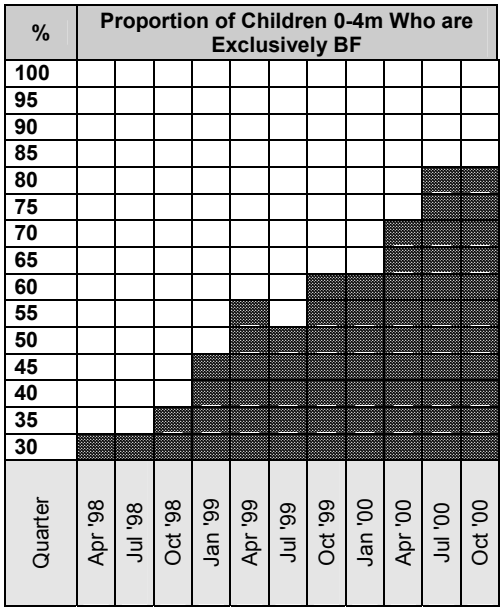
    An agriculture specialist aggregates the data and reviews the findings manually. A field team (e.g., one Ag Specialist and several technicians) follows up with farmers interviewed so that they re-dry the grain and apply the test again, when necessary, making any necessary modifications in the way that the silo is maintained and the grain is stored.

15. **Growth Monitoring using the Behavior Box**: Growth Monitoring using the "behavior box" **improves the growth monitoring / promotion process by allowing project staff to monitor key health and nutrition behaviors of program participants (e.g., exclusive breastfeeding) in addition to nutritional status and changes in weight.** Most organizations using this tool attach the behavior box to the current Ministry of Health (MOH) growth chart. The box has a section for the child's date of birth, and rows for each of the key behaviors to be monitored.

After the child is weighed and the weight is plotted on the chart, the CHW uses the box as a cue as to what questions should be asked of the mother. CHWs are trained to first use open-ended questions on feeding and illnesses, then to ask specific closed-ended questions in the behavior box to assess each behavior. As the mother responds to each question, the CHW marks the appropriate column, and does the counseling. For monitoring at the community-level, the CHW can use the behavior box to calculate the proportion of children being weighed whose mothers are doing each of the key behaviors. The CHW can also look for trends of diseases at the community level.

Things to ask the mother during EACH VISIT.	Born: 02/01 mon yr	**Month**	Ma	Apr	Ma	Jun	Jul	Au	Sep	Oct	No	De c	Jan	Feb
			1	2	3	4	5	6	7	8	9	10	11	12
1. Did you give your child colostrum within the first eight hours after birth?			+											
2. Are you currently breastfeeding?			+	+	+	+	+	+	+	+				
3. Are you currently giving your child any water, other liquids, food or anything else except breast milk?			+	+	-	-	-	+	+	+				
4. Are you presently giving your child solid or semisolid food?			+	-	-	-	-	+	+	+				
5. Are you currently bottle-feeding your child?			+	-	-	-	-	-	-	-				
6. Has your child had diarrhea during the past month?			-	+	-	-	-	+	-	-				
7. Has your child has cough/diff. breathing in the past month?			-	-	-	+	-	-	-	-				
8. Has your child had a fever during the past month?			-	-	-	-	-	-	-	-				
9. Has your child had any other illness in the past month?			-	-	+	-	-	-	-	-				

Organizations can also use the behavior box data to collect quarterly trend data for each of the indicators. To do this, development workers (e.g., CHWs) are asked to bring a copy of the growth charts to a meeting (if they keep a copy of the chart). Supervisory-level staff members take the CHWs through a series of sorting exercises to calculate each indicator needed. (Alternatively, this can be done at the community level with the mothers' copies of the growth cards.) This information is then used to make line graphs, target coverage charts (see Tool #2), or tables such as the one shown on the next page. Aside from being useful for monitoring key indicators, the behavior box can bring about improvements to the growth chart itself, in that it documents the mother's behavior and child's illness pattern during the child's first year of life. This tool has been used by the Foundation of Compassionate American Samaritans (FOCAS) in Haiti, and could be adapted to agricultural by monitoring monthly or quarterly adoption of agricultural practices during contact with farmers.



This compendium is not meant to be a complete guide in development of monitoring systems. FANTA (www.fantaproject.org) and its predecessors have produced a number of guides to support Title II PVO's in the development of monitoring and evaluation systems. Many of the guides have focused on methods of collecting data, analyzing, and reporting information for specific generic indicators. Readers should be aware that a new guide is forthcoming that is intended to provide ***guidance in developing monitoring and evaluation systems***, with an emphasis on program monitoring. This monitoring systems guide will be:

- directed towards field staff implementing a variety of Title II food aid-supported activities;
- grounded by examples of good and creative practice; and
- accompanied by some simple tools for the design of systems.

No distribution date has been set, at this point, for the release of this guide. The author of this monitoring toolkit has attempted to avoid duplication of effort by not focusing on development of monitoring systems, but instead providing an array of tools that can be quickly adopted and used within an existing monitoring system.

I. The Monitoring and Evaluation Framework

Monitoring and evaluation (M&E) is an essential component of all Title II programs. An effective M&E system is designed to collect and analyze reliable and accurate data that will be used in improving program performance. The capacity of the PVO community to design effective monitoring and evaluation (M&E) systems has progressed significantly in the last decade, but continued improvement is needed.

According to the United States Agency for International Development (USAID)[3], the two most important elements of a strong M&E system are: 1) involvement of key stakeholders in the design of the system (data collection, analysis, interpretation); and 2) use of data by stakeholders for program readjustment and redesign. (Because of this, an attempt is made to rate each tool in this toolkit in terms of the degree to which the method or tool can be participatory and the likelihood that the local partners or the community will be able to continue using the tool and the data it generates after program completion.) As donors and other stakeholders have demanded greater accountability in the use of resources, PVOs have explored and improved their capacity to develop logical frameworks with carefully planned and targeted indicators, to define and measure progress in reaching program objectives. Many PVOs, however, still lack expertise in the ability to effectively aggregate and use collected monitoring data at appropriate times to make management decisions.

Monitoring and Evaluation Defined

At first glance, there seems to be a relatively clear distinction between evaluation and monitoring. Simply defined, monitoring is "a continuing function that aims primarily to provide program or project management and the main stakeholders of an ongoing program or project with early indications of progress or lack thereof in the achievement of program/project input and output objectives."[4] Evaluations, on the other hand, "are systematic analytical efforts planned and conducted in response to specific management questions about performance of programs. Unlike performance monitoring, which is ongoing, evaluations are occasional – conducted when needed."[1]

The Food Aid Management (FAM) M&E Working Group states that: ". . . the group recognizes that monitoring and evaluation are two basically separate processes . . . Monitoring is understood in this context to be a management tool, while evaluation is defined as a measurement tool."[5]

Riely et al.[6], in their guide on indicators and M&E frameworks published by the Food And Nutrition Technical Assistance (FANta) Project, outline the following distinctions between

---

[3] USAID Bureau for Humanitarian Response, Office of Private and Voluntary Cooperation, PVO Child Survival Grants Program - Technical Reference Materials, December 2000.

[4] United Nations Development Programme, Programming Manual, Chapter 7: Monitoring, Reporting and Evaluation, April 1999.

[5] Food Aid Management, FAM Monitoring and Evaluation Working Group Proposal for PVO Collaborative Effort, March 18, 1998.

[6] Riely, F., Mock, N., Cogill, B., Bailey, L., Kenefick E. *Food Security Indicators and Framework for Use in the Monitoring and Evaluation of Food Aid Programs,* Food and Nutrition Technical Assistance (FANta), January 1999.

monitoring and evaluation in a table taken from UNICEF's *Guide for Monitoring and Evaluation* (1991).

Item	Monitoring	Evaluation
Frequency	periodic, regular	episodic
Main action	keeping track / oversight	assessment
Basic Purpose	improve efficiency, adjust work plan, accountability	improve effectiveness, impact, future programming
Focus	inputs, processes, outputs, work plans	effectiveness, relevance, impact, cost effectiveness
Information sources	routine or sentinel systems, field observations, progress reports, rapid assessments	same as monitoring, plus surveys, studies
Undertaken by	program managers, community workers, community (beneficiaries), supervisors, funders	program managers, supervisors, funders, external evaluators, community (beneficiaries)
Reporting to	program managers, community workers, community (beneficiaries) supervisors, funders	program managers, supervisors, funders, policy makers, community (beneficiaries)

The table suggests a fairly clear distinction between the two components, though overlap is seen in the latter items. In other documents and in practice, however, there is not always such a clear distinction.

An example of the sometimes blurred delineation between monitoring and evaluation can be seen in the following list of questions which, according to Riely et al.,[4] "are typically addressed through program monitoring":

- Were scheduled activities carried out as planned?
- How well were they carried out?
- Did expected changes occur at the program level in terms of improved access to services, quality of service, and improved use of services by program beneficiaries?

Though presented as *monitoring* questions in this document, all of the above are also questions that are typically answered as part of a mid-term or final *process evaluation* of a project.

Another example is the role of the KPC survey. While often considered an initial activity in a *monitoring* system, the same survey implemented in the final months of a project becomes part of the *evaluative* process. The difference at this point is not in the methodology used, but rather in the application of the findings for comparative and evaluative, rather than management and planning, purposes. Adding further ambiguity, results from the mid-term or final survey may take on a monitoring function, being used to improve efficiency and adjust the work plan for continuing or follow-on activities. Some of the overlap is a matter of semantics, though it also highlights the integrated nature of monitoring and evaluation.

The Role of Monitoring in the M & E Framework

The role of monitoring is traditionally defined in the literature as that of measuring the efficiency of a project in terms of converting inputs to outputs. Recently the definition has been expanded in the PVO community, to place greater emphasis on "benefit monitoring," or monitoring that leads to a greater indication of impact as well as process. In the context of Title II and other USAID-funded projects, monitoring is usually linked to the establishment of performance indicators, as part of a broader logical (results) framework. In this type of framework, monitoring and evaluation together allow performance and impact to be measured and quantified.

A monitoring system should be able to

- track inputs and outputs;
- provide relevant initial information to be used in project planning;
- provide relevant, ongoing information to be used in project management and reporting; and
- provide information on trends and gaps that may lead to project modification.

According to FAM[7], an effective monitoring framework should include:

- the type of data to be collected;
- the frequency of data collection;
- the methodology to be used;
- the population covered;
- key assumptions anticipated in the planned interpretation of data; and
- the personnel who will collect and analyze the data.

A monitoring system should collect quantitative and qualitative data, both of which should become inputs to an evaluative process. The interval of data collection may vary, depending on the type of data and project needs, but responsibility and accountability for data collection and analysis must be clearly assigned to avoid ambiguity or redundancy. A variety of quantitative and qualitative methods should be used to collect data, and monitoring systems should collect data at various levels, including the individual program participant level, facility level, program level, district level, etc. Key assumptions about data interpretation should relate directly to project goals and objectives

Missing from this list of effective monitoring framework components is the *flow of monitoring data*, specifying the frequency and methodology by which the data will be aggregated and assessed periodically. This data flow in monitoring must be clearly outlined, whether the data are collected at baseline or during ongoing monitoring. The collection of baseline data, both quantitative and qualitative, should help determine and shape – at least to some extent – the formulation of the monitoring strategy and methods to be used. After the baseline assessment, however, it must also be clearly spelled out and understood how and when data collected will be used to inform decision-making processes.

Relationship of Monitoring and Evaluation

[7] FAM – Monitoring & Evaluation Plan, (from Monitoring and Evaluation Documents and Links web page: http://www.foodaid.org/worddocs/meplan.doc)

Monitoring and evaluation have distinct but interrelated functions in a monitoring and evaluation system. Some sources portray them as intrinsically discrete processes, and others treat monitoring and evaluation as one simplified, uni-dimensional process. To have a truly effective system, monitoring and evaluation should be viewed as two separate but integrated components of an M&E system. Monitoring and evaluation are both essential management functions. They are equally important, interactive and mutually supportive[8].

It is clear that evaluation is a necessary adjunct to monitoring, in that routine data must be systematically aggregated, summarized, analyzed, interpreted, and used. Monitoring in itself cannot contribute fully to decision-making unless a pre-determined, deliberate effort is made to evaluate the monitoring data collected. Monitoring is an ongoing process, but should be punctuated with systematic process evaluation, using the monitoring data to draw periodic conclusions about the progress being made. In this way, evaluation can support the monitoring process, providing lessons and conclusions that can help to modify and refine monitoring indicators. While implied, many logical frameworks do not specify when assessment of monitoring data will be done, other than at mid-term or final evaluations.

An effective monitoring system also makes an important contribution to the evaluation process. Monitoring may reveal operational problems that can then be investigated in more detail through process evaluation. Good monitoring helps avoids "surprises" during evaluations that can increase the cost of evaluation.[9] In USAID Title II projects, a structured evaluation is almost always performed in the final months of a project, and is often done at the mid-term point. Causality cannot be clearly established in most Title II projects, and inferential statistical modeling that could control for confounding factors is beyond the scope of most operational research carried out by these projects. USAID guidelines and other documents urge caution in imputing causality to evaluation results showing change or impact over the life of the project, whether positive or negative. Results reporting "provides an indication of change, not causality or attribution."[10] However, projects that collect clear and systematic monitoring data can often make a strong empirical case linking project activities to favorable outcomes in a mid-term or final evaluation process. When impact evaluation is done, a project must be able to identify who received what quality and quantity of inputs / services, and at what cost, in order to correctly interpret the results of the evaluation and make proper program decisions. Impacts due to project influences can then be more clearly and confidently separated from those due to other external influences. Results of impact evaluation must always be interpreted in the context of data gathered through monitoring program inputs and outputs.

Levels of Information

---

[8] United Nations Development Programme (UNDP), Office of Evaluation and Strategic Planning, Results-oriented Monitoring and Evaluation - A Handbook For Programme Managers, 1997.

[9] For example, being current of a problem with low attendance at growth monitoring points during routine monitoring can allow an organization to avoid adding elements to a final evaluation (e.g., focus groups) to understand that problem.

[10] Bonnard P., Review of Agriculture Project Baseline Surveying Methods of Title II Funded PVOs, FAM, September 30, 1998

Monitoring takes place at several levels during the life of a project, and these levels may be viewed in a variety of ways. In general, routine monitoring of program-based data is typically related to inputs and outputs to assist in judging the efficiency of program performance. At a higher level, impact indicators are typically derived from information at the beneficiary level.

Riely et al.[7] suggest that the levels of monitoring needed may be determined by the various decision-making needs of project stakeholders, such as the following:

- **Field staff**: need continuous information on stocks, demand for services, trends in program participant level conditions, etc. (e.g., information from Tool #5, the *Food Distribution End Use Monitoring Report*, Tool #11, the *MCH Calendar*, Tool #14, the *Grain Storage Silos Maintenance Questionnaire,* or Tool #12, *Holistic Community Epidemiology System*);
- **Program Managers**: require information for basic supervision and accountability, program planning and design, and internal resource allocation decisions (e.g., information from Tool #1, *Quality Improvement and Verification Checklists*, or Tool #6, *Integrated Health Facility Assessment)*;
- **General Program**: needs information for advocacy and policy purposes, to effect important changes in government or donor policies, or to lobby for expanded program funding (e.g., Tool #6*, Exit Interviews*);
- **Host Government and Donors**: need information to assist in their own informed strategic planning and resource allocation decisions (e.g., information from Tool #10, *Rotating Mini-KPC Surveys*); and
- **Program beneficiaries**: need information on their own community and program participant level health/nutrition status to assist in their effectiveness and participation in participatory methods for problem identification and solutions (e.g., information from Tool #15, *Growth Monitoring Using the Behavior Box,* and Tool #12, the *Holistic Community Epidemiology System).*

The methodology of data collection in a monitoring system may also take place on two separate levels:

- First-level data collection – direct data gathered through evaluation and monitoring efforts of the project itself. This could involve data at the individual program participant, facility or project management level.
- Secondary sources of data are also important, since projects usually do not have adequate resources to collect all potential data of interest. These sources can be local, district, or national-level data collected or maintained by the MOH/MOA or local mission, or other NGOs/PVOs/donor agencies. In addition, sources of data on a global or international level are more accessible than ever.

The USAID Bureau of Humanitarian Response/Office of Private Voluntary Cooperation (BHR/PVC) notes several types of data collection processes, techniques, and sources useful for structuring an effective M&E system. Among these are:

- Household and Community: Quantitative Data (through surveys and census-based information)
- Household and Community: Qualitative Data
- Routine Facility-Based Information Systems
- Self-Assessment Methods and Peer-Assessment Methods

- Routine Surveillance
- Program reviews
- Review of Existing Data
- Exploratory Data Collection

Title II project staff should examine their M&E plans to assure that each of these elements is included in the plan, as appropriate.

Whatever the monitoring levels defined by a project, the M&E system must accommodate the need for data collection, aggregation and reporting at various levels, and indicator selection and measurement need to be appropriate to the level of program operation. Care must also be taken in the aggregation of data at different levels, as the process of aggregation may change the degree of relevance of the data to specified indicators.

Summary

Clearly, there is much variation among monitoring systems used by PVOs administering Title II programs. Monitoring may take on slightly different operational definitions within these diverse systems, but should always be a participatory process, including clearly outlined strategies for what data is collected, how often and by whom, and most importantly, how often the data will be aggregated and how it will feed into evaluation processes. Additionally, the M&E system should spell out how conclusions from evaluation will, in turn, feed back into the monitoring system to refine and improve indicators and other components of the monitoring process.

As monitoring tools are reviewed and summarized in this document, each will be examined with respect to its role and purpose within a monitoring and evaluation system.

II. Methodology for Review of Monitoring Tools

At the FAM Monitoring and Evaluation Working Group's request, the authors developed a questionnaire to solicit information on monitoring tools for four specific purposes[11]:

- monitoring the quality of service delivery;
- monitoring client satisfaction;
- monitoring acquisition of knowledge; and
- monitoring adoption of practices.

Modifications were made to a draft of the questionnaire by the FAM M&E Working Group, and the questionnaire was sent out to 54 contact people within the FAM network on April 23rd, 2001. Several organizations sent the questionnaire to overseas field staff and returned their responses. The organizations that eventually completed the questionnaire or turned in tools were:

- Agricultural Cooperative Development International/Volunteers in Overseas Cooperative Assistance (ACDI/VOCA)
- Adventist Development and Relief Agency (ADRA)
- American Red Cross (ARC)
- Cooperative for Assistance and Relief Everywhere (CARE)
- Counterpart International
- Food for the Hungry, International (FHI)
- Opportunities Industrialization Centers International, Inc (OICI)
- Project Concern International (PCI)
- Save the Children Foundation (SCF)
- World SHARE
- World Vision (WV)

Africare did not turn in a completed questionnaire or offer tools, but did participate in a phone interview on their monitoring systems. No personnel were available to respond to the questionnaire at CRS since they had no M&E specialist employed at the headquarters level at the time of the survey. BASICS, the Quality Assurance Project, the Child Survival Technical Support group, and NGO Networks for Health also contributed to this toolkit.

The purpose of this compendium is to provide Title II project field staff with tools and related information that can be used to monitor their Title II agriculture, health, and other activities. In each section below, a tool is presented along with:

- a contact person;
- the purpose of the tool;
- how the tool works, including
  - personnel used to collect the data,
  - type of data collected,
  - frequency of data collection, and
  - methodology;
- other attributes, such as
  - the level of rigor and quality of data obtained from the use of the method or tool;
  - circumstances / situations under which the use of the method or tool would be optimal and limitations associated with the use of the method or tool;

[11] per the SOW developed for this work.

- the degree to which the method or tool can be participatory;
- the likelihood that the local partners or the community will be able to continue using the tool after program completion (sustainability); and
- key assumptions anticipated in the planned interpretation of data.

Each group of tools is preceded by a matrix that shows whether the tool has each of the following attributes (according to the authors review of the information provided to them):

1. Lends itself to participation by program stakeholders in modification of tools;
2. Requires two days or fewer of training;
3. Can collect and analyze data in one week or less;
4. Provides quantitative data to facilitate measurement of changes -- numerical quality scores or indicator levels;
5. Provides information that is easily interpreted and used for program modifications;
6. Can generally be conducted with existing staff.

Classification of each tool in this matrix is somewhat subjective and depends on how the tool is implemented by an organization, especially in terms of participation by program stakeholders and ease of interpretation.

Given the paucity of tools for monitoring acquisition of knowledge separately, and the overlap of tools which were used to monitor concurrently adoption of practices and acquisition of knowledge, two of the tool categories were merged into one category: “Tools for Monitoring Adoption of Practices (Techniques/Behaviors) and Acquisition of Knowledge.”

III. Review of Monitoring Tools

A. Tools for Monitoring Quality of Service Delivery

✪ = tool meets the criteria

Tool	*Lends itself to Participation by Program Stakeholders in Use & Modification of Tools*	*Requires Two Days or Less of Training*	*Can Collect and Analyze Data in one Week or Less*	*Provides numerical quality scores or indicator levels*	*Provides information that is easily interpreted and used for program modifications*	*Can Generally be Conducted with Existing Staff*
#1: Quality Improvement and Verification Checklists	✪	✪	✪	✪	✪	✪
#2. Target Coverage Charts	✪	✪	✪	✪	✪	✪
#3. Verbal Case Review for IMCI Clinical Practices	-	✪	✪	✪	✪	✪
#4. Integrated Health Facility Assessment	✪	-	-	✪	✪	-
#5. Food Distribution End Use Monitoring Report	-	✪	✪	✪	✪	✪
Other Tools/ Methods for Monitoring Quality of Services or Key Processes	*(Varies)*					

#1. Quality Improvement and Verification Checklists (QIVCs)

Contact: **Tom Davis, MPH (Food for the Hungry, Int.),** tdavis@fhi.net

Purpose: These checklists provide information on the quality of key processes done in an organization in agriculture, health, administration, and other areas, and how the quality changes over time. When combined with coverage data, it can support and enhance the quality of impact data.

How it Works:

- **Personnel Used to Collect the Data**: The staff who collect the data are usually agriculture and health technical staff members who are literate and are responsible for the supervision of other paid or volunteer workers. The tools, however, can be used by a wide variety of staff members who have supervisory responsibility over others who have specific processes that they complete on a regular basis.
- **Type of Data Collected**: The data collected is a series of yes/no and rating questions concerning the quality of defined processes in an organization (e.g., health or agriculture education sessions, growth monitoring / promotion, distribution of food supplements). The process that is measured should generally be one that can be observed in one day or less, is key to program success, and is repeated often.
- **Frequency of data collection:** Data are generally collected once per month per staff member supervised, shortly after the introduction of a new process (e.g., training in growth monitoring). Afterwards, it is used less frequently (e.g., every two to three months) as quality scores improve.
- **Methodology**:
  An observational *Quality Improvement and Verification Checklist* is a tool used by a supervisor to do a detailed check of all elements of a development worker's performance of a given process in order to monitor and improve performance, and encourage the worker. QIV checklists are being used in many countries throughout the world to improve key processes in Title II agriculture and health projects, as well as Child Survival projects. Food for the Hungry, International is using them in Kenya, Ethiopia, Bolivia, and Mozambique. MAP International is now using the checklists in Ecuador, and Curamericas (formerly ARHC) and FOCAS are using them in Haiti and Bolivia. In those countries, what has been stressed is that QIV checklists – while helping to *monitor* the quality of development work – are principally tools for *improving* the quality of the work being done. For that improvement to take place, supervisors need to become excellent at offering encouragement to the people with whom they work.

  One full day of training of Supervisors is required to learn how to use the existing checklists and how to make new QIV checklists. Training guides for these tools have been developed in English, Spanish, and Haitian Creole. The classroom part of the training generally lasts four hours. A half-day to full-day practicum using the checklists in project communities is recommended, as well.

  Each QIV checklist is developed by team members who understand the process to be evaluated (e.g., promotion of breastfeeding). The simplest processes will have a

checklist that is about two pages long, but processes that are more complex may require checklists that are much longer (e.g., 5 pages). First, a process is chosen for which a QIV checklist can be useful. The process should be something that a development worker does, that is repeated many times during the life of a project, that has multiple steps, and that can be observed. A question is developed to assess each part of the process. Questions are phrased so that all "yes" responses correspond to a positive behavior. Parts of processes that are usually done properly by workers (e.g., setting a balance to zero prior to weighing a child) should not be excluded from the checklist. It is important to keep the checklists detailed so that there is ample opportunity to compliment the worker on his or her performance, and to identify specific parts of the process that are problematic for a particular development worker and the development workers in aggregate.

This is a good time for benchmarking: The team developing the checklist should consult the agricultural or health literature and other organizations to see who has had the best results, and which methodology was used by those projects. If there are parts of the process that are not included presently, but which can be added to the process, or unnecessary steps which should be omitted, those modifications should be made to the process design prior to retraining. The checklist should be tested on a small-scale in the setting in which it will be used (e.g., project communities, the clinical setting). The checklist should be modified to include any steps that were overlooked during initial development.

At this point, it is usually necessary to give the development workers a brief retraining on the process being measured (e.g., GM/P, teaching construction of improved silos) in order to explain the changes that they will need to make to the process. They should receive a copy of the checklist at that time and be asked to study it. The steps involved in attaining perfect performance should not be a secret, but should be understood by all staff members. Once the development workers have learned what is expected of them, copies of the checklist should be distributed to all supervisory-level staff.

On the day that the checklist is used in each community or clinic, the supervisor should visit with the development worker in a private place, explain the main purpose of the checklist (to improve their work), quiet any fears that they have, and ask the worker to do his or her work as s/he normally does it during the observation. The development worker is asked to refrain from asking questions of the supervisor during the observed session, but to save his or her questions for later when they meet privately.

During the process being observed (e.g., an educational session, management of an ill child), the supervisor is briefly introduced, but does not comment on the process. S/he marks the checklist, but says nothing. After the process, the development worker and supervisor return to a private location where the supervisor can go over the results of the checklist with the development worker.

During the feedback to the development worker, each item is mentioned and the worker is asked to take notes on the feedback. For elements of the process that the

development worker performed properly, he or she is encouraged (e.g., “you did a great job introducing the topic”). Some elements can be combined into one statement, but all should be mentioned (e.g., “You did an excellent job of speaking loud enough for everyone to hear, speaking slowly and clearly, using proper eye contact, and making changes in your voice intonation. That really helps the listeners to follow what you are saying.”). When opportunities arise to point out where the worker is doing exceptionally good work, that should be mentioned, as well (e.g., “Of all our promoters, I think you do the best job of demonstrating how to make oral rehydration solution [ORS].”) The supervisor avoids giving too many “mixed comments” on the steps of the process (e.g., “you gave a good introduction overall, but you forgot to mention how long the session would be.”). In general, the supervisor should either be able to compliment the worker for doing something properly, or talk to him or her about how to improve performance. When too many mixed comments arise, it is a sign that the checklist needs to be more detailed.

For elements that are done improperly, the supervisor should begin by asking the worker his or her opinion on whether or not they did a particular part of the process (e.g., “Do you think you paraphrased what people said during the session?”). This gives the worker the opportunity to evaluate their own performance, which is usually easier than hearing another person’s critique, and gets them in the habit of asking themselves the same question as they carry out the process unsupervised. Once the development worker has had a chance to comment on his or her performance, the supervisor does so and uses examples to explain how to do the step properly. The supervisor uses questions to help the development worker find solutions to any problems that arose during the session (e.g., “How could have you had the mother participate more in the GM/P session?”).

Once each step has been discussed, the supervisor asks the worker being evaluated to give a summary of the things that should be improved. The supervisor completes the list, if necessary, and asks the worker to indicate whether s/he will commit to improve the things that have been mentioned. If the development worker has a fairly good score (e.g., over 60%), the supervisor can mention the score to the worker. In order to calculate the score, the number of “yes” responses is divided by the total number of questions used on the checklist. It is generally advisable not to mention lower scores to the workers, but to concentrate instead on the list of things being done properly and improperly.

In order to end on a positive note, the development worker is then asked to list the things that s/he did well, and the supervisor completes this list. All of the above steps are listed in the Monitoring Manager’s Tool, a checklist that can be used by project directors and others to evaluate their supervisors’ use of the checklists.

On a regular basis, the names or codes of the development workers and their QIV checklist scores for a particular evaluation period can be entered into an Excel spreadsheet or a database in order to identify which workers are making the most and the least progress, and to track their progress over time (e.g., using line graphs). The data can be used, as well, to identify what parts of the process are the most problematic for all development workers. This information can be particularly helpful

when a process is being redesigned in order to have more impact. When using for the purpose of *verification of quality only* (and not improvement of workers' skills), a sample can be used rather than using the checklist with all workers.

At first, the checklist is used on each supervision visit. As development workers reach higher levels of quality (e.g., over 85%), the checklist is used less frequently (e.g., every three months). Once a very high score has been obtained (e.g., ≥95%), the checklist can be used yearly to assure that the quality has not dropped.

Training notes for using QIV checklists have been developed in English, Spanish, and Haitian Creole.[12] QIV checklists have been developed for 16 different processes in five different languages (see below). It is hoped that, as more organizations use these tools, they can be shared so that standardization of food security processes and better benchmarking can be achieved.

QI Checklist Theme (process evaluated)	Available in These Languages
➢ **Immunizations,** ➢ **Management of Diarrhea,** ➢ **Conducting Training Sessions** (Ag and Health), ➢ **Individual Counseling** (Ag and Health), ➢ **Nonformal Education Methods:** Songs/Poems, Stories, Puppetry, and Guided Testimonies (Ag and Health).	English only
➢ **Conducting Educational Sessions** (Ag and Health)	English, Spanish, Haitian Creole
➢ **Growth Monitoring & Promotion** (Health)	English, Spanish, Haitian Creole
➢ **KPC Survey Interviewing** (Ag and Health)	English, Spanish, Haitian Creole
➢ **IMCI Home Visits** (Children 2m to 4 years)	Spanish only
➢ **Rally Post activities** (immunization, vitamin A/iodine dosing/education, deworming, iron supplementation), ➢ **Acute Respiratory Infection (ARI) Management**	Haitian Creole
➢ **Clinic/Hospital Management of Severe Malnutrition**	English (draft)
➢ **Monitoring Manager's Tool** (for evaluating and improving supervisors use of QIV checklists)	English, Spanish, Haitian Creole, Portuguese

This tool has been evaluated on a small scale in several countries and shown to rapidly increase the quality of development workers' performance of key tasks.[13]

[12] Notes in Portuguese may be available from Food for the Hungry, International in Mozambique.
[13] See paper at:
http://home.nc.rr.com/tomdavismph/Attaining%20High%20Quality%20Through%20Use%20of%20QI%20Checklists%20(GHC).doc

Other Attributes:

- The level of **rigor and quality of data obtained** is good, but the inter-observer reliability can be further improved by adding a day of training. During that day of training, Supervisors would witness the same processes, mark their checklists separately, look for agreement between their forms, and correct any differences in definitions that exist among observers (e.g., what is "asking the mother to participate in weighing?"). The inter-observer reliability can also be improved by having two supervisors regularly work together to complete the assessment, comparing their checklists after each observation.
- This **tool should generally be used shortly after training or retraining in a process, and then on a regular basis** until quality scores are high (e.g., >90%).
- One of the tool's **limitations** is that development workers may put on their best performance during supervision. (This can be overcome by having a staff person or independent evaluator serve as a "confederate," observing the process unbeknownst to the development worker [e.g., as a farmer during an educational session], and later marking the form, and giving feedback to the development worker.) **Another limitation** is that the process to be observed (e.g., dietary counseling of the mother of a child with diarrhea) may not be happening on the day that the supervisor visits. A "work-around" for this is having the Supervisor and development worker go through the process to be observed in the form of a simulation (e.g., having the Supervisor act like a mother of a child with diarrhea). The form is then marked after the simulation, and feedback is given to the development worker.
- The tool is **participatory** in that the development worker is asked to identify his or her own errors before the Supervisor comments on them. The training notes also specify that the development workers who will be supervised should participate in the creation of the checklist, and should receive a copy of the checklist so that they will know what is expected of them in each process evaluated. As written, community members are not involved in this essentially technical supervision of the development workers skills, but this could be done if community members were taught how to use the checklist and were invited to participate in the monitoring of quality.
- It is unknown whether local partners would continue to use the tool after program completion. FHI, however, has found that these tools are **among the supervision tools most often continued by field staff** after initial training.

References/ Sources of Training and Technical Assistance

A full list of QIV checklists already developed, and training guides for creation and use of the checklists in different languages can be found at:
http://home.nc.rr.com/tomdavismph/qilists.html.

A professional paper on results of using the checklists can be found at:
Attaining High Quality Through Use of QI Checklists (GHC).doc[14]

[14] http://home.nc.rr.com/tdavismph/qilists.html

Trainers / Training Consultants for QIV Checklists:

- Julie Mobley, MSPH (mobley@csranet.com)
- Tom Davis, MPH (tdavis@fhi.net)

Other Books / Websites on Quality Improvement:

- The Quality Assurance Project: http://www.urc-chs.com/worldwide.html
- Chang, Richard Y, and Niedzwiecki, M. Continuous Improvement Tools, Volume 2. Jossey-Bass Pfeiffer publishers. 1993. IBSN: 0-7879-5081-5.
- Chang, Richard Y. Continuous Process Improvement. Jossey-Bass Pfeiffer publishers. 1994. ISBN: 0-7879-5083-1.
- Scholters, P., Joiner, B., and Streibel, B. The Team Handbook, Second Edition. Oriel publishers. 1996. Available at www.orielinc.com.

#2. Target Coverage Charts (TCCs)

Contact: Tom Davis, FHI (tdavis@fhi.net)

Purpose: Target Coverage Charts provide managers and other staff with a monthly, graphical representation of progress to date in achieving coverage levels (e.g., proportion of farmers trained on a topic, proportion of children receiving vitamin A). These charts can be included as part of a CSR4.

How it Works:

- **Personnel Used to Collect the Data**: Data on activities associated with coverage are collected from the information system by front-line personnel.
- **Type of Data Collected:** Data on activities that are done only a set number of times in a given period for each program participant or community involved in a program (e.g., wells dug, farmers educated on contour farming, children receiving measles vaccine).
- **Frequency of data collection:** Monthly, usually.
- **Methodology**:

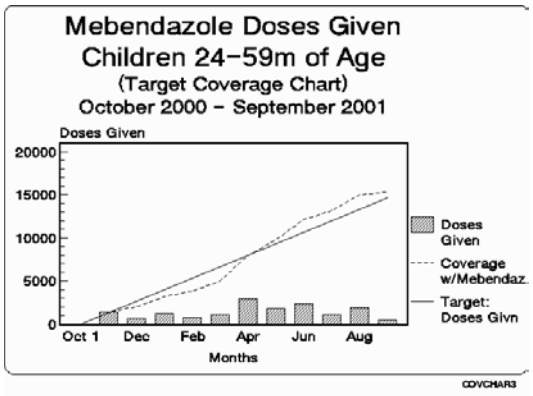
  Target Coverage Charts are used by Ministries of Health in many countries, and possibly by other agencies and organizations. A TCC is a tool for monitoring the level of coverage of a particular service during a given period. In general, they provide a proxy for the *proportion* of beneficiaries who have received a particular service based on the *number* of services provided (e.g., estimating vitamin A coverage based on the number of doses of vitamin A given to children during a given period).

  In order to develop a Target Coverage Chart, one needs to assess the coverage at baseline for a specific indicator and set a final level of coverage that the organization wants to obtain by the final evaluation. For example, let's say that we have a goal of increasing the proportion of children 24-59 months of age who have received two doses of mebendazole from 23% (found at baseline) to 70% one year later. If there are 10,000 children 24-59 months of age in the project communities, we would thus estimate that we need to give 14,000 doses (10,000 * 2* 0.70) to children 24-59 months of age during the upcoming year (assuming that there will not be an unusually high influx of children "graduating" into the 24-59 month age group). If we expected about 5% of doses to be wasted, we would adjust our target to 14,700 (14,000*1.05).

  In order to track our coverage of children who have received mebendazole, we prepare a chart with a y-axis that goes from 0 to a number somewhat higher than the total number of beneficiaries that we want to "cover" with the service by the end of the year, but no higher than the total number of beneficiaries who could receive the service. (In our example, we could set 21,000 [10,000*2*1*1.05] as the upper limit of the y-axis.) Along the x-axis, we plot the months of the year. We make one point on the first month of the year that represents the current number of beneficiaries who have received the service. Since we have to keep giving mebendazole each year (unlike measles vaccine, for example), our starting point would be zero. The first point on the graph would be (Oct,0). On the right side of the chart, we plot a point representing the coverage target. In our example, that would be (Sep,14,700). A

heavy line is drawn between the two points to represent the trend that we hope to see as coverage increases from month to month.

Each month, the number of doses of mebendazole used is added to the number covered in the previous month, and a point is plotted representing this new coverage level. A line is drawn connecting the points representing coverage month-to-month. (A bar graph can also be superimposed on the chart to indicate the actual number of doses given in a given month.)



When the coverage line is consistently below the target line (as during the December – April period), the coverage target will most likely not be met. When the coverage line follows or is higher than the target line (as in the May – September period), then the coverage target will most likely be met.

It should be understood by staff that this chart gives an approximation of coverage only. If there is a sudden influx of beneficiaries during the year, this type of chart would obviously over-estimate coverage levels. This type of chart can also be used to monitor coverage with services that need to be given more than once to each program participant (e.g., multi-dose vaccines), but the calculation of the final target number is more difficult, and the results are less valid.

- **Constraints:** Target Coverage Charts are **very useful for *monitoring coverage, or monitoring input usage as a proxy for coverage, especially where service delivery is expected to follow a fairly linear pattern of growth*** (rather than through sudden jumps in coverage, as achieved with campaigns). In order to use this tool, **beneficiaries entering and leaving the target group for the indicator should be roughly equal** (e.g., the number of farmers in a given area remains stable, or the number of children entering and leaving the 12-23 months old age group remains fairly stable).
- **When using this type of chart to monitor *input usage*, and inputs are being monitored as a proxy for coverage, the user should take into account the expected amount of *wastage* of the input.** (For example, one should not assume that 300 children received Vitamin A just because 300 vitamin A capsules have been used.)

References / Sources of Training and Technical Assistance

Most organizations would probably feel comfortable simply reviewing the forms and documentation, and doing their own training on the process.

#3. Verbal Case Review for IMCI Clinical Practices

Contact: Youssef Tawfik, Academy for Educational Development (AED) (ytawfik@smtp.aed.org) or Beth Ann Plowman, MA, Deputy Director, Performance and Results Monitoring, BASICS Project (1600 Wilson Blvd., Arlington, VA 22209, tel: 703-312-6800).

Purpose: The Verbal Case Review (VCR) is a household-based survey for assessing the quality of clinical care of sick children provided by healthcare providers, and the care-seeking behavior of the parents of sick children. It has also included assessment of the adequacy and effectiveness of care and nutritional counseling being provided to parents of sick children in the home, prior to seeking external care. Healthcare providers include unlicensed and traditional providers as well as government and other trained health workers serving the target population. The implementation of integrated management of childhood illnesses (IMCI) protocols generally leads to health professionals doing a better job of screening for malnutrition and counseling of mothers on breastfeeding and other feeding practices (including feeding during illnesses). In that way, implementation of IMCI contributes to Title II health program indicators by improving food utilization. Information on the quality of care provided to sick children, particularly with regard to care being provided by private practitioners, is of immediate interest and use to program managers and health providers in government, NGOs and donor agencies. The data from the use of this tool has stimulated higher-level decision makers to devote additional resources to private practitioners, rather than concentrating solely on the government health system. **The principle of the tool -- a delayed exit interview at the community level – may be readily adapted to monitor other aspects of quality of services** (e.g. quality of agricultural extension, quality of counseling during growth monitoring/promotion). The data from the VCR have been presented to healthcare providers in an intervention target area to stimulate participation in the intervention. This same type of activity could be applied in other Title II fields in order to stimulate interest in involvement in Title II interventions.

How it Works:

- **Personnel Used to Collect the Data**: Personnel used to collect the data have ranged from community-level volunteers to professional interviewers. With training, supervisory staff of most Title II programs could use these tools in monitoring. The number of interviewers used has ranged from two over a two-month period, to 25-30 during an intervention. Depending on the number of additions to the basic questions in the survey instrument, the VCR takes from 15 to 45 minutes to administer.
- **Type of Data Collected**: Most of the data collected with this instrument are quantitative, but qualitative information can be collected, as well. Data are collected on:
  - to whom the sick child was taken for care during the illness,
  - what was done by the healthcare provider during case management, for example, whether healthcare provider:

  - asked about each of the illnesses (covered by the IMCI protocol),
  - assessed for danger signs,
  - weighed the child and recorded the weight,
  - asked the proper questions and conducted the proper evaluation tasks for each illness,
  - asked about home care of the child including feeding during illness,
  - gave proper counseling on dietary management of the illness,
  - recommended immunization, and
  - gave and explained medication properly.
- where medications were purchased, and
- what was done in terms of home care and nutrition of the child.

The Verbal Case Review forms are included in Annex B.

- **Frequency of data collection:** A baseline cross-sectional assessment using the instrument may be followed with a subsequent cross-sectional evaluation assessment after sufficient time has been allowed for intervention activities to take place. In BASICS' application of the tool in India, Indonesia, and Pakistan, the interval between surveys was six to nine months. **When the VCR is used by a program for ongoing monitoring and feedback to practitioners, it is carried out continuously in target communities.** The VCRs completed during the monitoring cycle (two or three month intervals) are summarized, and individual as well as group reports are prepared and fed back to practitioners.

- **Methodology**:

The Verbal Case Review is a household survey instrument and methodology used for assessing the quality of clinical care provided to sick children under five years by the full range of practitioners and vendors who are consulted in a target population. Households with children under five years are screened to identify children who have been sick with diarrhea, fever, or cough/respiratory symptoms during the previous two weeks. The mothers of these children are then interviewed using the VCR instrument. They are asked to recall from whom they purchased medicines, from whom they obtained clinical care, and the actions or behaviors of those drug sellers and practitioners consulted for the child's illness. The World Health Organization (WHO) protocol for the Integrated Management of Childhood Illness (IMCI) is the clinical standard from which the questions regarding clinical quality in the interview instrument are derived. Practitioners' behaviors are compared to these standards to determine the gap between current practices and the quality standard.

In settings where initial assessment using the VCR has led to an intervention to improve the quality of care, the VCR has been used in ongoing longitudinal monitoring of care quality. The results of such monitoring have been fed back to the practitioners in monitoring cycles of two-to-three months to stimulate further improvements. Carried out by community representatives, these monitoring activities have also generated improved interaction between the practitioners and the community. They have also indicated to practitioners that the community is concerned with the quality of care being provided and is willing to accept certain changes in care, such as not giving injections or not giving anti-diarrheal medicines. In some monitoring applications, the VCR has been simplified to facilitate implementation by community members.

In the majority of applications of this tool, the VCR has been used for monitoring, as part of an intervention effort. In those situations, the targeted population has been the catchment population of the institution implementing the intervention. For monitoring, three to six patients per healthcare provider are needed to provide specific individual feedback during one monitoring cycle. Interviewers go house-to-house to identify households with children less than five years of age who have been sick with diarrhea, fever, or cough/respiratory symptoms during the previous two weeks. The mothers of these children are interviewed and are asked to recall the actions or behaviors of drug sellers or other health care providers consulted for the child's illness. (In some applications, this target group has been further screened to select only those children whose parents bought medicines outside the house, or consulted a healthcare provider.) In the monitoring mode, rates of illness in the population, rates of care seeking outside the home, and the mix of healthcare providers used should not be determined since the sample size would be too small to provide meaningful results. However, if a larger sample is used (e.g., 500-800 sick children), these illness rates and the provider usage rates can be determined, and records must be kept of the responses in each of the preliminary screening steps, either in registers or special screening forms that can be analyzed separately from the verbal case review questions.

In a monitoring mode as part of an intervention, the units of analysis are individual health care providers or institutions (e.g. health centers, hospitals). It should use the same rate of use of individual practitioners or institutions in that population. Statistical significance has not been a priority for monitoring data, but feedback that is convincing to a particular practitioner must include at least three patients overall. Meaningful discourse on a particular illness (e.g. management of ARI) must include at least three patients with that type of illness, seen by the specific practitioner. In addition, project staff should estimate how many interviews a volunteer community worker or health center staff member can carry out each month on an ongoing basis (given budget and time limitations) when determining the intervals at which the data is collected.

Interviewers are generally trained for two to three days, with detailed explanation of the reasons for the individual questions, role play in the training site, and observed interviews in the community. The extent of training has varied. When professional interviewers are used, less training is required. When CHWs or community members are used, training is more extensive. In the beginning of the monitoring process, it is necessary to conduct field level reviews of completed questionnaires, and repeat interviews with 10% or 15% of respondents to ensure that interviews are done appropriately, and the questionnaires are being filled out properly. Feedback to the interviewers should follow.

When a large sample size is used, a computer running Epi-Info is usually used to tabulate data. Simple tabulations of data and two-way comparisons using Chi square are the basic outputs, showing rates of performance and incidence rates comparing different subgroups in the sample. For a small sample (in monitoring mode), data can be tabulated manually. Time and labor requirements depend on the cleanliness of the data coming from the field. Once the data are clean, preparation of the basic tables can be accomplished in a few days. A software program could be developed to produce a monitoring report for an individual practitioner based on VCR assessment of patients he or she has seen during the previous monitoring cycle. (This was done in Indonesia, but the program was not

finalized and is not available to other organizations.) Collective reports provide tables comparing rates of current performance of desired behaviors with the standards, or with individual targets set as part of individual behavioral contracts made during intervention activities. A narrative is usually produced, as well, which points out the critical observed gaps between practitioner behaviors and the IMCI based standards of practitioner case management.

Other Attributes:

- One of the key assumptions anticipated in the interpretation of data is that **parents will be able to remember** what was done when the healthcare provider saw their child. Studies have shown that **validity is variable with this instrument:** The VCR was derived initially from the instrument used for exit interviews as part of the IMCI health facility assessment process. It has been validated in India (Rajesthan and Bihar) by Sarbani Chakraborty[15], using a comparison of directly observed actions performed by a practitioner with those reported by the mother of the child being cared for. The study compared reliability of the mother's observations at one, seven, and 15 days after the encounter. The results indicate substantial variation in reliability depending on the particular practice being recalled, some being less accurately noted by the mothers than others. Overall reliability was similar at one and seven days, and showed some decay at the 15-day recall period.
- **This tool can be used in areas where a Title II project plans to implement IMCI as part of its Title II health program or where use of health facilities is good and the project staff plan to upgrade the nutritional counseling done by health staff in those health facilities**. If a project was going to focus only on nutritional assessment and counseling at the clinical level, a modified version of the tool could be developed which would focus only on the nutritional assessment and counseling aspects of the health worker's case management. However – given malaria and other diseases' effects on malnutrition – organizations would be wise to consider a more complete evaluation of, and intervention in, case management. Use of this tool requires that an organization has, or will develop, an ongoing relationship with healthcare providers in a given area who have committed to improving their institutional capacity.
- **Constraints**: It has proven particularly difficult to differentiate clearly between: a) use of drugs available at home from a previous purchase; b) purchase of drugs from a drug seller who does not see the sick child; and c) dispensing of drugs by a practitioner who has examined the child. This aspect must receive adequate attention in training. Also, basic skills in carrying out surveys, managing forms and data entry into computers, and analyzing survey data are important to enable the process to run smoothly. Community organizations and district or sub-district health offices typically need technical support from a local institution.
- **External technical assistance has been useful in the development phase** of this instrument, helping to establish a set of questions which are answerable based on mothers' recall. The person providing TA should also help staff to manage the survey process and data management issues, and keep the analysis focused on the critical case management issues amenable to intervention. Involvement of people with public health experience and some knowledge of IMCI has been very helpful.

---

[15] Sarbani Chakraborty, Sister Ann D'Souza, and Robert S Northrup. December 2000. Improving private practitioner care of sick children: testing new approaches in rural Bihar. Health Policy Plan 15: 400-407.

- Since an IMCI protocol is generally established at the national level (based on an international pattern), there is **less room for modification of the tool and involvement of local providers in the development of the survey instrument**. However, to get the best results, local health providers need to be involved in making modifications to the instruments and implementing the assessment.
- In terms of healthcare providers who are supervised in an ongoing and indefinite manner (e.g., MOH nurses), this is tool can be integrated into the routine supervision. Thus it should not be difficult for local partners to continue to use the tool after program completion during regular supervision visits *(*if supervision is done regularly and not hindered by transportation or other constraints). For healthcare providers who are not regularly supervised (or not supervised at all) such as drug venders, use of the tool will probably cease once the program has ended. (By that time, certain case management skills, however, should become part of the healthcare providers' regular routine.)

REFERENCES / SOURCES OF TRAINING AND TECHNICAL ASSISTANCE

- Robert S. Northrup and Youssef Tawfik, BASICS Project; Sarbani Chakraborty, Johns Hopkins School of Hygiene and Public Health (Baltimore); Retna Siwi Padmawati, Clinical Epidemiology and Biostatistics Unit, Gadjah Mada University Faculty of Medicine, Yogyakarta, Indonesia; and Stephen Luby, Department of Community Health, Aga Khan University School of Medicine, Karachi, Pakistan.
- This tool has not been formally evaluated, but a paper has been submitted for publication describing the Bihar, India experience with the VCR and subsequent intervention approach. The forms are presently available in English and Indonesian.
- A more complete discussion of this tool can be found at the following link: http://www.cpc.unc.edu/projects/measure/techassist/tools_methods/inventory/tool10.htm
- One person who can train people in the use of these tools is Youssef Tawfik, AED (ytawfik@smtp.aed.org). Two others are Dr. Robert S. Northrup, Senior Technical Advisor, Project HOPE (rnorthrup@projhope.org) and Sarbani Chakraborty at the World Bank. Most organizations would probably feel comfortable simply reviewing the forms and documentation, and doing their own training on the process.

#4. Integrated Health Facility Assessment[16]

Contact: BASICS. An online manual is available for download at: http://www.basics.org/Publications/hfa/hfa_toc.htm Other HFA publications are available at: http://www.basics.org/asp_scripts/Pubs.asp – 7

Purpose: The Integrated Health Facility Assessment (HFA) is designed for use by health programs that are planning to integrate child health care services at the district level. The implementation of integrated management of childhood illnesses (IMCI) protocols generally leads to health professionals doing a better job of screening for malnutrition and counseling of mothers on breastfeeding and other feeding practices (including feeding during illnesses). In that way, implementation of IMCI contributes to Title II health program indicators by improving food utilization. The HFA would be useful to Title II health program managers who wish to upgrade the quality of local health services. It is worth examining the structure of this tool when creating tools to monitor the local capacity of local institutional partners, as well.

This tool allows program staff to have a better idea of what improvements need to be made in local health services. During the assessment, information is collected on the case management of all important causes of infant and childhood morbidity and mortality in developing countries (ARI, diarrhea, malaria, measles, and malnutrition) and on the program elements that are required to allow integrated practice (health worker training, health worker supervision, drug supply, availability of essential equipment, and health facility organization). This information is collected through inspection of facilities, observation of the management of illnesses by health workers, exit interviews with patients, and interviews with staff members. As part of the HFA process, indicators are chosen which are used in an ongoing system of monitoring (using parts of the HFA methodology in an ongoing manner). Changes in these indicators over time can be useful in supporting the findings of impact evaluation data.

---

[16] Murray, John, and Serge Manoncourt. 1998. *Integrated health facility assessment manual: Using local planning to improve the quality of child care at health facilities.* Published for the U.S. Agency for International Development by the Basic Support for Institutionalizing Child Survival (BASICS) Project. Arlington, Va.

BASICS' stated objectives of the health facility assessment are:

1. To determine—
   - Current knowledge and practices of health workers at outpatient clinics regarding the assessment and management of sick children
   - Principal barriers to effective case-management practices
   - Adequacy of training and supervision of health workers
2. To use the information to—
   - Prioritize and plan improvements in the quality of care at outpatient health facilities, including staffing, clinic organization, equipment requirements, drug and material supplies, and case-management practices
   - Improve or develop pre- and in-service training for outpatient health workers
   - Improve or develop a strategy for supervising and monitoring health worker performance over time
3. To train local health workers in survey techniques, in collection and analysis of survey data, and in the use of data to improve the quality of integrated case management in outpatient health facilities.

How it Works:

- **Personnel Used to Collect the Data / Sample Size**: Existing project staff and personnel from local health services can be used to do the initial assessment. For each health facility assessed, there are generally three people who do the assessment (one of whom should have good case management skills). If a Title II program is only planning on working with a smaller number of health facilities, only the facilities in that area need to be included in the assessment. If an administrative unit is chosen for analysis that includes a large number of health facilities (e.g., a province with 100 health facilities), then a sample size of 25–30 facilities is recommended.

  Generally, one team can assess one health facility each day. The number of personnel needed to do the initial assessment depends on how fast the organization wants to complete the process. Usually, five to ten teams are used of three people each, and data collection takes about a week.

  However, once the initial assessment is done, and indicators are selected for ongoing monitoring, each facility supervisor could collect data for the monitoring system. In one longer supervision visit (where about 10 sick children are observed), information could be collected on case management of sick children. On another visit, exit interviews could be done with patients to collect information on client satisfaction, recall of educational/counseling messages, and other indicators.

- **Type of data collected:** Data are collected by the survey teams on:
  - client satisfaction (mothers' satisfaction with health facilities and staff),
  - quality of education done by medical staff with mothers or others bringing children to the health facility (including nutrition education),
  - quality of case management skills of medical staff,
  - health worker training,

- health worker supervision,
- drug, biologicals, and vitamin supply,
- availability of essential equipment, and
- health facility organization.

➢ **Frequency of data collection:** Once the initial assessment is done, data could be collected on each supervision visit, but this is not necessary. Data collected once per quarter or once per semester would be adequate to track changes in indicators.

➢ **Methodology**:

Preparation for the initial survey should begin about 15-30 days prior to the HFA training. The training takes 5 days and includes a field practicum. A facilitator to participant ratio of 1:6 is recommended. During the training, participants learn how to use the four forms (listed below with links), and how to do proper interviewing and observation. The forms are modified during this training week, as well, to reflect the local reality and to answer questions that the participants have about district health facilities and services.

A sample size of 25–30 facilities is recommended for this assessment. (Sometimes, there will be fewer than 25 facilities in the district. In that case, all facilities are assessed.) At the district level, it usually takes about 4-8 days to conduct and supervise the assessment. During the assessment:

- one person observes the case management of about 10 sick children or more,
- one person does an exit interview with mothers of these 10+ sick children in the local language, and
- one supervisor interviews the health worker, checks the quality of the assessment as it is in progress, and checks the health facilities medications, supplies, and cold chain.

There are four forms that are filled out during the HFA:
1. an Observation Checklist (for sick Children),
2. an Exit Interview (for mothers/caretakers of sick children),
3. a Health Worker Interview, and
4. an Equipment and Supplies Checklist.

Data entry can begin during the assessment. Analysis (calculation of key indicators) can take from one to three days, depending on the number of health facilities included in the assessment, and can be done manually or using data software (e.g., Epi-Info). Following that, two days are taken for selection and discussion of key indicators, and to produce and present a summary report. Follow-up, such as feedback and planning meetings with local staff, development of action plans and supervision strategies, and production of the final report, are usually completed during the quarter following the assessment.

Other Attributes:

The HFA has five key attributes:

- It is designed to be **rapid**. The total duration of the survey, including training of surveyors, data collection, data entry, and analysis, is three weeks.
- It is designed to be **conducted before IMCI training has been implemented**. This survey is an important tool for preparing for the implementation of IMCI. If necessary, the performance of health workers can be compared with the IMCI case management algorithm, by having validators check the classification of each sick child.
- It is designed to be **cost-effective**. Costs are reduced by keeping the total number of surveyors to a minimum (a total of 15 surveyors and supervisors is proposed) and by completing all survey activities in a three-week period.
- It is designed to be a **local-level program planning tool**. It is hoped that lower-level health staff will use this survey for evaluating and monitoring child health programs in their areas and for developing local strategies to improve the delivery of integrated child health services.
- It is designed to be **one step in a process** of integrated infant and child health program development. The data that are collected should be used by local program managers and health staff to develop strategies that are appropriate for the local conditions.

- The **level of rigor** of HFAs is generally high if training is done properly. Having one supervisor per pair of interviewers improves the reliability of the findings. Having one person trained in IMCI on each team allows the surveyors to validate whether the proper diagnosis was made.
- This tool is **best used in Title II health programs where IMCI will be introduced, or where use of health facilities is good and the project staff plan to upgrade the nutritional counseling done by health staff in those health facilities**. If a project was going to focus only on nutritional assessment and counseling at the clinical level, a modified version of the observation checklist could be developed which would focus only on the nutritional assessment counseling part of the health worker's case management. However given malaria and other diseases' effects on malnutrition, organizations would be wise to consider a more complete evaluation of – and intervention in – case management.
- Since an IMCI protocol is generally established at the national level (based on an international pattern), there is **less room for modification of the tool and involvement of local providers in the development of the survey instrument**. However, to get the best results, local health providers need to make some modifications to the instruments and be involved on the health team. In an area with a small number of health facilities, it is important that health providers do not evaluate their own health facilities. Also, where health professionals are part of the evaluation team, <u>and</u> also part of the group evaluated, expect that the survey training itself will improve their case management skills. Since the survey training will effect the skills which the organization wants to measure, it will be difficult to get both participation from local health staff and a true baseline concurrently. This is one limitation of the assessment.
- **External technical assistance has been useful in the modification of this instrument**, helping to establish a set of questions which are useful given the local context, and answerable based on mothers' recall (for the exit interview portion of the

HFA). The person providing TA should also help staff to manage the survey process and data management issues, and keep the analysis focused on the critical case management issues amenable to intervention. Involvement of people with public health experience and some knowledge of IMCI has been very helpful.

- Many public health workers need the skills in clinical supervision that are provided during the HFA survey training. It is thus **likely that they will continue to use the tool** – or least elements of the tool – during supervision visits after completion of the program if supervision is done regularly and not hindered by transportation or other constraints. However, getting community members (and often partners) to "buy in" to the high level of structure and rigor implicit in an IMCI protocols may be difficult, especially in health facilities where the patient load is very high (e.g., >40 patients/healthcare provider/day). Many times, if a community member sees a doctor for a child's illness and is given medications, she is happy with the care, despite how incomplete the case management may be. The MOH and other NGOs will probably need to be the ones responsible for using this tool for quite a while since the tool is used to build the capacity of a local institution. (This same principle holds for the Verbal Case Review for IMCI Clinical Practices tool [Tool #3], as well.)
- One key assumption that is made during the **interpretation of data** is that the health staff members are not doing things completely differently when the evaluators are present. Like everyone else, health workers can be very thorough when someone is watching. Since at least the care of at least 10 children needs to be observed, it is not possible to do this evaluation as a "mystery patient[17]". One alternative is using the Verbal Case Review for IMCI Clinical Practices tool [#3].

References / Sources of Training and Technical Assistance

- References, including the training manual and forms completed during the assessment, are provided at the web sites mentioned above.
- HFA trainers include staff from BASICS in the countries in which they have offices (see map at http://www.basics.org/Country/Homemap.htm). Please see the **Consultant Training Skills Matrix** in **Annex C** for a list of consultants who have trained others in the HFA methodology.

---

[17] This is the technique whereby a researcher (a confederate) poses as the mother of a sick child to see how the medical personnel manage the case.

#5. Food Distribution End Use Monitoring Report

Contact: Mark Smith (mailto:SmithM@usa.redcross.org), Senior Associate, Commodity Management, & Carol Puzone (PuzoneC@usa.redcross.org), Senior M&E Delegate, American Red Cross.

Purpose: This integrated tool includes eight sections: (a) visual inspection of the distribution site, (b) verification of beneficiary lists, (c) verification of commodity distribution, (d) verification of the accuracy of the distribution, (e) verification of staffing for the distribution, (f) verification of financial management of the distribution, (g) verification of quality of the distribution and client satisfaction via program participant exit interviews, and (h) a market survey. This data is summarized in a distribution site summary report. While food distribution end use monitoring should routinely be done to collect information on commodity usage (which is beyond the scope of this toolkit), some of the elements of ARC's application of this tool can be adapted for use when monitoring the quality of other services and client satisfaction.

The purpose of the *program participant exit interview* part of this integrated tool is to assess:

- average waiting time for food distribution,
- transportation costs to the distribution site,
- evidence of corruption,
- client satisfaction, and
- information dissemination concerning food distribution.

The purpose of the *market survey* is to:

- monitor price trends,[18]
- monitor changes in prices as compared to the previous year (using a government report for comparison),
- monitor changes in purchasing power (based on a five-item market basket),
- monitor purchases of luxury foods (as a barometer of household [HH] food security beyond the donated ration),
- support and enhance the quality of impact evaluation data, and
- verify if donated foods are being sold in marketplaces.

The purpose of the *district level summary* is to:

- independently verify the quality and accuracy of the monthly food distribution (e.g., underweight/overweight bags, open/leaking cans),
- independently verify the staffing and administration of monthly food distribution,
- independently verify that no corruption is/has been occurring in the food distribution program,
- independently verify program participant satisfaction with monthly the food distribution program, and
- collect vulnerability information from the market survey.

[18] Availability of food items, as well as price, should be monitored during market surveys.

The district level summary is also used to:

- summarize the information in the program participant exit interview and the market survey, and
- guide the narrative on any problems noted during the monthly monitoring.

How it Works:

- **Personnel Used to Collect the Data**: Approximately two days of training are given to those who will be using the tool. The Food Programming Officer provides ongoing support. For the market survey, Field Monitors in each district are used to collect market prices during their monthly distribution monitoring.

  The number of exit interviews done is based on how many beneficiaries are in the district. In Albania, ARC recommended that each of their monitors conduct five interviews per distribution day. (The format has been adapted to other countries in which ARC operates.) Selection of the individuals to interview is left to the Field Monitor. However, monitors are instructed to conduct the interviews during the course of the whole day (rather than clustering all interviews in the morning or evening) in order to give the monitor flexibility to respond to different problems that arise during the day, and to avoid some selection bias.

  Sampling of commodity packs was based on a proportionate sample size calculation. In Albania where this tool was developed and tested, this resulted in a sample size of 22 to 139 commodity packs, depending on the district.

- **Type of Data Collected:** Some of the questions in the program participant exit interview are yes/no and short answer type questions. Each interview is expected to take 10 minutes. There are many qualitative questions included in the questionnaire, as well (e.g., "Explain why you are satisfied / not satisfied with the Red Cross Food Distribution Program"). A calculator is all that is required to fill in the district level summary report. Whenever possible, reporting was designed with 'thresholds' so that the monitor only has to count the number of people who exceed the 'threshold' rather than having to calculate averages. For the market survey, Field Monitors need to collect the prices for 13 food items in one shop and one "green" market place, assess whether donated commodities are being sold in the local market, and assess luxury item sales. The district level summary generally takes a worker 1-2 hours to complete. The time required for the narrative portion of the report varies depending on the issues raised. In general, workers were given five days to get their reports completed and turned in.

- **Frequency of data collection:** Data collection is done on a monthly basis when the project is on a monthly distribution schedule.

- **Methodology**:

For the market survey, each monitor selects one shop and one market in their district to visit each month for price monitoring. The prices of 13 different products are assessed in these same shops and markets at approximately the same time each month. The prices of certain products are assessed in shops, and the prices of other products are assessed in markets. Field Monitors are told to pick any shop and market they wish (where the foods are sold), as long as they visit the same shop and market each month. Field Monitors also do an inspection and talk to venders to determine if any commodities from the distribution are being sold.

The Market Survey takes about 10-15 minutes in each market, and one hour to enter the data into a spreadsheet on a project computer that automatically tabulates the data. All of the data is documented on a monthly monitoring report form. Field Monitors also compare this information to the average prices from the previous month located on the monthly data collection sheets. Any abrupt changes in prices found are investigated immediately in the field by the program assistant before returning to the office. Guidance is given in the instructions for the forms on what to do if prices have changed abruptly, and on the implications of those price changes. Forms are then sent to the project office on a monthly basis for compilation into a global spreadsheet. The results are then reported to the program manager(s) for action (if appropriate).

In Albania, each Field Monitor conducts an exit interviews with five beneficiaries per day using a simple, two-page questionnaire. The number of interviews will vary program to program. (All of the forms can be found at the website listed below). Each interview is prefaced with an introductory statement that mentions the purpose of the interview, the time required, that participation in the survey is optional and in no way affects eligibility in the program, and that the information will be kept confidential. Interviewees are given the option of not participating.

The district level summary is completed by a Field Monitor through inspection and observation of the distribution center in each district on the first day of distribution. *In Albania, satisfaction grew from 79% to over 90% by the end of the program during the use of this tool.*

Other Attributes:

- In ARC's system, the **Field Monitors were *external* monitors** who checked on the quality of work being done by the Albanian Red Cross staff and volunteers. This provides more rigor and should improve the quality of data by avoiding having employees "checking on themselves" (e.g., conducting the exit interviews to monitor the quality and honesty of their own work).
- This would be an **excellent tool to use for programs involving distribution of food**. As implemented in Albania, the methodology would probably generate more data than necessary to get an accurate picture of what is happening in the distribution points. ARC is presently reworking the sampling methodology (e.g., decreasing the number of commodity packs in the sample). **A similar methodology (exit interviews with beneficiaries and direct observation) could be used in programs that involve some sort of regular distribution activity (e.g., seeds,**

tools) where the organization wishes to gather other information (e.g., client satisfaction) at the same time.

- The external **Field Monitors participate in the analysis of the data** collected by giving a narrative of successes and problems identified, and action taken to resolve any problems. Problems were discussed each month during meetings between the Food Programming Officer and the Field Monitors.
- It may be possible to use LQAS when sampling the commodity packs, which would bring the sample size down to a much lower number [i.e., 19-33] without losing much precision.
- ARC taught its partner – the Albanian Red Cross – how to use the tool. Project leaders with the ARC felt that **the local partner will be able to continue to use this tool without ARC involvement**.
- There could be a **selection bias** in ARC's application of this tool, in that the Field Monitors are not given guidance as to which shop and market they are to monitor. It would be good for organizations to provide more detailed information to staff on how this process is done. If prices vary between markets/ shops (e.g., if prices are more stable/volatile in some markets than in others) or certain types of venders in markets are more likely to sell Title II foods, then some guidance should be given to avoid selection bias unless the Field Monitor will observe and talk to each vender.
- Market surveys are just one tool that can be used to monitor peoples' availability and access to food in emergency and transitional situations. Others measures include the number of head of cattle in the market & price per head, consumption levels of various household foods (HH food stocks, 24 hour recall), and possession of other assets per HH (e.g., permanent home, cultivatable land, heads of cattle, tools). Modifications to the tool could be made so as to collect information on these other markers of food insecurity, as well.

References / Sources of Training and Technical Assistance

The tools and instructions can be found at: http://www.foodaid.org/mne3.htm – Docs. The documents provided at this web page should be adequate for an organization to implement the system using its own trainers. Specific questions could be directed to the contact personnel at ARC (listed above). Carol Puzone at ARC (PuzoneC@usa.redcross.org) can be contacted for informal backstopping on this tool.

Other Tools/Methods for Monitoring Quality of Services or Key Processes

FHI (and probably many other organizations) uses *monthly activity and output checklists* to monitor mostly quantitative aspects of health, agriculture and water activities and outputs, and in some cases to measure quality. In most cases, these checklists deal strictly with the quantitative aspects of activities and outputs (i.e., whether they were done or not) and not their quality. In Bolivia, they are being used to measure the quality of the output, as well (e.g., that a well was completed according to specification and that it is producing the recommended amount of water). Technical supervisory level staff members and extensionists complete these checklists. The example on the next page would be filled out by the field-level staff, and then supervisors would fill out a similar form that aggregates the data. The checklists generally have columns for:

- the *planned activity or output* for a given month (e.g., training session or water well constructed),
- *completed activity or output* (where the staff person either checks *yes, no* or *partial completion*),
- *comments on the level of completion,* and
- a *revised date for completion*.

These are reviewed by program managers to monitor the activities and outputs. At present, no one spot-checks the data to assure that it is accurate, but some organizations have added that step in order to improve the reliability of the data.

OICI monitors quality of service delivery through Technical Officers who supervise the activities of field personnel. Technical Officers are required to observe at least two training sessions of a 15-session course carried out by field staff, and prepare short comments on the training observed (which is written in a 1" x 2" box on a monitoring form). This could be improved by giving guidance in the M&E plan as to what elements to look for in the training sessions observed.

Most of World Vision's food security staff use Gantt charts and activity timelines extensively, which can improve the *timeliness* of key processes (one aspect of service quality). The charts usually include a brief description of the activities, who is responsible, a timeline of when it will be completed, and sometimes a proposed and actual completion date. World Vision's Title II program in Bangladesh has partially automated this process by using Microsoft Project® to track and monitor the majority of the activities in their program. Microsoft Project allows project personnel to enter in a global timeline. Individual Gantt charts can be generated that outline each team member's own tasks across multiple projects or project areas.

This software has many useful features for program monitoring:

- Team members can create tasks to be added to the plan, and the project manager can approve those new tasks before adding them to the overall project plan.
- Delegation is allowed through the software: Once assigned by the project manger, tasks may be delegated from leads to team members or from peer to peer. (Delegation can be also be disabled.)
- Managers can reduce time spent in administrative activities by establishing rules to automatically accept actual hours, percent complete of task, or any information in a custom field.

- Team members can report nonworking time to the project manager or can report nonproject time, such as vacation or sick leave.
- Senior executives, managers and team members can access different views of projects, such as View Your Portfolio, View Your Project and View Assignments.
- All team members do not need to enter their data while networked: Team members can take their timesheets and status reports offline and continue working on them from wherever they are.
- Users can specify consumable resources (e.g., Title II foods, vitamin A, vaccines) and assign them to tasks.
- Users can remind other team members of upcoming deadlines and alert them visually if deadlines will not be met.
- Staff can save to Web servers just as they save to network locations. For workgroup users, this feature provides a way to share Microsoft Project files globally.
- Microsoft Project® generally runs on a PC with a Pentium 75 MHz or higher processor. It requires 30-204 MB of available hard-disk space.[19] MS Project currently costs $499 for first-time users, and $199 for users who are upgrading from an earlier version.[20]

WV has found MS Project® to be most useful for *project planning* and less so for *monitoring* of their Title II work. One of the reasons for that is that the Gantt charts work best with discrete, interconnected activities rather than repetitive activities. WV/Bangladesh is currently in the process of preparing training modules on CD on how to use MS Project®. Eventually, organizations will be able to get these from Brett Gresham (brett_gresham@worldvision.org). Food for the Hungry, International (and presumably other organizations) are using MS Project® to monitor a some of their project activities.

For commodity tracking, World Vision has developed a global computer-based tracking database for their programs that have commodities as a component, and an internal financial reporting system which tracks income and expenditures. It is unknown whether this system will be made available to other organizations.

ACDI/VOCA (and presumably other organizations) use *standard spreadsheets and databases* to track monetization funds, local expenses, and microfinance activities in Cape Verde. ACDI/VOCA's microfinance accounting and loan accounting system database are now being used by three local NGOs in their microfinance activities. Their soil and water conservation (SWC) database was adapted and is now being used by a general contractor (*Oasis*). ACDI/VOCA has found these systems built on standard database and spreadsheet software packages (e.g., Lotus® and Lotus Approach®) can be easily transferred to local partners.

---

[19] 30 MB for typical installation on system running Windows NT Workstation 4.0 with Microsoft Office 2000 installed; 204 MB for full installation on similar system without Office 2000 installed. Hard-disk usage varies depending on configuration.

[20] See: http://shop.microsoft.com/Products/Products_Feed/Online/MicrosoftProject2000[804]/ProductOverview.asp

Technical skills promoted through ACDI/VOCA's programs in Cape Verde (e.g., the construction of SWC works) are monitored through *spot checks* by Ministry of Agriculture and Fisheries technicians, as well as ACDI/VOCA and others. The MOA technicians are trained by ACDI/VOCA's NRM specialist, watershed development specialist, and an engineer. Training is done using a workbook, and workers are taught to use a form and checklist to do this spot check. Associations that construct the SWC works are continually assessed on-the-job for their technical skills as well as understanding of association benefits by informal interviews.

B. Tools for Monitoring Client Satisfaction

(✪ = tool meets the criteria)

Tool	***Lends itself to Participation by Program Stakeholders in Use & Modification of Tools***	***Requires Two Days or Less of Training***	***Can Collect and Analyze Data in one Week or Less***	***Provides numerical scores or indicator levels***	***Provides information that is easily interpreted and used for program modifications***	***Can Generally be Conducted with Existing Staff***
#6. Exit Interviews (See also the EI part of the Food Distribution End Use Monitoring Report [Tool #2] and IHFA [Tool #3].)	✪	✪	✪	✪	✪	✪
#7. Key Informant Interviews	✪	✪	✪	-	-	✪
#8. Focus Group Discussions	✪	✪	✪	-	-	✪

Measuring Client Satisfaction using Exit Interviews – an Introduction

Measuring Client Satisfaction using Exit interviews

Definitions of quality should always include both subjective and objective elements. Objectively, services should meet or surpass certain standards of safety, proper function, and otherwise general excellence. In the past few decades, the subjective side of quality has also been recognized as vital, and clients' opinions – especially their degree of satisfaction – are seen as essential to understanding it. There are many reasons to measure and respond to client satisfaction levels with services, including:

- prioritizing "opportunities for improvement" (problem areas),
- empowering clients to give their ideas to facility-based or community-based service providers,
- giving providers the opportunity to listen to clients and respond to their needs, and
- increasing sustainability by making services more client-oriented.[21]

Satisfied clients make repeat purchases and return for services, produce positive word of mouth, spend more per purchase/service, and become loyal to a particular brand or facility. Dissatisfied clients may tell twice as many contacts about their negative experiences as satisfied clients tell about theirs. They are also far less likely to return to buy the product or service in the future. People who are unhappy with services usually do not tell service providers: fewer than 30% of clients who experience quality related problems complain directly to the provider of the product or service, and only 1-5% of complaints reach the headquarters level.[22] Health-related studies have found associations between client satisfaction and compliance with treatment and advice, willingness to return for follow-up and future services, and willingness to pay for services.[23] Client satisfaction is key to clients' decisions to use and to continue using services, and is essential to long-term sustainability of services.

There is not one methodology for conducting exit interviews, but there is literature on how the tool has been used most effectively. In this section, we will first examine exit interviews in general, and then present a specific methodology for using them effectively.

Exit interviews are one of the chief tools used to measure client satisfaction. They are basically interviews carried out with clients once they have received a service, usually at a physical facility (e.g., clinic, tree nursery), but the term has also been applied to interviews done with community members after receiving a community-based service. Exit interviews are simpler, less expensive, and more practical and rapid than many other methods of measuring client satisfaction (e.g., focus groups), and also allow for rapid

---

[21] Barksy JD. World-class Customer Satisfaction, New York: Richard D. Irwin, 1995.

[22] Technical Assistance Research Programs Institute, Consumer complaint handling in America: an update study, executive summary, Washington, DC: Technical Assistance Research Programs Institute, 1986.

[23] Aharony, L and Strasser, S. 1993. Patient satisfaction: What we know about and what we still need to explore. Medical Care Review 50(1): 49-79. Lochman, JE. 1983. Factors related to patients' satisfaction with their medical care. Journal of Community Health. Winter 9(2):91-109. Scott, A and Smith, R. 1994. Keeping the customer satisfied: Issues in the interpretation and use of patient satisfaction surveys. International Journal for Quality in Health Care 6(4): 353-359. As cited in QAP's Operations Research Summary, "Improving Client Satisfaction in Peruvian Health Clinics," which is available for download at: http://www.qaproject.org/pdf/clientsatisfaction.pdf

feedback. They can be used both to measure quality, and as a management tool to improve quality, program performance, and sustainability.

The Quality Assurance Project (QAP) has conducted a study looking at the *validity, utility, feasibility, and costs*[24] of exit interviews and focus groups as tools for measuring client satisfaction with services.[25]

- Their findings suggest that **exit interviews are significantly more *valid* in terms of the actual content recorded than was a structured focus group tool**. Clients are less subject to recall problems, and exit interviews collect clients' unedited first impressions.
- However, because exit interviews include only current users, **they may systematically report higher levels of client satisfaction**.
- Contrary to expectations, **exit interviews rated higher on *utility*** by offering **greater depth of information per person interviewed**. In terms of "key comments" (comments expressing strong opinions or emotions), exit interviews gave 42% more information than focus groups.
- **Focus groups were more *efficient* in data collection**, however, since data collectors were able to gather information from a larger number of clients within a given period of time. Time spent in data analysis, though, generally runs higher with focus groups than with exit interviews.
- Exit interviews are generally **lower cost** than other methods, and data can be processed quickly.
- When compared using a matrix, **exit interviews received the highest overall rating of the two tools.**

Other studies have found that the feasibility of exit interviews is high since they are generally conducted in one place, and the duration of the interview is short. It is also easy to replace clients who decline to be interviewed. One limitation is that exit interviews rarely capture comments on effectiveness of services since clients may not know the outcome of their visit (e.g., effectiveness of antibiotics or seeds given) at the time that they are interviewed. A soon to be published paper will present more of the advantages and disadvantages of different tools for measuring client satisfaction.[26]

Exit interviews with fixed questions and rating scales have not generally been useful if those developing the interview questions have not clarified what clients consider to be the

---

[24] *Feasibility* refers to how easy or difficult it is to obtain participants, apply tools, analyze findings, present results and routinely use the data collection tool. *Validity* refers to the degree to which the data seems to accurately capture what it is supposed to capture (i.e., face validity). *Utility* is how useful the information is for quality improvement activities. *Cost* takes into account the amount of time and other resources required for preparation, data collection, analysis and feedback.

[25] Kelley, E. and M. Boucar. Helping district teams measure and act on client satisfaction data in Niger. Operations Research Results 1(1). Published for the U.S. Agency for International Development (USAID) by the Quality Assurance Project (QAP): Bethesda, Maryland. Available for download at: http://www.qaproject.org/pdf/nigeroresults.pdf. A summary of the report is available at: http://www.qaproject.org/pdf/clientfocused.pdf. (Tools are compared in this document, looking at feasibility, utility, cost, and variability.)

[26] Santillán, D., and M.E. Figueroa. 2001. Implementing a client feedback system to improve the quality of NGO healthcare services in Peru. Operations Research Results (1)7. Bethesda, MD: Published for the United States Agency for International Development (USAID) by the Quality Assurance Project (QA Project).

key characteristics of quality.[27] Therefore, when using exit interviews, **it is important to use qualitative methods first** (e.g., as part of the baseline or pre-program assessment) **to better understand how clients define quality.**

A note on rating scales: In industrialized countries, scales (e.g., five-point Likert scales[28]) have been widely used for collecting data on client satisfaction. Staff members who design questionnaires, however, should realize that how *coarse* the scale is affects how reliable it is. It is easy to see that – when asked if someone agrees with a statement on a given product or service -- having *three* possible responses ("agree, neither agree nor disagree, disagree") will probably not lead to as reliable and precise results as having *five* possible responses. There is a limit, however, to how many responses one can keep in mind while making a decision, so more is not always better.

Researchers have calculated the number of scale points necessary to keep the difference between the true reliability and the reliability using a coarse scale to not more than 0.01 when the true reliability is 0.91. The researchers recommended using a *seven-point scale* when constructing scales for personality traits. The number of points, however, is context-dependent (as well as study-dependent), so using scales in some settings (e.g., developing countries) may require more or fewer scale points. After finding that a regular five-point, Likert-type scale was not valid during a pretest of an instrument, **staff of the Quality Assurance Project developed a two-step Likert-type scale**. Respondents were first asked to answer yes, no, or no opinion to a question about each parameter in their study (e.g., "Was the doctor attentive?"). If the person responded "yes," the respondent was asked if the doctor was "very" or "somewhat" attentive. If the person responded "no," the respondent was asked if the doctor was "somewhat" or "not at all" attentive. In this way a five-point scale ("very positive, somewhat positive, no opinion, somewhat negative, very negative") was created for the respondent group. **This may be a good approach for other organizations to take when working in areas of low-literacy and settings where the traditional five-point scale is found to not be valid or too difficult for respondents to understand.**[29]

Management staff need to be briefed on what to expect when monitoring quality. Exit interviews are sometimes analyzed by looking at the proportion of people who were satisfied with a given area of service (e.g., waiting time). Satisfaction scores are often well over 90% (for many different types of services, no matter how poorly done). One of the reasons for this is that clients in certain settings (e.g., health) are reluctant to express dissatisfaction with their service when questioned using exit interviews.[30] If service providers are not accustomed to looking at client satisfaction data, they can think that these levels of satisfaction are adequate and require no intervention.

---

27 Stinson, W. Data for Quality Management. University Research Corporation, 7200 Wisconsin Ave., Suite 500, Bethesda, MD 20814-4024.

28 For more information on the Likhert scale, see http://www.cultsock.ndirect.co.uk/MUHome/cshtml/psy/likert.html

29 See the Qualty Assurance Project's, Training health care providers in interpersonal communication: An evaluation of impact on performance in Honduras" (Available for download at: http://www.qaproject.org/pdf/ipcpart2.pdf.)

30 Avis, M, Bond M, and Arthur A (1997). Questioning patient satisfaction: an empirical investigation in two outpatient clinics. Social Science and Medicine, 1997, 44(1): 84-92.

"Courtesy bias" is another traditional problem with the use of exit interviews: clients are often reluctant to express negative opinions of services, especially in one-on-one meetings with interviewers, while they are still at the service site. Since questionnaires that are filled in by clients are often not a good option in developing countries, this presents a dilemma. One way to work around this problem is to use triangulation: use several different methods (e.g., exit interviews and focus groups) to measure the same thing. Some organizations have used follow-up home visits to some clients in order to gain more information from them "on their own turf." These home visits are often done with clients who express dissatisfaction so that more detailed information about problems encountered can be explored.

The International Planned Parent Federation (IPPF) developed a practical way to get service providers to give attention to even low levels of dissatisfaction with certain areas of service, despite overall low levels of dissatisfaction. Their method was also designed to diminish the problem of courtesy bias by focusing on areas for improvement rather than absolute levels of satisfaction. The IPPF method, which we will term "exit interviews using negative response cases," is explained on the following pages.

#6. Exit Interviews Using Negative Response Cases (IPPF)[31]

Contact: *(None of the organizations polled listed exit interviews as a stand-alone monitoring tool that they use. However, information sources for exit interviews are given in the footnotes above and at the end of this section.)*

Purpose: To prioritize opportunities for improvement (problem areas that need improvement), enable dialogue between clients and service providers about service quality and access, and to eventually increase sustainability by making services more client-oriented.

How it Works:[32]

- **Personnel Used to Collect the Data**: Objective, trained interviewers who are not staff members that normally interact with clients at the facility or community where the service is being rendered. (For example, a clinic would not use its own staff.) Other paid people, supervisors, or district/regional-level staff with whom the interviewees do not have regular contact can be used.
- **Type of Data Collected:** Quantitative questionnaire data on client satisfaction.
- **Frequency of data collection:** Periodically. Clinics in IPPF that used this tool would conduct follow-up surveys once a given set of improvement activities were completed, and then start a new quality improvement cycle with a new set of issues. All clinic visitors were interviewed over a one-week period, in order to cover all days of the week and all hours of each day.
- **Methodology**:
  A single-page model questionnaire was developed by IPPF to assess client satisfaction during exit interviews. The original questionnaire contained 24 mostly yes-no type questions, and took 3-5 minutes to complete. Based on feedback from health facilities, the model questionnaire was revised to include 28 questions, 12 of which are yes-no in format. Questions that were meant to get at the reasons why people were dissatisfied with services were added. More detailed information on the IPPF training is not available, but given the length of the questionnaire, training should not take any longer than two to three days.

  During preparation of surveys on ***client satisfaction with center-based services,*** questions on satisfaction with the following areas of service should be considered:
  - access to services (e.g., satisfaction with travel time, hours open)
  - interpersonal relations (e.g., how one was greeted),
  - physical aspects of the facility (e.g., comfortableness of benches),
  - wait time for service,
  - perceived technical competence of staff,
  - effectiveness of services (e.g., whether the medicine given stopped their pain),

---

[31] Much of the information in this section is taken from, Williams, T, Shutt-Ainé, J, and Cuca, Y: Measuring family planning service quality through client satisfaction exit interviews. International Family Planning Perspectives, 2000, 26(2): 63-71. Available for download at: http://www.agi-usa.org/pubs/journals/2606300.pdf

[32] More complete details on this methodology are available from a document downloadable at: http://www.ippfwhr.org/resources/Annex4.PDF

- efficiency of services (e.g., if they had trouble finding their way around the clinic),
- lag time in getting information from the service (e.g., results of any diagnostic tests, feedback from monitoring activities or evaluations), and
- cost.

During preparation of surveys on ***client satisfaction with community-based services***, questions on satisfaction with the following areas of service should be considered:

- frequency of contact by staff,
- access to meetings (e.g., satisfaction with walk time to community meeting sites),
- interpersonal relations,
- physical appearance of the staff,
- ease of understanding of staff,
- perceived technical competence of staff,
- appropriateness of suggestions made by staff, and
- amount of information given by staff.
- effectiveness of services,
- efficiency of services, and
- cost of services.

Those who design questionnaires should keep in mind that some studies have suggested that specific and detailed questions are more likely to elicit true client responses than more general ones.[33]

The suggested sample size is 100, approximately the same as what would be required of a simple random sample with a precision of 10%. All patients seen on consecutive days should be interviewed until this sample size is met or surpassed (e.g., 32+37+39 patients during three days). In actuality, IPPF found that many surveys included more than 100 respondents, with an average sample size of 176 respondents. For small clinics that did not have 100 patients in a one-week period, quota samples by time of day were used. Interviewing was carried out in a private area out of earshot of the staff so that clients would feel freer to speak openly about the aspects of the service that they felt needed improvement.

Clients were interviewed at the end of their visit by trained interviewers who were not members of the clinic's staff. Following the interviews, the staff identified "areas for improvement" as those items in the questionnaire about which at least 5% of respondents expressed dissatisfaction. These items were called "negative response cases" (NRCs). The threshold of 5% for identifying dissatisfaction was based on observed results of earlier surveys, and was meant to flag a manageable number of areas for improvement with each survey. IPPF found that this threshold was successful in identifying a workable number of problem areas and in drawing attention to client concerns that might have otherwise been overlooked or undervalued.

For each NRC, service facilities were required to follow-up with actions that addressed each area for improvement. By using a threshold, the tool can be used to place more attention on improving the situation rather than debating whether 94% satisfaction is

---

[33] Simmons R and Elias C. The study of client-provider interactions: a review of methodological issues. Studies in Family Planning, 1994, 25(1): 1-17.

problematic or not. Except for questions that were NRCs (i.e., questions with a dissatisfaction rate of 5% or more), actual levels of satisfaction were not even reported to a higher level.

IPPF tracked all surveys carried out, the NRCs identified, and the proposed actions for improvement. From that data, IPPF was able to determine which questions generate the most negative response cases, and which had revealed the highest levels of dissatisfaction. IPPF also analyzed the content of the proposed improvements (the action plans) in order to assess how appropriate they were to the NRCs they were meant to address. Later, they assessed the extent to which improvements resulted in greater client satisfaction.

An organization could systematize this part of the methodology by developing a form to track the question that had the 5% or greater dissatisfaction level, the specific changes that are planned, intended completion dates, and follow-up satisfaction levels for the same questions once action plans are carried out. An organization could then highlight successful, low-cost solutions to areas for improvement in a publication or during supervision visits. IPPF found that about 3.2 NRCs were reported per survey (out of 89 total surveys).

IPPF's Results: The results of the follow-up surveys done by IPPF affiliates indicate that **in all five countries where this methodology was used, both the mean number of negative response cases and the mean level of dissatisfaction among those cases decreased.** (The percentage decrease in dissatisfaction ranged from 28% in Trinidad and Tobago to 76% in Paraguay.) Strong decreases in dissatisfaction were evident for each of the variables measured, suggesting that the improvements implemented by service centers were effective.

Caution should be applied in the interpretation of these results, though: In the majority of these follow-up surveys, at least one new negative response case (NCR) appeared. It is unknown to what degree the same results would be found if this sort of exit interview was repeated two months in a row, all other things being equal. Furthermore, although aggregate dissatisfaction decreased strongly for all variables, the average level of dissatisfaction remained greater than 5% in four of the seven areas for improvement.

Other Attributes:

- **Other biases that can affect the data should be taken into account during analysis**. **For example, high levels of** dropout of clients due to poor quality in certain components of services could conceivably lead to higher levels of client satisfaction in other variables, simply because workers have smaller caseloads. (For example, an agricultural extensionist may have more quality time to dedicate to the five farmers with whom s/he works after the other farmers reject his/her services!) This problem can be controlled for in part by looking at trends in the number of clients over time. (If volume decreases sharply, for example, while satisfaction levels increase, one might suspect that improvements in quality are due to smaller caseloads.)[34]
- **This tool would be used optimally where outside interviewers can be hired locally or brought in easily to conduct the client satisfaction interviews.**
- **This tool can be very participatory, especially if clients are asked first to define those things that are part of good quality for a given service**. (This can be done most easily by qualitative methods like focus groups.) Client satisfaction surveys are sometimes the only chance that clients get to say how they truly feel about the services that they receive. Sometimes clients are so disempowered that they feel that they must accept whatever quality that they are offered. Just asking clients their opinion during a brief interview – and letting them know that their opinion does make a difference -- is one way to increase their feelings of empowerment. In order to increase local involvement, results from the survey and action plans should be disseminated to clients.

References / Sources of Training and Technical Assistance

- Wiliams, Timothy, and Schutt-Ainé, Jessie, and Cuca, Yvette. Measuring family planning service quality through client satisfaction exit interviews. International Family Planning Perspectives, 2000, 26(2): 63-71 (available for download at: http://www.agi-usa.org/pubs/journals/2606300.pdf).
- Bessinger, R and Bertrand, J. Monitoring quality of care in family planning programs: a comparison of observation and client exit interviews. December 2000. Carolina Population Center, 123 W. Franklin Street, Suite 304, Chapel Hill, NC 27516. Available for download at: http://www.cpc.unc.edu/measure/publications/workingpapers/wp0027.pdf
- Schmidt, F and Strickland, T. Client satisfaction surveying: a manager's guide. Citizen-Centred Service Network, Canadian Centre for Management Development, December 1998. Available for download at: http://www.ccmd-ccg.gc.ca/pdfs/guide_e.pdf
- Schmidt, Faye and Strickland, Teresa. Client Satisfaction Surveying: Common Measurements Tool, December 1998. Available for download at: http://www.ccmd-ccg.gc.ca/pdfs/tool_e.pdf
- Marson, Brian D. and Dinsdale, Geoff. *Citizen/Client Survey: Dispelling Myths and Redrawing Maps*, March 1999. Available for download at: http://www.ccmd-ccg.gc.ca/pdfs/dmrm.PDF.
- IPPF's Manual to Evaluate Quality of Care from a gender perspective. See Annex 4, especially, of this document at: http://www.ippfwhr.org/resources/QCGPtoc.htm

[34] More ideas on possible biases when working with this type of system can be found in Williams and Schutt-Ainé (*op cit.*).

- Gerson, Richard F., Ph.D. Measuring Customer Satisfaction. Crisp Publications, 1993.
- Hayes, Bob E. Measuring Customer Satisfaction: Survey Design, Use, and Statistical Methods. ASQC Quality Press, 1998.
- Hill, Nigel. Handbook of Customer Satisfaction Measurement. Gower Publishing, 1996.

Please see the **Consultant Training Skills Matrix** in **Annex C** for a list of consultants who have trained others in the use of Exit Interviews.

#7. Key Informant Interviews

Contact: *(None of the organizations polled listed key informant interviews as a stand-alone monitoring tool that they use. However, information sources for key informant interviews are given at the end of this section.)*

Purpose: Key informant interviews are used to obtain client satisfaction and other types of information from a community member who is in a position to know the community as a whole, or the particular portion of a community in which you are interested. (That community member can be a leader who works with the group for which more information is sought, or a member of the target group that your project serves.)

How it Works:[35]

- **Personnel Used to Collect the Data**: On-site staff, other staff, or community members serve as interviewers.
- **Type of Data Collected:** Qualitative questionnaire data on client satisfaction. (Key informant interviews can be used to gather information on other topics, as well.)
- **Frequency of data collection:** Periodic
- **Methodology**:

Either project staff or community volunteers can be used to conduct the interviews. Using community volunteers has the benefit of establishing more rapport between community members and project staff. Community members also do not directly represent the organization, and as a result, interviewees may be more willing to voice negative comments about services that need to be addressed. Regardless, interviewers for key informant interviews should:

- interact well with the people they will be interviewing;
- be able to put interviewees at ease during interviews;
- understand what it means to be a facilitator, to put aside their own agenda and really listen to what the key informant is saying; and
- be willing to push their "comfort zones" by interviewing people with whom they might not otherwise come in contact.

Project staff (and community volunteers, if they are used) will need to develop a sampling scheme to help insure that the interviews (taken as a group) provide a high degree of representation of community members' perceptions of problems. Once that is done, interviewers should be assigned to key informants whom they will interview (e.g., key informant who they do not know). (Otherwise, interviewers may be tempted to "visit" only with their friends and neighbors).

Project staff should work with stakeholders (e.g., community members) to come up with a question guide, a general list of questions to be used by all key informant interviewers. Training should be provided to the interviewers, including good interviewing techniques,

---

[35] Much of this information is taken from (1) University of Illinois' Extension Program Planning and Assessment Modules on key informant interviews, available for download at: http://www.aces.uiuc.edu/~PPA/KeyInform.htm, and (2) Performance Monitoring and Evaluation TIPS, USAID Center for Development Information and Evaluation 1996(2). Available for download at: http://www.dec.org/pdf_docs/pnabs541.pdf

and how to summarize what they learn. Training should include supervised practice in interviewing and feedback on performance.

Informants should be selected who not only understand the situation that is the focus of the interviews, but who have reflected on it, as well. A good informant will be able to express thoughts, feelings, opinions, and his or her perspective on the topic. Informants of different ages, ethnic backgrounds, religious affiliations, and educational affiliations should be chosen.

First, groups and organizations should be identified from which key informants will be drawn (e.g., host government agencies, project implementing agencies, beneficiaries). It is best to include all major stakeholders so that divergent interests and perceptions can be captured. Second, select a few people from each category after consulting with people familiar with the groups under consideration. Each informant may be asked to suggest other people who may be interviewed, as well.

After potential interviewees are selected, interviewers should contact the key informant, introducing him- or herself, and his/her relationship to the organization conducting the interviews. The interviewee is thanked and is briefed on the purpose of the interview, what will be done with the information received, and confidentiality. This introduction should help to establish the relationship between the interviewer and the informant and establish the credibility of the interviewer. Explaining to the informant why they were chosen for the interview often provides them with the motivation needed to provide quality information.

As with most qualitative interviews, the interview should begin with some basic “ice-breaking” questions (e.g., “tell me about your role in the community as chief”). More general and objective questions should be used first, then more specific and subjective (or delicate) questions should be used later in the interview. Open-ended questions should be used for the main questions. (Probes will often include closed-ended questions.) It is important to express naiveté and use active listening techniques (e.g., nodding the head, asking for more information) during the interview so that interviewees are encouraged to provide more rich, descriptive answers. During the interview, the interviewers should not be required to go through each question one-by-one, but rather follow the general order of the questions, and ask all relevant questions at some point during the interview. Informants can be asked to rank items during the interview, as well.

After the interviewer has used the last question, s/he should give a summary of what has been said, and ask for feedback and any modifications that need to be made to the information that is collected. If the interviewer has misunderstood any information, this gives the informant a chance to clarify their position.

To analyze the information, some organizations have asked interviewers to make brief notes on cards, which are later grouped in a variety of ways (e.g., positive comments vs. negative, problems with staff vs. with project design) to look for trends in the information provided. It is useful to have interviewers write down details of the interview immediately after it is finished (including emotions that the informant expressed during the interview).

Other Attributes:

- When used several times during the life of a project, **key informant interviews can provide staff with qualitative information on client satisfaction** (and other things). **They cannot be used, however, to reliably track trends in client satisfaction** since the interview is qualitative in nature and the sample size is small and not always representative of the community at large.
- **There are many advantages to using key informant interviews to measure client satisfaction. Key informant interviews:**
  - provide information directly from knowledgeable people;
  - offer an opportunity to establish rapport with community members and get an insider's view;
  - provide flexibility to explore new ideas and issues not anticipated during planning;
  - provide in-depth information about causes of a given problem;
  - allow an organization to obtain information from many different people, including minority or "silent majority" viewpoints;
  - can build community awareness and support for a project (if community volunteers are involved in the process);
  - allow an organization to clarify ideas and information on a continual basis;
  - may avoid high cost of using a larger sample;
  - can be used with all age groups, including elderly and youth; and
  - are generally inexpensive and simple to conduct.

- **There are some disadvantages to using key informant interviews, as well, since:**
  - they are not appropriate if quantitative data are needed;
  - they may be biased if informants are not carefully selected;
  - other community members who are not being used as key informants may become jealous and resent being left out;
  - the relationship that an organization has with the informant may influence the information received (i.e., they are susceptible to interviewer biases);
  - informants may give their own impressions and biases rather than reporting objectively what others feel;
  - representation of the community may not be equitable;
  - the information received may be difficult to quantify or organize;
  - perspectives of community members who are less visible may be under-represented; and
  - time is necessary to select good informants and build trust with them.
- Doing good qualitative interviews requires either ample training (including a lot of supervised practice in interviews), or use of professional interviewers.
- This method would be **best used in a project where** s**taff members understand the communities' social structure, can readily identify good key informants, and have good rapport with the community.**
- This tool can be very participatory when community members are involved in the interviewing. However, when they are used, training will need to include extensive practice and coaching. The difficulty of qualitative interviewing is sometimes under-estimated.

References / Sources of Training and Technical Assistance

- University of Illinois' Extension Program Planning and Assessment Modules on key informant interviews, available at: http://www.aces.uiuc.edu/~PPA/KeyInform.htm
- Performance Monitoring and Evaluation TIPS: Conducting Key Informant Interviews, USAID Center for Development Information and Evaluation 1996(2). Available for download at: http://www.dec.org/pdf_docs/pnabs541.pdf

Please see the **Consultant Training Skills Matrix** in **Annex C** for a list of consultants who have trained others in Key Informant Interviews.

#8. Focus Groups

Contact: *(None of the organizations polled listed focus groups as a stand-alone monitoring tool that they use. However, information sources for focus group interviews are given at the end of this section.)*

Purpose: Focus Groups are used to obtain information on client satisfaction and other issues from groups of people who share common traits that affect their satisfaction with services and generally a common life situation or worldview.

How it Works:[36]

- **Personnel Used to Collect the Data**: Project staff members trained in focus group interviews.
- **Type of Data Collected:** Qualitative questionnaire data on client satisfaction. (Focus groups can be used to gather information on other topics, as well.)
- **Frequency of data collection:** Periodic
- **Methodology**:

Please see Annex D, Food for the Hungry International's guide to using focus groups for details on how this methodology is used.

Other Attributes:

- When used several times during the life of a project, **focus groups can provide staff with qualitative information on client satisfaction** (and other things). **They cannot be used, however, to reliably track trends in client satisfaction** since the interview is qualitative in nature and the sample size is small and not always representative of the community at large.
- **In many settings, focus groups often turn into "interviews done in groups" where each person in the group gives an answer to a question that is unrelated to what the last person said in the group. This is not the intent of the methodology.** The discussion in a focus group should be a free-flowing *conversation* amongst the participants where the facilitator plays a smaller and smaller role once the question is understood by the participants. Responses by participants are made in reference to the original question, but are also made in response to comments made by other participants in the group. Good training is required to assure that facilitators know how to bring about a true group discussion, and good supervision in the field is required to assure that this is happening.
- Some studies have found that **focus groups are significantly less *valid* in terms of the actual content recorded when compared with exit interviews.**[37] **Those taking notes on the content of the focus groups need to be trained to take copious notes (quickly) and should be supervised at first.** Someone with good local language skills who can write quickly and legibly is one option. Another is

---

[36] Much of this information is taken from Performance Monitoring and Evaluation TIPS: Conducting Focus Group Interviews, USAID Center for Development Information and Evaluation, 1996(10). Available for download at: http://www.usaid.gov/pubs/usaid_eval/pdf_docs/pnaby233.pdf

[37] Kelley and Boucar, *op cit*.

using a tape recorder and having someone else make a transcript of the tapes or take notes while listening to the tape at a later time. This is a very time consuming process, though, and it is difficult to understand all comments made unless the acoustics are excellent and the tape recorder used is very high quality.

References / Sources of Training and Technical Assistance

- Performance Monitoring and Evaluation TIPS: Conducting Focus Group Interviews, USAID Center for Development Information and Evaluation 1996(10). Available for download at: http://www.usaid.gov/pubs/usaid_eval/pdf_docs/pnaby233.pdf
- Quality Assurance Project. Client-Focused Care: An Evaluation of Tools for Gathering Client Satisfaction data. (Compares focus groups and exit interviews.) Available for download at: http://www.qaproject.org/pdf/clientfocused.pdf

Please see the **Consultant Training Skills Matrix** in **Annex C** for a list of consultants who have trained others in the use of Focus Groups.

Other Tools/Methods for Monitoring Client Satisfaction

The headquarters' staff of most Title II partners interviewed did not know of any monitoring tools currently in use in their organizations to measure client satisfaction. **This appears to be a great need of most Title II programs.** Several organizations mentioned tools for measuring client satisfaction as one of the main areas for which their organization needed tools.

In FHI, at least two of the four Title II programs (Ethiopia and Bolivia) conduct an annual internal review using some variation of a participatory evaluation tool entitled Participatory Program Evaluation: A manual for involving program stakeholders in the evaluation process, by Judi Aubel. This annual internal review yields qualitative information that includes each staff person's evaluation of various criteria including the degree of community participation and organization, and program barriers and proposed solutions. In addition, a cross-section of beneficiaries and representatives of all the collaborating partners participate in the evaluation by offering their appraisal of program staff, degree and quality of service provided by FHI, and the degree to which their program-related needs were met by the program during the year.

OICI does not monitor client satisfaction, but does verify that commodities packaged for each community are indeed delivered. This is done by requiring Technical Officers to visit each client community to carry out one informal interview with a key informant. This process could be improved by requiring Technical Officers to interview several key informants per community, and by providing Technical Officers with a questionnaire to monitor aspects of client satisfaction (e.g., timeliness, how they heard about the distribution, evidence of corruption, the person's transportation cost to the delivery site, overall satisfaction with the program). At this point, OICI relies on each technical officer to develop his or her own questions for this assessment.

C. Tools for Monitoring Adoption of Practices (Techniques/ Behaviors) and Acquisition of Knowledge

✪ = tool meets the criteria

Tool	*Lends itself to Significant Participation by Program Stakeholders in Use & Modification of Tools*	*Requires Two Days or Less of Training*	*Can Collect and Analyze Data in one Week or Less*	*Provides numerical quality scores or indicator levels*	*Provides information that is easily interpreted and used for program modifications*	*Can Generally be Conducted with Existing Staff*
#9. Pretests and Posttests	✪	✪	✪	✪	✪	✪
#10: Rotating Mini-KPCs	-	-	-	✪	-	✪
#11. MCH Calendar (PCI)	✪	✪	✪	✪	?	✪
#12. Holistic Community Epidemiology System (SCF)	✪	-	?	✪	✪	✪
#13. LQAS with KPC Questions	-	-	-	✪	✪	✪
#14. Grain Storage Silos Maintenance Questionnaire (PCI)	-	✪	✪	✪	✪	✪
#15 Growth Monitoring Using the Behavior Box	✪	-	-	✪	✪	✪

#9. Pretests and Posttests

Contact: (Many different organizations use this tool. Tom Davis at FHI (tdavis@fhi.net) is available for backstopping on pre/posttests.)

Purpose: The purpose of pretests/posttests is to measure the amount of knowledge that has been retained following an educational or training session.

How it Works:

- **Personnel Used to Collect the Data**: Educators or trainers.
- **Type of Data Collected:** Proportion of knowledge questions answered correctly by participants in the educational or training session.
- **Frequency of data collection:** Each training/educational session, or a sample of them.
- **Some Background on Monitoring and Evaluation of Trainings and Educational Sessions:** One of the most comprehensive and widely referenced models of evaluation of trainings programs is Donald Kirkpatrick's.[38] The four levels of that model are:
  - ***Reaction*** (i.e., how well the participants liked a particular training program): The typical instrument used to gather information regarding reactions is a "short, quickly constructed, open-ended questionnaire that provides subjective impressions and no data that can withstand statistical analysis or measures for reliability." It focuses on participants' reactions – not learning or the transfer of learning. While providing a general estimate of a particular course's success based upon the views of the participants, participants may have a tendency to report what a trainer wants to hear.[39] Also, some trainers and researchers feel that measurements of participant reactions are inaccurate and counter-productive. Conway and Ross[40] found that participants have a tendency to underestimate their pretraining skills and overestimate their posttraining skills in an attempt to justify participation in a training. (This is consistent with findings from the field of social psychology, which indicates that people have a strong need to justify their behavior and actions, and consequently may alter their opinions and their interpretation of past events.) Some researchers go as far as to say that "the use of participant reaction forms can cause more problems than benefits for the training function of an organization,"[41] especially when it creates expectations that training must be entertaining or that learning is a passive rather than active process.
  - ***Learning*** (i.e., principles, facts and techniques that were understood and absorbed by the participants): *This level of evaluation is used by many Title II*

---

[38] Kirkpatrick, DL. (1979). Techniques for evaluating training programs. Training and Development Journal, 33(6), 78-92, as referenced in "Evaluating the effectiveness of training programs" (Boverie, P, Mulachy, DS, and Zondlo, JA, downloadable at: http://www.zondlo.com/access/eval.htm).

[39] Fisher, HE, and Weinberg R. (1988). Making training accountable: Assess its impact. Personnel Journal, 67(1), 73-77.

[40] Conway, M. & Ross M. (1984). Getting what you want by revising what you had. Journal of Personality and Social Psychology, 47(4), 738-748.

[41] Dixon, NM. (1987). Meet training's goals without reaction forms. Personnel Journal, 66*8), 108-115.

organizations, usually through pencil-and-paper or oral pre/posttests. Kirkpatrick[42] recommends that each participant's learning should be measured by quantitative means, using a pretest and posttest so that any learning can be attributed to the training program or educational session, and subjecting the results to statistical analysis in order to discover correlations and/or levels of confidence. Paper-and-pencil tests are the most common form of pre/posttests, but simulations and demonstrations can be used, as well. Trainers and educators should keep in mind that –like paper-and-pencil tests – return demonstrations and performance in simulations merely indicate whether a participant can use the skills they have obtained, not whether he or she will actually use the skills.

- ***Behavior*** (i.e., the transfer of skills and knowledge learned to the work environment, "transfer of learning): Researchers warn that "evaluation of training programs in terms of on the job behavior is more difficult than the reaction and learning evaluations.... As a result, much training is delivered without a plan for measuring the transfer of training."[43] Kirkpatrick suggests a framework for evaluating training programs in terms of behavioral changes. That framework includes a systematic appraisal of on-the-job performance – by the participant and the participant's superior, subordinates, and/or peers -- before and three months after a training program. Statistical analysis should be done to compare before and after performance. Bandura found that any learning that may have been gained by observing the behavior of models was completely wiped out by the subsequent incentives received for the performance of a specific task. This fact led Bandura to conclude that "mere exposure to modeling stimuli does not provide sufficient conditions for imitative or observational learning."[44] 'Seeing may be believing,' but unless participants can discover how a change in their behavior will make things better for them or those they care about, behavior will not necessarily change. Thus, educators and trainers need to think about how the knowledge or skills learned in a training or educational session will make life better for participants. In order to have effective change at this behavioral level, an organization needs to include within the training or educational program a plan for transfer of skills and knowledge, and identify in that plan changes in the environment which provide positive incentives to apply skills gained in training.
- ***Results*** (i.e., impact due to a training program or educational session). It is very difficult to tease apart impact due to a training program, and program impact caused by other inputs and factors. For this reason, many organizations choose not to measure impact of training programs, especially in field situations where strict protocols for measurement cannot be easily carried out.

---

[42] *Op cit.*

[43] *Op cit.*, p. 86.

[44] Bandura, A. (1965). Influence of models' reinforcement contingencies on the acquisition of imitative responses. Journal of Personality and Social Psychology, 1(6) 589-595.

- **Methodology**:

Pre/posttests are useful in measuring principles, facts and techniques that were understood and absorbed by participants. Many Title II organizations use pre- and posttests to monitor the effectiveness of training programs conducted for project staff. Some organizations are now beginning to use pre- and posttests at the program participant level, as well, to measure the effectiveness of educational sessions.

Please see Annex E for a copy of FHI's guidance on preparation of verbal and pencil-and-paper pre- and posttests. (Also included in these notes is a methodology for calculating and reporting changes from pre- to posttest using a performance index.)

When pre/posttests are used, organizations should track both overall scores, and correct responses for each question in the test. Changes in the mean score from pre- to posttest helps an organization to monitor the *overall quality of trainings*. Looking at participant-level (disaggregated) data, supervisors can see *which participants are responding the best to trainings and educational sessions*, and which require more individualized attention. Looking for increases in correct responses for each question in a test can help an organization to see *which parts of a training are generally problematic for learners* and require more follow-up.

Organizations should also consider using "*post-posttests*" (PPTs) to monitor retention of knowledge. A PPT is simply a reapplication of the same posttest to the same group of people after an extended period to measure how much knowledge has been retained. PPTs are often administered one to two years after a training has been conducted (e.g., during a midterm evaluation). Average scores on a PPT from a given workshop are compared to the posttest score several years previously. These averages can be used to gauge differences between fields or communities that participated in the same trainings. The results may also be used to determine how individuals have retained knowledge that they gained in a training or educational session. PPTs compliment pre/posttests and are important in gauging the ultimate success of the original training.

FHI recently used PPTs to measure retention of knowledge among staff trained in ISA workshops. In its use of PPTs, FHI found that PPTs gave a good indication of which things had been *applied* in a work setting since a workshop. When participants were applying a given thing that had been learned, PPT scores were generally higher for that topic. This indicates that high scores on PPTs applied an extended period after a community-level training may also indicate that beneficiaries are applying what has been learned. PPTs may also serve as motivation for staff to use the knowledge they have received in a training since they know they will be periodically tested on how well they retain that knowledge. If applied in a rotating fashion (e.g., applying a different posttest every quarter to monitor retention of a workshop from the previous year), PPTs could be used in monitoring.

Other Attributes:

- The **rigor and quality** of pencil-and-paper pre- and posttests is often high since questions are posed to participants in a standard, objective way. Verbal posttests, when done reading from a standard, written list of questions on key points, can also be rigorous. As mentioned earlier, simple statistics (e.g., means and standard deviations of test scores) should be used when comparing scores. Also, it is helpful to build in a process whereby a supervisor goes over each participant's posttest so that errors will not remain uncorrected.
- **Pretests and posttests are most useful in programs where educational messages and methods are (or should be) standardized.** When educators and trainers are given a lot of leeway in deciding the content and key educational messages for educational sessions or training, pre- and posttests are not as useful since the content of trainings will vary from trainer-to-trainer and week-to-week.
- It should be remembered that **pre- and posttests are useful only for measuring what knowledge and skills participants have and could use at the end of a training**, not to determine the knowledge and skills that they will use on the job.
- **Pre- and posttests are usually not very participatory unless the educational content is developed by multiple stakeholders, including community members.** Also, given the format, participants may feel that they are "in school again" which can be disempowering, and hinder projects from developing a relationship with community members where the community and an organization are partners in the development process. One way to work around this potential problem is to involve community members in the development of the pre- and posttest, and base questions on the results of a participatory training needs assessment (e.g., asking questions in pre/posttests on how to prevent post-harvest loss when participants indicate that they want to learn how to prevent it).
- This is a **simple tool for NGOs and other government agencies to use** as part of their training process. The likelihood that local partners will continue to use the tool after program completion is probably high as long as partners are convinced of the need for monitoring the results of their educational and training programs.

References / Sources of Training and Technical Assistance

- Kirkpatrick, DL. (1979). Techniques for evaluating training programs. Training and Development Journal, 33(6), 78-92, as referenced in "Evaluating the effectiveness of training programs" (Boverie, P, Mulachy, DS, and Zondlo, JA, downloadable at: http://www.zondlo.com/access/eval.htm).
- Endres, G.J., & Kleiner, B.H. (1990). How to measure management training and development effectiveness. Journal of European Industrial Training, 14(9), 3-7.
- Kirkpatrick, D.L. (1979). Techniques for evaluating training programs. Training and Development Journal, 33(6), 78-92.

Please see the **Consultant Training Skills Matrix** in **Annex C** for a list of consultants who have trained others in the use of pre/posttests.

#10. Rotating Mini-KPC Surveys

Contact: Many different organizations use similar mini-KPC type tools for annual performance tracking. **Adugna Kebede (akebede@fhi.net) or Tom Davis (**tdavis@fhi.net**), Food for the Hungry, International** can be contacted about the particular application of the tool discussed below.

Purpose: To monitor changes in knowledge, practice and coverage of program beneficiaries. Changes in KPC indicators over time can be useful in supporting the findings of impact evaluation data.

How it Works:

- **Personnel Used to Collect the Data**: Supervisory-level staff and paid Health or Agriculture staff
- **Type of Data Collected:** Data on knowledge, practices, and coverage of program beneficiaries, based on program participant's (or program participant's mother's) report.
- **Frequency of data collection:** Every three to six months. (FHI used the tool every six months, and World Relief used the tool every three months.)
- **Methodology**:

FHI's maternal/child health and nutrition program assists approximately 42,000 families with almost 100% coverage in assisted areas in Mozambique. Through use of "Care Groups"[45] in this health program, FHI has lowered stunting by 25% and severe stunting by 48%. In this multiplier model, paid Promoters meet every two weeks with a group of 8-10 volunteer mothers. (Each Promoter meets with eight groups every two weeks.) In FHI's use of this tool, volunteers mothers are educated during the meeting on a given topic using a flipchart then the volunteer mothers practice giving the education themselves – supervised by the Promoter -- using a small flipchart. (WR uses training materials prepared in the local language, but stresses oral methods, including story-telling, songs and dance.) Between the biweekly meetings with the Promoters, the Volunteer Mothers visit nine (previously-chosen) mothers in their neighborhood and give them individual education using their flipchart. To assess the knowledge and behavior change that has occurred, FHI has used Rotating Mini-KPCs.

The training for this tool initially takes one week. Each year, a three-day refresher course is given to assure that skills are not lost and to train new personnel. The time required for each monitoring session in FHI's programs in Mozambique is one week per district.

The questionnaire used for the Rotating Mini-KPCs was developed using questions modified from the KPC Survey developed by Johns Hopkins University and was based on the objectives delineated in the Development Assistance Proposal (DAP). It has twelve to sixteen questions (depending on the organization using the questionnaire, and whether or not the child has had diarrhea), and uses mostly yes/no questions to ensure that the interviewing process is rapid. (On average, one interview with a mother takes about 20 minutes for a first-time interviewer, and about 12 minutes for interviewers that had more

[45] Please contact World Relief or FHI for more information about the structure and purpose of Care Groups.

experience.[46]) In Mozambique, information was gathered on the following elements for each mother/child pair in the sample (see **Annex F**):

- Age in months
- DOB (for verification of age in months)
- Child breastfed?
- Child given other foods?
- Child eats three or more times daily?
- Oil is added to potatoes?

  In last two weeks:
- ...has the child had diarrhea?
- ...did the child w/diarrhea received more liquids ?
- ...did the child w/diarrhea received more foods?
- ...did the child w/diarrhea received more breastmilk?
- ...did the child w/diarrhea received ORT?
- Has the child had DTP3? (verified with card)
- Number of signs of dehydration the mother knows?
- Has the child had Vitamin A in last six months? (mother's report or card)
- Has the child has had mebendazole in last six months? (mother's report or card)
- Has the child eaten a vitamin A rich food today?

Other questions can be used, such as those found in an organization's baseline KPC questionnaire, or questions in the generic KPC questionnaire promoted by the Child Survival Technical Support group (CSTS).[47]

FHI chose to include one entire Care Group (100 mothers) for each Promoter in their sample, which resulted in having about 12% of the mothers involved in the program in their sample. This was accomplished by randomly selecting one of the eight bi-weekly meetings held by each Promoter. (Please see the diagram on the next page.) All of the volunteer mothers who meet on that day are instructed to bring all of their mothers with children under two years of age to the meeting site on the day of the survey in their community. In this way, some mothers who are educated by each promoter (12% in each monitoring period) are interviewed. (Other organizations should consider using a smaller sample size – stratified by Promoter – than what FHI used in their program. Using LQAS would significantly decrease the time required for interviews, while allowing the organization to still have data on relative performance at the community level – see Tool #13.)

During the interviews, Promoters are usually sent to sites other than their own to reduce interviewer bias. When Promoters interview mothers with whom they have not worked before, the Supervisor repeats the interview with 10% of the mothers to assure accuracy. In areas where Promoters must be involved in the interviewing of "their own" mothers[48], 50% of their interviewees are re-interviewed by a supervisor or another Promoter to

---

[46] Some mothers took as much as 30 minutes to complete the interview, but they only represented about 5% of the mothers.

[47] See http://www.childsurvival.com/kpc2000/kpc2000.cfm for a copy of the latest KPC questionnaire.

[48] The main reasons that Promoters sometimes had to be involved in the interviewing process with their own mothers in some communities was that (a) outside Promoters rarely knew the geographical area well enough to find where the interviews would be held; and (b) some communities were very suspicious of outsiders, especially those from communities that were largely populated by people associated with an opposing political party (i.e., RENAMO vs. FRELIMO).

assure that the results are accurate. Also, the selection of Care Groups included in the sample is done *without replacement* in order to avoid the bias inherent in re-interviewing mothers using the same questionnaire every six months (i.e., once a group is chosen for monitoring, it is not chosen again until the next DAP).

The interviews are done in teams with three or four interviewers and one supervisor visiting each meeting site on a pre-arranged day and time. The Health Director, District Coordinators, District Supervisors, Promoters, and Supervisors from all districts served are involved in the monitoring process. On a given day of monitoring, interviews usually begin at 7 a.m. and end by 2:00 p.m. Afterwards (on each day), a debriefing is done to discuss any problems that came up in the process. The Health Director, District Coordinator, Supervisors, and Promoters often put in 9-12 hours a day during these monitoring weeks. The monitoring process generally takes one week per district in FHI's project area. (WR's process usually takes three days for surveying, analysis and discussion.)

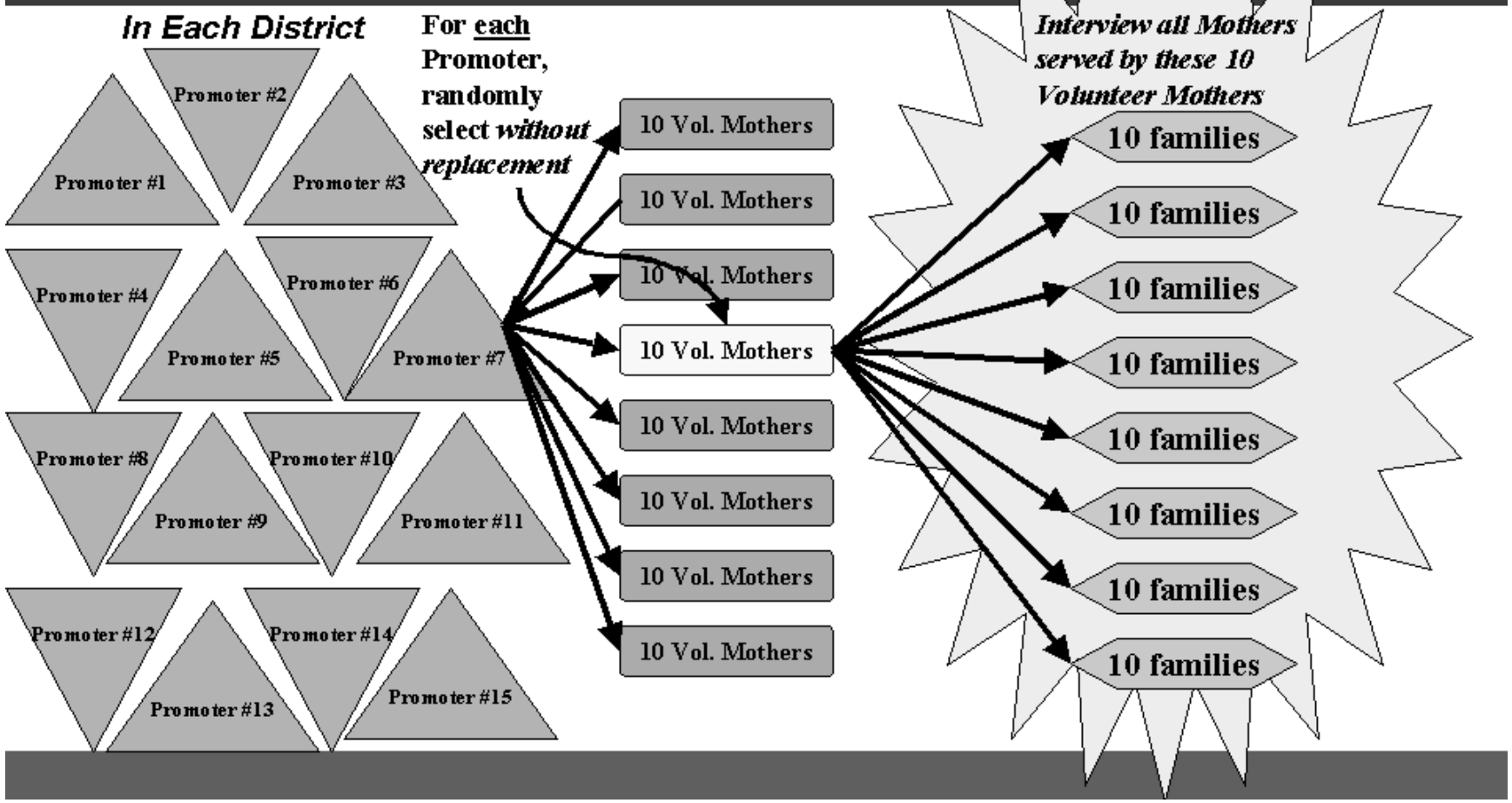
Questions are asked about all children under 24 months of age. Data entry generally takes about 12 person-days (e.g., 3 people x 4 days) . Writing the analysis program initially took the Health Director about three days, but less than one day of programming changes and file creation are usually required after the first monitoring period. Following data entry, it takes about one week for analysis (using Epi-Info software) and report generation. Reports can also be analyzed using Excel. (This report, of course, becomes the bulk of what is included in the CSR4 report.)

The indicator levels found are compared to baseline and to the preceding six-month monitoring period. Indicator levels are plotted on individual line graphs and the graphs were posted at the offices. Promoters get individual statistics from their own communities. Also, during one two-week teaching period, each Volunteer Mother is given a small flipchart which graphically presents the coverage levels of mothers in the district in which they live.[49] Community leaders and fathers were also invited to this particular educational meeting so that they could be informed of the results, as well. (See the sample graphs with FHI/Mozambique data on the following page.)

In WR's use of this tool, all animators analyze the data together, then report back to their groups. If one group is found to not be doing well, or particular volunteers are not doing well, the volunteers are paired up to support each other. They are graded as "A," "B," or "C," and a volunteer rated an "A" will then do visits with a "C" volunteer.

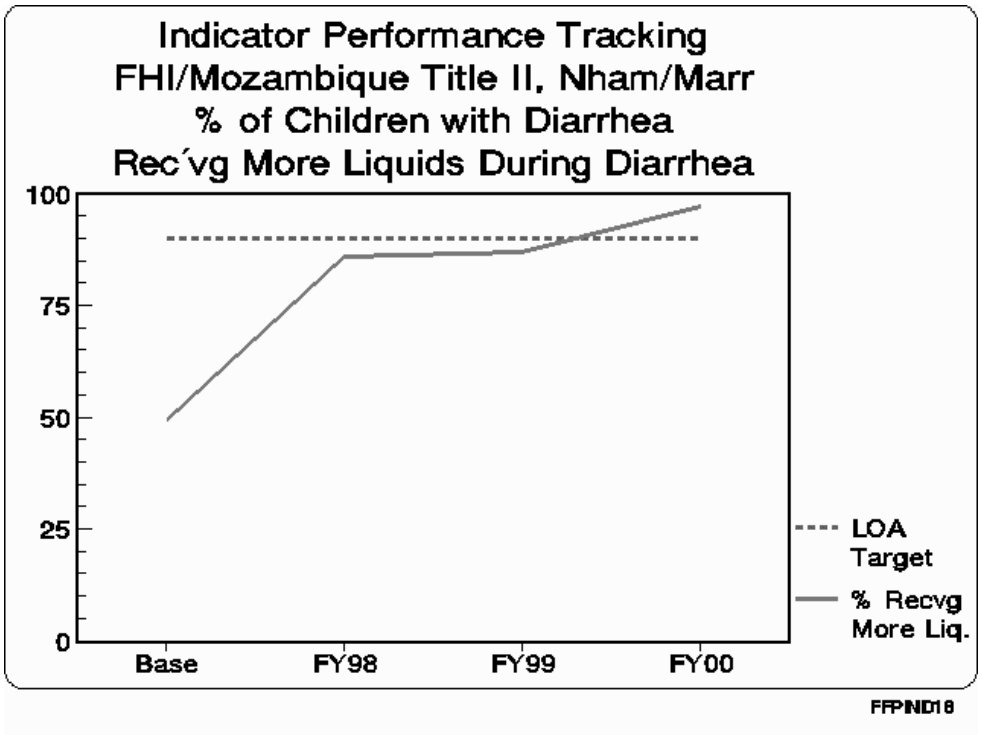
[49] Basically, a line drawing of ten mothers in a row is included under each icon representing an indicator and a description of the indicator in words. The proportion of mothers who are *not* already covered, or are *not* doing a given practice, is depicted by whiting out several of the mothers in the group of ten. In order to keep the drawings simple and understandable, the baseline levels were not indicated on the graphic, just the current situation.

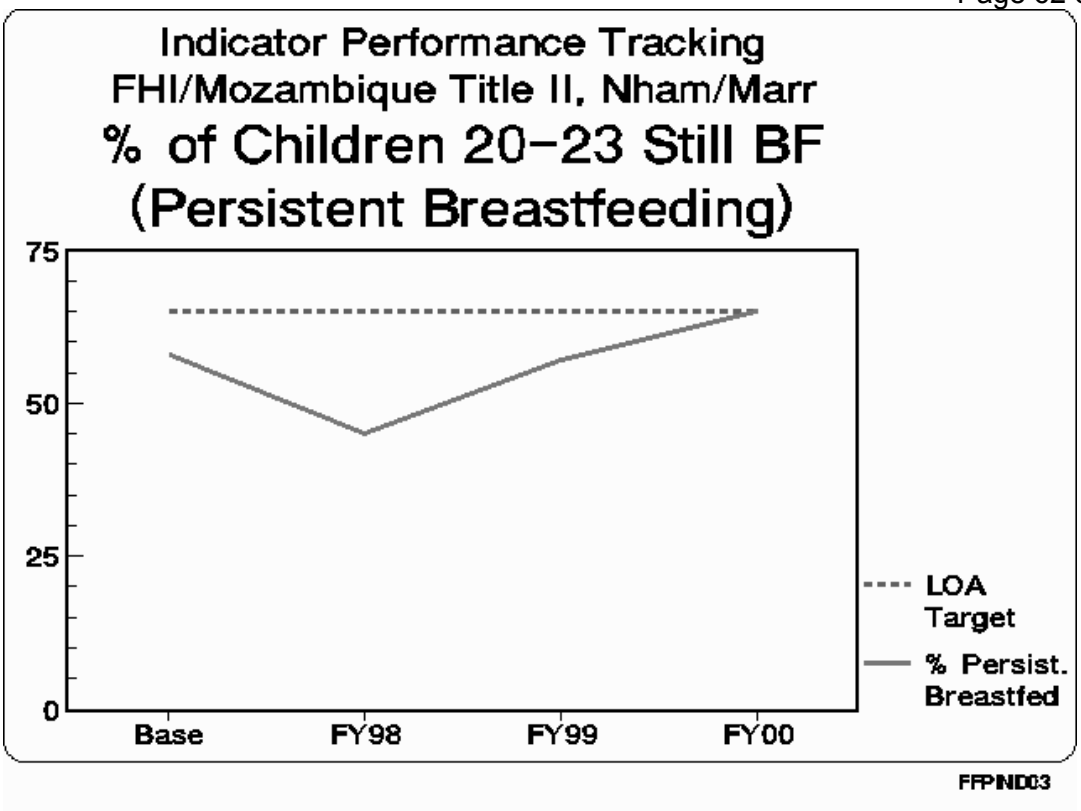
Health Program Monitoring, FHI/Mozambique



Other Attributes:

- **Rigor and Bias:** Promoters were trained and retrained (after finding rapid changes in some indicators) to be sensitive to the fact that respondents may provide false responses concerning their current childcare practices. Promoters were trained to avoid leading questions and to always give neutral reactions to mothers' responses (regardless of the response). Also, the Promoters are closely supervised during the monitoring process to avoid problems with leading questions. As mentioned above, re-interviewing is done to assure a high level of rigor in the process. Most of the questions included in the questionnaire are behavior questions (as opposed to knowledge questions). **Since many of the mothers now know what answers the project staff hopes that they will give, many mothers <u>may</u> answer these behavior questions 'correctly' whether or not they were correctly performing the behavior** (e.g. increasing liquids when the child has diarrhea.) **In order to combat this potential bias, Promoters probe for inconsistencies for some questions**. For example, regarding exclusive breastfeeding, the mother was asked if she was breastfeeding, and then if she was giving <u>anything</u> else to the child. Promoters then proceeded to ask the question in other ways and to give examples of water, tea, traditional medicines, and bananas in order to see if the mother was indeed exclusively breastfeeding. To further improve the quality and reliability of the interviews, a quality checklist could be used to verify and improve the quality of the interviews being conducted. Also, it would be helpful to conduct yearly nutritional anthropometry (e.g., WAZ) to see if corresponding changes in nutritional status are being achieved by the project.





There is data that supports the conclusion that the answers that mothers provide are truthful and accurate. For example, despite education on persistent breastfeeding (continuing breastfeeding to 24 months), the rate of persistent breastfeeding dropped early in the project. This is not uncommon in many health projects since the secular trend for persistent breastfeeding is negative (i.e., fewer mothers persistently breastfeed each year in most countries.) In FHI's program in Mozambique, there was strong resistant to continuation of breastfeeding when a mother became pregnant. If mothers were only giving the expected responses for breastfeeding, one would expect that they would tend to give expected responses for all of the breastfeeding questions asked, not just a few of them. Also, indicators for interventions not yet implemented (but for which mothers generally knew the "correct" answer) generally did not move upward until the intervention was carried out. **The level of truthful responses that mothers give may vary, however, from country to country, and program to program. This monitoring system would be expected to provide the most reliable results concerning changes in knowledge levels of beneficiaries.** ***It should also be kept in mind that this potential bias affects most systems where people are questioned about their current practices and services that they have received.***

Bias could also be introduced if the Promoters know too far in advance which communities will be included in the sample for the upcoming monitoring activities, and devote extra attention to these communities. In order to avoid this as much as possible (and still assemble the mothers for the interviews), **the groups included in the sample are chosen at random** (as explained above), and **the Promoter is told which groups will be in the sample no earlier than three weeks**

prior to the monitoring. This allows for only one contact between the Promoter and the group of mothers in the sample prior to the interviews.

- WR reported an initial concern that KPC mini-surveys might be more representative of one animator's work than the overall project, but found that **quarterly reports corresponded closely to midterm and final evaluation KPCs**.

- **This monitoring system would be most useful where an accurate sample can be selected quickly** (e.g., where Care Groups or some other sort of census-based system is used). In FHI/Mozambique's program, 50% of the households in the districts served are covered by these Care Groups. Thus this monitoring system only gives results on the *direct beneficiaries* in the program, not the indirect beneficiaries. In areas covered by the program, FHI can quickly assemble the mothers in a given community so that all mothers can be interviewed in a single morning. For gathering data on changes made in the households of indirect beneficiaries, a good system for interviewing all of the mothers in a given community quickly would need to be established, or another method would need to be used. In areas where all mothers (or other beneficiaries of interest such as farmers) are not included in program activities, the sample selection and interviewing of a group of indirect beneficiaries would probably require much more time and expense.

- One benefit of this system is that it **can provide feedback on the changes made in each community monitored and each Promoter's area of responsibility[50],** (as well as aggregate data on the entire program area). Approximately 100 mothers are interviewed per Promoter. However, since these mothers all belong to the same community, the Promoter and other project staff need to interpret the results carefully, and preferably should only make judgments on an individual promoter's performance based on multiple measurements (e.g., after 3, six-month monitoring periods). The most reliable results will be the aggregate data from all the Promoters combined.

- **Community participation** in this process is limited in that trained interviewers need to be used to ensure accurate results. However, community members in communities included in the sample are involved in the interpretation of the data and follow-up plans. Since 10 monitorings are completed during the course of the DAP, all communities can eventually get data on how their individual community is doing in relationship to the project objectives. **Participation by other NGOs and the MOH** can easily be arranged by having them trained as interviewers, and involving them in the monitoring process as interviewers.

- **Sustainability:** As presently developed, this monitoring system could be used by the MOH to continue monitoring program results, assuming that they would continue to use the Care Groups for education (which they have agreed to do in Mozambique). Local community leaders would probably be less likely to use the tool since it would require them to first be trained in good interviewing techniques and

---

[50] FHI chose not do this with their system, but generating the community-level reports would be easy since the results were in a computerized database.

the correct responses to each question. If local community members were taught these things, however, the tool could be used locally to monitor changes in knowledge, practice, and coverage.

- **Applicability to Other Sectors:** ***This same methodology could be used in agricultural and other development areas where people are systematically organized into small groups for the purpose of education or service delivery.***

References / Sources of Training and Technical Assistance

The explanation above should be adequate for an organization to implement the system using its own trainers. Specific questions could be directed to the contact personnel at FHI (Adugna Kebede (akebede@fhi.net) or Tom Davis (tdavis@fhi.net)) for informal backstopping on this tool.

Please see the **Consultant Training Skills Matrix** in **Annex C** for a list of consultants who have trained others in KPC survey methodology.

#11. The MCH Calendar

Contact: Leonel Arguello, M.D., MPH (leonel@ibw.com.ni) **and**
Chris Bessenecker (cbessenecker@projectconcern.org**),**
Project Concern International (http://www.projectconcern.org/**)**

Purpose:
The purpose of this tool is to **track events important to a development project – with the help of community members -- at the household level**. In its present application, the calendar is used to track health behaviors and events (e.g., exclusive breastfeeding, illnesses, and services) that occur each month in each household. While useful with C-IMCI (i.e., in conducting and facilitating verbal case reviews), *this tool also lends itself to monitoring of* ***agricultural*** *and other practices, as well.* The MCH Calendar also helps to prompt the development worker as to questions that should be used with the program participant, and which topics should be discussed during home visits in order to promote behavior change. By referring to the calendar, it is easier for the development worker to document dates of different events.

How it Works:

- **Personnel Used to Collect the Data**: In its present application, Community Health Workers (*Brigadistas*)
- **Type of Data Collected:** Data on practices (breastfeeding, exclusive breastfeeding), illnesses (diarrhea, cough or cold), and services received (prenatal care visits, growth monitoring/promotion, family planning visits, immunization, and Vitamin A supplementation) are recorded on a calendar by program participants.
- **Frequency of data collection:** Each month one sheet of the calendar (with one month of data) is collected and entered into a database.
- **Methodology**:

CHWs (*Brigadistas* in Nicaragua) give the calendar to pregnant women or mothers with children under two during a home visit. (Every mother that moves into the project area during the course of the project also receives a copy.) The calendar has a space on the cover page for entering the mother and child's names, child's DOB, and vaccines that the child and mother have received. Each monthly page has a traditional calendar with a row of seven icons at the top indicating the aforementioned illnesses and services delivered. (See following page.) The mother is asked to mark an X over any of the icons at the top of the calendar that represent an illness that the child has had, or a service that the mother or child has received during the given month. Additionally, the MCH Calendar has a box for marking whether or not the child is breastfed, and exclusively breastfed. Each numbered square representing one day on the calendar has a small box at the bottom where the mother can indicate if the child was breastfed that day. In this way, breastfeeding practices can be monitored, as well.

When the *Brigadista* comes, s/he asks the mother about the event. When the child has had an illness, s/he uses questions to see if the mother has managed the illness appropriately. The *Brigadistas* review the calendar each month with the mother to make sure that all of the tracked events are marked properly. In practice (in Nicaragua), PCI found that many mothers do not fill out the calendar completely each

month. Illiteracy is a problem in the communities in which PCI/Nicaragua works, but given the graphical nature of the calendar, this cannot explain the problem completely. PCI's solution to this problem was to have the Brigadistas help these mothers to fill out the calendar during their regular visits.

After assuring that the data is complete, the monthly sheet is taken from the mother by the *Brigadista*. The Brigadistas and PCI Promoters tabulate data from the calendars manually each month in order to analyze the community's results. The data is sometimes entered in Epi-Info, as well. Trends are then monitored for a given community or aggregated to look at larger areas (e.g., an area served by a *Brigadista*). In PCI/Nicaragua's program, about 60% of the calendar sheets are usually turned in (owing in part to poor roads and transportation in the project area). This limits the usefulness of the data at levels higher than the community level. This problem may not be encountered in other applications of the tool, but ways to improve compliance should be discussed during the planning phase.

This tool lends itself to monitoring of agricultural practices, as well. Icons on a calendar used in the agricultural sector could include events and activities such as:

- tilling,
- planting,
- weeding,
- fertilization,
- days with rainfall,
- days with flooding,
- pesticide application or IPM activities,
- harvesting, and
- extensionist visits.

Other icons could include problems encountered during the month in the fields or with storage facilities (e.g, rats, birds, insects). Use of this type of calendar could help

project staff to better document and understand current agricultural practices and patterns in project communities, as well as serving as a point of discussion for Extensionists during visits to farmers. If data on crop yields and inputs used were included in a database and cross-referenced with this seasonal information, project staff could use the database to look for reasons why some farmers have higher yields relative to other farmers in the same income bracket (i.e., the practices that lead to some farmers becoming "positive deviants."[51])

"Reminder Calendars" have also been developed and used in Bolivia and Indonesia for women to use in their homes to remember when to take iron supplements. These reminder calendars could be used to check compliance with other supplements or practices.[52]

Other Attributes:

- The level of **rigor of data obtained** from the use of this tool is not very high in its present application since only about 60% of the calendar sheets are usually turned in. If a low proportion of sheets is turned in, this may lead to a selection bias, and may reduce an organization's ability to get reliable data or trends from the tool. Selection bias could be significant in this case, since communities with better access in general (e.g., to roads, to health care) and more commitment to the program are more likely to turn in their data. There is no reason to believe, however, that this problem is associated with the tool, itself, just in its current application in this rugged area of Nicaragua.
- Good training and supervision of the staff using this tool needs to be done to ensure that they are helping the mother to fill out the calendar correctly. In the present application, training of mothers in how to use the MCH calendar is done at the household level. This process should be heavily supervised if a project intends to use the data for monitoring of program results.
- When making a calendar, an organization should assure that the activities monitored with the calendar are understandable to the mothers. (Mothers will be able to report on *whether or not* the child received vaccines [yes or no], for example, more reliably than *which* vaccines the child received. Farmers will be able to report more reliably on insects being a problem in a given month [yes or no] more than the type of insect.) Since the *Brigadista* is able to compare the mother's response with the child's growth/vaccine card, the data given by the mother should be checked against a written record when possible.
- A **study on mothers' use and reaction to the MCH Calendar** was conducted in 1999 in Nicaragua, [53] but no studies have been conducted at this point to see if the calendar actually leads to health behavior change.
- Caution should be exercised in the **interpretation of the results** since the calendar is based on a household rather than a single child. (For example, the calendar can be used to get the proportion of mothers with a preschool child who

---

[51] For more information on positive deviance in agriculture, contact Dave Evans (devans@fhi.net) with Food for the Hungry, International. FHI has begun to study positive deviance in agriculture in it's Title II fields.

[52] See http://www.jsi.com/intl/mothercare/PUBS/Nutrition/Guidance_Anemia.PDF for more information.

[53] See **Annex G**, "*Informe Sobre Percepción y Manejo del Calendario Materno Infantil*."

had diarrhea, but not the percentage of preschool children who had diarrhea in a given month, nor the number of diarrheal episodes.)

- Like the "behavior box" (see Tool #15), in addition to helping a program to monitor certain practices, **the tool helps to prompt the development worker** as to what s/he should be asking and discussing with the community member. This tool should also help mothers to be more mindful of their own activities and how they affect their children.
- One **benefit** over the behavior box is that the data collected in the household can be taken and analyzed without copying the information down (since the sheets are removed from the calendar). The **cost** of reproducing the calendar, of course, would be higher than the behavior box. One possible modification that might bring costs down would be to print all of the monthly boxes on one poster. If an organization wanted to collect that data, a *Brigadista* could have a separate register in which to record which icons had been marked for a given month (rather than collecting the monthly sheets from a calendar). This register could then be given to project staff for data entry and analysis.
- This tool would be most useful for programs that have paid or volunteer development workers who make **monthly or bimonthly contact with all or a relatively unchanging subset of beneficiaries.**
- This tool encourages much **more participation of community members** than many monitoring methods. The mother is actively involved in monitoring important events herself. The degree to which this happens depends on how comfortable mothers are with using the calendar, which, in turn, is affected by literacy and other factors.
- PCI has consistently experienced a positive relationship between the use of the MCH calendar and a **higher level and quality of involvement** by local development workers in educational activities directed at the community.
- **Sustainability**: While *Brigadista* visits may continue once a program is ended, the cost of reproducing the calendar may make it difficult for some communities or the MOH to continue using the calendars once the program is complete. However, if they are made attractive and mothers become accustomed to using the calendar for many purposes, it is possible that mothers would be willing to purchase them and continue using them to track health events.
- Like most methods used to monitor and evaluate health practices, this method **relies on mothers being truthful and accurate** in their report on the events that occurred in a given month. Other documentation available at the household (e.g., growth charts, mother's vaccination card) could be used to spot check whether the information given to the *Brigadista* is accurate.
- The mothers using this system must be able to learn how to use a calendar (if they are unfamiliar with that in their culture), and a certain degree of **literacy** is required to fill it in properly.

References / Sources of Training and Technical Assistance

- Chris Bessenecker (cbessenecker@projectconcern.org) of Project Concern International is available to answer questions on this tool for organizations interested in applying it in their program.

- *Informe Sobre Percepción y Manejo del Calendario Materno Infantil* (see **Annex G**), PCI/Nicaragua (contact: Leonel Arguello, 505-2-660-718 or 505-2-663-740 [w], 505-2-224-075 [fax], P.O. Box 4667, Managua, Nicaragua).
- Many trainers/consultants could design a training on this tool given the information in this description.

#12. Holistic Community Epidemiology System

Contact: Lisa Howard-Grabman, Senior Community Mobilization Advisor, Save the Children, (LhowardG@dc.savechildren.org), (202) 530-4385.

Purpose:
Managers can use this tool to receive information on vital events, coverage levels, compliance with promoted practices, and health status for making program decisions. This system is used by community-level volunteers (e.g., CHWs or extensionists) who:

- collect information at the community level monthly or bimonthly;
- add information from local facilities (e.g., clinics);
- return information to the community for analysis and discussion; and
- mobilize the community to take action to prevent and confront problems.

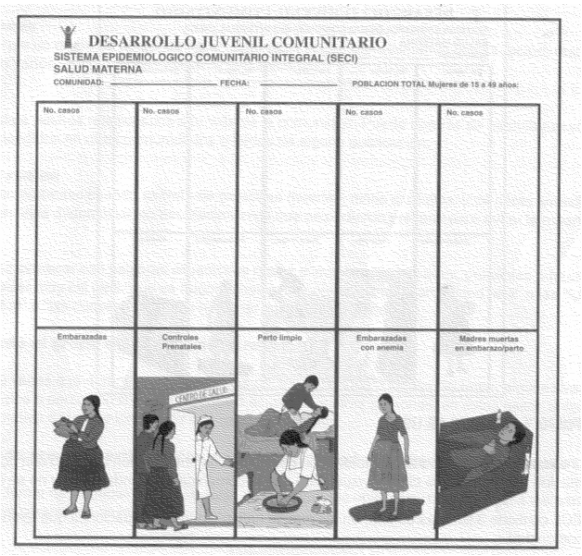
This system could be adapted easily for work in agriculture and other development areas, as well.

How it Works:

- **Personnel Used to Collect the Data**: Community Health Workers (CHWs)
- **Type of Data Collected:** Information on child births, stillbirths, child deaths, child illnesses, childhood malnutrition, pregnancies, illnesses during pregnancies, deliveries, deaths during pregnancy/delivery, prenatal control visits. ***This system, however, could be adapted for use in agriculture and other development areas where personnel wish to track and hold community-level discussions on promoted practices and events that a community wants to prevent.***
- **Frequency of data collection:** Monthly or bimonthly
- **Methodology**:

Following a two-week training in the methodology, CHWs (with the help of community members) conduct a simple census (names, relationship, age, sex) at the community level. A community map is sometimes developed, as well. Monthly or bimonthly, the CHW visits each family, and interviews a family member (usually the mother) to collect the information listed above. This information is written on a form that holds information for 20 families (one family per column). The CHW meets with the personnel in the local health facility to add this data to a consolidated form. (The consolidated form has information collected by the CHW at the community level, and by the health personnel at the local health facility.) The health facility data is largely taken from the forms used by the MOH, but data is disaggregated for each community. This consolidated report is used to prepare the flipcharts, which help the community to monitor their own health. Sometimes, the data from the consolidated report are written on newsprint and put up as a poster in the community. This consolidated report is collected and entered into a software package developed by (and available from) SCF in Bolivia (contact Ned Olney, SCF/Bolivia Field Office Director, bolivia@savechildren.org), then analyzed by managers, as well. (An additional 2.5 – 3.5 day training of project staff is needed to use the software package for analysis, assuming trainees have already been trained in the community epidemiology system. If they have not received that training, an additional 4 days should be added for a field visit.)

This information is sent back to the community using a three-page flipchart. The flipchart has three cloth pages with pictures on them representing vital events and promoted practices that are being tracked. Each page has a row of pictures on the bottom with the event or promoted practice in words, as well. On the top, there is a space for writing in the number of cases for each event/practice and a blank space where the number is represented graphically by gender. Cut-outs of women and men are used to represent the data. For small numbers, multiple cut-outs can be used. For large numbers, one is used to represent each sex with a number beside it showing the quantity.

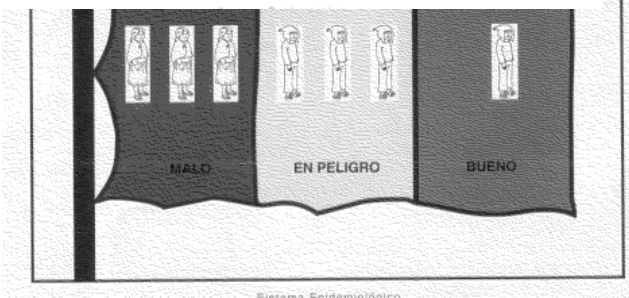


The first page of the flipchart is used to report back to the community on the number of:

- pregnancies,
- prenatal controls,
- clean deliveries,
- pregnant women with anemia,
- mothers dying during pregnancy/delivery.

The second page is used to report back to the community on the number of:

- children with pneumonia,
- children with vaccines,
- children with malnutrition,
- children with diarrhea,
- child deaths.



The third page is a flag with the same three color stripes as the Bolivian flag (but oriented vertically rather than horizontally): red, yellow, and green. Cutouts are placed on

each stripe of the flag to represent the number of individuals in a good (green), at-risk (yellow), and poor (red) situation. This flag is used to represent the following different situations, one after another:

- Nutritional status (e.g., good weight-for-age, at-risk, and malnourished),
- Vaccine coverage (e.g., no vaccines, some vaccines, all vaccines),
- Prenatal controls (e.g., no controls, 1-3 controls, 4 or more controls), and
- Other situations.

Community leaders, women's group members, youth, teachers, health facility personnel, and others are invited to the meetings to **analyze the data**. Comparisons are drawn to previous months and other communities. Participants discuss why and how the problems occur. CHWs are specifically instructed to discuss access, quality, availability and demand for health services. Ability to practice new behaviors is also discussed. Early in the process, participants are asked to rank the problems noted in terms of their frequency, severity, possible solutions of problems, and their cost. This information is used to plan strategies to confront problems, determine who will be responsible for taking action, and to convince authorities that they need to invest resources in the community (advocacy). Communities are also encouraged to evaluate the results of their work.

In June 1999, an informal **evaluation** was done of this methodology, comparing communities with and without the use of the community epidemiology system. In communities where the system was being used, 3.38 times more children had completed immunization records. They also had 2.55 more children who had had their growth monitored more than three times in the past year (in comparison with the control communities).

This simple system for giving results back to community members could be adapted easily for work in agriculture and other development areas. Problems such as rat, bird, and insect infestations, and plant diseases, could be tracked. Farmers who are using good farming techniques such as chemical or natural fertilizers, proper pesticide application or IPM activities, crop rotation, and frequent weeding could be monitored and reported back to a community, as well. Use of this tool could help project staff to better document and understand current agricultural practices and patterns in project communities, as well as serving as a point of discussion for extensionists during visits to farmers groups. A system for categorizing farmers according to their practices and yields could be established to use with the flag page of the flipchart.

Other Attributes:

- The **quality of data** is partially dependent on the thoroughness of the CHW in visiting every household with a preschool child or pregnant mother. CHWs instead of experienced interviewers are used. In communities that do not trust outsiders, this may lead to greater reliability of the results. In communities that trust outsiders with the information included on the form, reliability may be higher if more experienced interviewers are used to collect the data.
- This tool would be **best applied** in projects that have regular (monthly or bimonthly) contact with every program participant who is interviewed. It is

especially applicable for census-based systems. Areas with low-literacy can use this tool to understand what is happening in their community and make plans to confront community-level problems, as long as people can understand the drawings used on the flipcharts. It is important to note that even simple pictures are not understandable in some communities where pictures are used infrequently. In these communities **where pictorial literacy is very low**, community members will need to be taught to read the pictures, or other methods will have to be used to demonstrate the trends without pictures (e.g., using rocks or people to demonstrate proportions).

- The tool and method are **highly participatory** since communities are brought together regularly to see, hear, and discuss the results for their own community.
- No studies have been done to see if communities and CHWs continue to use this tool once project funding has ended. However, in Bolivia, the MOH has begun to use this methodology at the District level.
- Save the Children is currently producing the **English version of the SECI manual** developed in Bolivia. A draft of **a manual on how organizations can develop their own community-based health information system** should be available by August 2001 from SCF. The software (in Spanish) is currently available from SCF staff in Bolivia, and SCF plans to translate it into English by January 2002. (This software will be made available on FAM's webpage.)

References / Sources of Training and Technical Assistance

- Lisa Howard-Grabman, Save the Children, (LhowardG@dc.savechildren.org), (202) 530-4385.
- Ned Olney, SCF/Bolivia Field Office Director (bolivia@savechildren.org)

#13. Lot Quality Assessment using KPC Questions

Contact: Joseph Valadez (JosephValadez@compuserve.com)
NGO Networks for Health (http://www.ngonetworks.org/)

Purpose: To monitor changes in knowledge, practice and coverage of program beneficiaries (in health, agriculture, and other development areas). Changes in KPC indicators over time can be useful in supporting the findings of impact evaluation data.

How it Works:

- **Personnel Used to Collect the Data**: Supervisory-level staff and paid Health or Agriculture staff
- **Type of Data Collected:** Data on knowledge, practices, and coverage of program beneficiaries, based on program participant's (or program participant's mother's) report.
- **Frequency of data collection:** From once to four times per year. If only a few questions are used (e.g., 10, as is done with the Rotating Mini-KPCs) then quarterly surveys would be possible for many organizations.
- **Methodology**:

This methodology is explained in detail in a separate downloadable document.[54] In this document, the author states:

> In brief, LQAS provides an interesting and viable alternative to the 30-cluster approach for conducting baseline surveys and follow-up assessments. It is a proven tool for assessment surveys and routine monitoring, and has more recently been used for baseline studies. A number of features make the technique attractive, among them its ability to provide information for management at the local program unit level, and to provide estimates of indicator values (coverage, etc.) for an entire program area. On the other hand, like the KPC, LQAS is not a good tool for providing point estimates of coverage or other performance measures in each production unit (e.g., each district or sub-unit within a district). In terms of cost, LQAS may be very cost effective, if data are collected by local field workers. If a special evaluation team is hired centrally to conduct an LQAS survey, the survey can be more expensive than the traditional KPC survey.

LQAS is a sampling methodology that uses simple random samples of 19 respondents in each supervision area (e.g, a district) defined by a project. A KPC-type survey questionnaire can be used with each of these respondents. One benefit of using LQAS is that you will then be able to speak about the situation (e.g., coverage levels) in each of these supervision areas, as well as the situation in the entire project area. You will not be able to give an exact coverage level for each supervision area (e.g., 72% of

[54] Haggerty, Patricia A, Ph.D. Review of Health and Nutrition Project Baseline Research Methods of Title II Funded PVOs. October 2000. Available for download at: http://www.foodaid.org/worddocs/moneval/HNSurveyReviewWeb.doc

.

farmers use fertilizer), but you will be able to safely say whether coverage is above a given target level or not (e.g., whether or not 80% of the farmers are using fertilizer).

One of the main things that LQAS will help you do is to **identify low- and high-coverage supervision areas**. By knowing which supervision areas have low coverage, you can:

- identify the causes of low coverage;
- focus more efforts and resources on these supervision areas; and
- improve coverage of the whole NGO program area by improving coverage in these supervision areas.

By knowing which supervision areas have high coverage, you can:

- study and learn what is working well, and
- identify things that can be applied to other supervision areas.

At the same time this *local* information is found, you will be able to also determine the *overall* coverage for each indicator for the whole project area. When the samples from four or more of these supervision areas are added together, it results in a larger stratified sample that has no design effect. Having four samples of nineteen respondents will yield a total sample of 76, resulting in point estimates (e.g., proportion of farmers using fertilizer) with a relatively small confidence interval (e.g., 11% when coverage is 50%, and even smaller when the coverage is less than or more than 50%).[55]

As a sampling methodology, LQAS could also be used for sampling when using other tools included in this compendium (e.g., the Rotating Mini-KPCs [#10], the Grain Storage Silos Maintenance Questionnaire [#14]).

Other Attributes:

- ***This tool could be adapted for use in agriculture and other development areas where personnel wish to track promoted practices (e.g., contour farming) and have census data or an accurate list of program participants.***
- Other things being equal (e.g., interviewing technique), the data found from using this methodology is as **rigorous** as that obtained with the KPC survey. However, given the smaller sample size, the time requirements for conducting the survey may be lower (making it more appropriate for regular monitoring). Unlike the traditional 30-cluster sample used in many KPC surveys, information on the situation at the local level (i.e., within one supervision area) is attainable using this sampling methodology.
- **This sampling methodology is best used when *simple random samples can be drawn easily*** (e.g., in a census-based system), and ***differences in knowledge, coverage, and practices between supervision areas are expected to be* (or known to be) *significant***. If coverage is very similar among supervision areas, LQAS will not help a program to define higher-performing and lower-performing areas.
- The most time-consuming part of using this methodology is probably **the selection of survey participants at random**. This is made easier when a census-based system is used by the organization. Without that, the organization needs to use

[55] Personal communication with Joseph Valadez.

some other method to choose survey respondents. As with 30-cluster sampling, a sampling frame is often used to choose communities where interviews will be taken, then households are numbered and one is chosen at random. Whereas with 30-cluster sampling, one sampling frame is produced for the entire project area, with LQAS, a sampling frame is devised for each of the supervision areas. (This is generally a small price to pay for the added benefit of having data on each supervision area.)

- **The training time required to explain the LQAS methodology to health workers is generally four days** (depending on the level of computer skills). Following the training, additional days are required to conduct the study, and the time period for that is variable (depending on transportation availability, the terrain, etc.). **Following data collection, three days are generally adequate for a Tabulation and Data Analysis Workshop**.
- It may be necessary for senior program staff to receive training in LQAS before attempting to conduct a training in LQAS using the training notes presently available.

References / Sources of Training and Technical Assistance

- A full list of references can be found in Appendix 7 of Dr. Haggerty's paper (*op cit*).
- Sample training notes in English and Spanish are available from Joseph Valadez. **(**JosephValadez@compuserve.com).

Please see the **Consultant Training Skills Matrix** in **Annex C** for a list of consultants who have trained others in the HFA methodology.

#14. Grain Storage Silos Maintenance Questionnaire

Contact: **Gail Montano**, Project Director, Project Concern International's Regional Initiative for Central America (pci.rica.gail@telecam.net), (503) 279-2167/224-6005.

Purpose: To monitor grain storage and silo maintenance practices in order to prevent grain loss, and to enable farmers to troubleshoot problems encountered with grain storage. **Similar methodologies could be developed (based on this model) to monitor the use and maintenance of other facilities maintained by program participants or community-level volunteers (e.g., latrines, health equipment, wells).**

How it Works:

- **Personnel Used to Collect the Data**: Field technical staff.
- **Type of Data Collected:** Data on silo and grain condition, and farmers' knowledge gathered during a survey of farmers with grain storage silos.
- **Frequency of data collection:** The monitoring is conducted every three months during the time period in which there is grain remaining in the silo.
- **Methodology**:

Technicians are provided with a **day-long training** in how to conduct the interview and observation. (*Postcosecha*[56], a technical institute in El Salvador, provided this training for PCI.) The training included proper interviewing techniques, as well. PCI used a **convenience sample** of farmers who could be visited within a one-week period per department where the monitoring took place.

The first page of the form filled out by the technicians includes **questions for the farmer** on:

- who trained the farmer
- which institution supports the farmer,
- year the silo was bought,
- type and amount of grain(s) stored in the silo,
- month and year the grain was stored,
- presence of losses of grain in the silo and reason for loss,
- activities realized before storage of grain (selection, cleaning, cooling),
- silo conditions checked before use (cleanliness, presence of holes, rusting),
- utilization of phosphate for fumigation,
- sealing of the silo,
- periodic observation of the grain in the silo,
- emptying the silo,
- presence of rings for locking the silo,
- desire to buy another silo.

The second page of the form is used for the **visual inspection of the silo**. It includes questions on:

[56] More information on Postcosecha is available at: http://www.postcosecha.org.ni/english/index.html

- location of the silo,
- protection from rain,
- condition of the silo (e.g., dents, holes, rust)
- sealing of the silo,
- grain humidity (> 15% or < 15% -- see below),
- grain condition (healthy or damaged, clean or dirty), and
- the smell of the grain (normal or abnormal).

(See **Annex H** for a copy of the form in Spanish.)

In order **to test the humidity level of the grain, a "salt test" is used**. One teaspoon of salt is applied to 1 cup of corn in a glass jar. The jar is shaken, and if salt sticks to the grain, then the humidity is judged to be above 15% (too humid). The **interview/inspection takes about 15 minutes per farmer** (plus transportation time between interviews).

The technician turns in the form to the project's Agriculture Specialist and Project Director who aggregate the data and review the findings by hand. The field team (one Ag Specialist and five technicians) follows up with farmers interviewed so that they re-dry the grain and apply the test again, when necessary, making any necessary modifications in the way that the silo is maintained and the grain is stored.

Other Attributes:

- The **use of convenience samples** limits the usefulness of tools in drawing conclusions about the quality of the organization's work and the adoption of practices in the project areas. This can be easily remedied, however, by **using a more scientifically drawn sample.** For example, if a list of farmers with silos and their locations is available, a **simple random sample** might be the easiest sample to draw. In a project with numerous communities with silos, a **30-cluster sample with 3 silos per cluster**[57] may be more appropriate in order to limit transportation needs.
- The **quality of data** is partially dependent on how well the technicians are trained in interviewing techniques and the use of the forms, and how well supervision of the process is done. **PCI plans to use spot-checks** of the technicians' use of the forms in the future in order to assure that interviewing technique and use of the form is high quality. Spot checks will make the results more reliable since a supervisor could assure that interviewers/inspectors were using the tool in the same way with each farmer.
- In the forms used with this tool presently, many closed-ended leading questions are used (e.g., "Is phosphate used for the fumigation of the stored grain?"). This could be improved by using **questions that are open-ended with response categories** – rather than closed-ended questions that include the correct response -- to avoid leading the interviewee (e.g., "What do you do to your grain or put on it to protect it from insects? ❑ Phosphate ❑ Expose to smoke ❑ Nothing ❑ Other (Specify: ___)"). Also, response categories should be included that cover every

[57] A sample size of 90 in a cluster sample with a design effect of 2.0 would yield a precision of 15% (adequate for monitoring). This is assuming that good use of silos would not "cluster" to a large degree in certain communities. (This is more likely to happen if different organizations do the training for different communities. If that is the case, a stratified sample would probably be better.)

possible response. For example, the question, "Do you seal your silo?" could have response categories, " ❑ Yes ❑ No ❑ Occasionally" instead of just "yes" and "no."

- Technicians are expected to come up with their own questions in order to fill out some parts of the form. For example, one part of the questionnaire says, "Number of applications applied: " Interviewers will sometimes take liberty with these entries and word the question in different ways since it is not phrased as a question (e.g., asking, "How many applications do you *usually* use?" or "How many applications did you use *the last time you did it*?"). This results in different questions being asked of different farmers, and reliability of the data decreases. In order to avoid this, **questions should be worded in the questionnaire exactly as they should be asked during the interview**. If a farmer does not understand the question the first time, interviewers should be instructed to repeat the question without modification. If the respondent still does not understand, interviewers should be instructed to reword the question, but to be careful not to change its meaning.
- **The tool could be improved by including the detailed criteria used during the visual inspection of the silo in the questionnaire itself**. For example, one question to be answered during the visual inspection is, "Is it sealed correctly?" In order to avoid different technicians using different criteria for this question, it is useful to include in parentheses the criteria used for this decision. If these criteria are given in the form of separate questions (rather than one global question), it helps staff to pinpoint problems, as well (e.g., knowing that the problem is that the "intake throat was not sealed with its soldered interlocking joints facing forward" rather than just knowing that "something is wrong with the seal").
- This method would be **most useful for projects that have regular contact with farmers with silos and where training in the use of silos is standardized**.
- Organizations using this tool should **develop mechanisms to assure feedback of the findings from the sample of farmers used in the monitoring activity** to the universe of farmers in a given project area. Having such a mechanism would make this tool more useful to a wider group of farmers and more participatory.
- In El Salvador, the form is **currently in use by the Ministry of Agriculture**, so it is very possible that the tool will be used once the program is finished.

References / Sources of Training and Technical Assistance

- **Gail Montano**, Project Director, Project Concern International's, Regional Initiative for Central America (pci.rica.gail@telecam.net), (503) 279-2167/224-6005.

#15. Growth Monitoring and Promotion Using the Behavior Box

Contact: Amy Metzger (focasamy@aol.com), FOCAS,
Tom Davis (tdavis@fhi.net), Food for the Hungry, International, or
Claire Boswell (cboswell76@hotmail.com), MAP, International.

Purpose: Growth Monitoring using the "behavior box" allows project staff to monitor nutritional status, changes in weight, and key health and nutrition behaviors (e.g., exclusive breastfeeding) of project beneficiaries.

How it Works:

- **Personnel Used to Collect the Data**: Volunteer or paid Community Health Workers.
- **Type of Data Collected:** Yes/no responses on key health behaviors and selected illnesses.
- **Frequency of data collection:** Each time the child is weighed (e.g., monthly).

- **Methodology**:

Traditional growth monitoring and promotion generally includes several steps:

- preparing the growth chart,
- weighing the child,
- plotting the child's weight on the growth chart,
- giving feedback to the mother on the child's growth and nutritional status, and
- providing counsel to the mother on the child's growth and nutrition.

A more complete growth monitoring and promotion activity will include a diagnostic phase and these additional steps, as well:

- asking the mother what she was doing to make the child gain weight (if the child gained) and complimenting her;
- asking the mother open-ended and closed-ended questions about recent illnesses and the child's current eating patterns (including breastfeeding);
- negotiating with the mother about what she should do with her child in the coming month, including:
  - asking the mother to continue doing what she is presently doing correctly;
  - counseling the mother to change any negative behaviors that need to be changed (identified in the diagnostic phase);
  - using questions to identify possible barriers to behavior change, and helping the mother work through those barriers;
  - using questions to verify that the mother understood the advice given to her;
- asking the mother to commit to the suggested behaviors; and
- asking the mother if she has any questions about her child's growth or health.

Several organizations now monitor the current practices of mothers through the use of a "behavior box." The behavior box is essentially a form for recording key nutritional practices of mothers of infants, using questions during growth monitoring and promotion.

FOCAS, FHI and other organizations have appended the behavior box to the current MOH growth chart, generally printing the box on a sticker, and placing the sticker on each growth chart (over a picture or other unused part on the chart). The box has a section for the child's date of birth, and rows for each of the key behaviors to be monitored. (See below.)

Things to ask the mother during EACH VISIT.		**Month**											
		1	2	3	4	5	6	7	8	9	10	11	12
1. Did you give your child colostrum within the first eight hours after birth?													
2. Are you currently breastfeeding?													
3. Are you currently giving your child any water, other liquids, food or anything else except breast milk?													
4. Are you presently giving your child solid or semisolid food?													
5. Are you currently bottle-feeding your child?													
6. Has your child had diarrhea during the past month?													
7. Has your child has cough/diff. breathing in the past month?													
8. Has your child had a fever during the past month?													
9. Has your child had any other illness in the past month?													

- Write the months in the boxes on the top line.
- Ask the mother each of the 8 questions each time you weight her child.
- Put a + in the column if the mother says yes.
- Put an - in the column when the mother says No.

After the child is weighed and the weight is plotted on the chart, the CHW uses the box as a cue as to what questions should be asked of the mother. CHWs are trained to first use open-ended questions:

- How are you feeding your child presently? What did you feed your child yesterday?
- What illnesses has your child had during the past month?

After the open-ended questions are used, the CHW asks the specific, closed-ended questions in the behavior box to assess each behavior. As each question is marked, the CHW marks the appropriate column, and provides counseling. During the counseling, the CHW either compliments the mother for following the recommended advice, or works with the mother to convince her of the importance of following the key message (e.g., exclusive breastfeeding). The CHW also tells the mother whether or not she should continue the behavior in the upcoming month (e.g., when to introduce semi-solid food).

Certain questions are asked only during a given period (e.g., asking about colostrum during the one-month weighing only). Once all of the questions are asked, and counseling is given, the CHW has a record – not only of the child's growth pattern – but of the mother's behaviors and the child's illness pattern associated with that growth, as well. (See below for an example of what the form may look like for an eight-month-old child.)

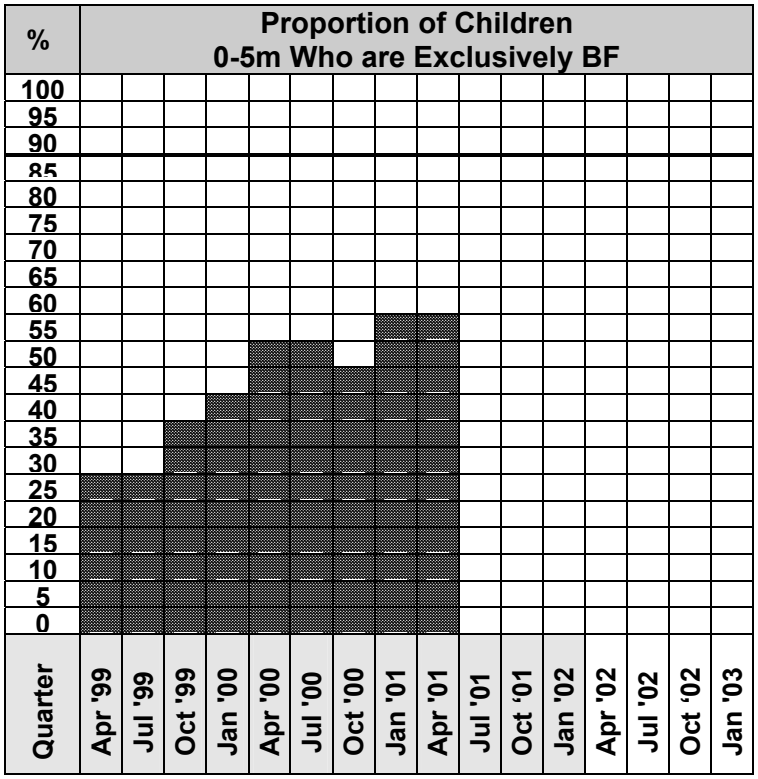
Things to ask the mother during EACH VISIT.	Born: 02/01 mon yr	**Month**	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
			1	2	3	4	5	6	7	8	9	10	11	12
1. Did you give your child colostrum within the first eight hours after birth?			+											
2. Are you currently breastfeeding?			+	+	+	+	+	+	+	+				
3. Are you currently giving your child any water, other liquids, food or anything else except breast milk?			+	+	-	-	-	+	+	+				
4. Are you presently giving your child solid or semisolid food?			+	-	-	-	-	+	+	+				
5. Are you currently bottle-feeding your child?			+	-	-	-	-	-	-	-				
6. Has your child had diarrhea during the past month?			-	+	-	-	-	+	-	-				
7. Has your child has cough/diff. breathing in the past month?			-	-	-	+	-	-	-	-				
8. Has your child had a fever during the past month?			-	-	-	-	-	-	-	-				
9. Has your child had any other illness in the past month?			-	-	+	-	-	-	-	-				

For monitoring at the community-level, the CHW can use the behavior box to calculate the proportion of children being weighed who are doing each of the key behaviors. The CHW can also look for trends of diseases at the community level.

FOCAS has used the behavior box data to collect quarterly trend data for each of the indicators. To do this, the CHWs are asked to bring their growth charts to a meeting, and supervisory-level staff members take the CHWs through a series of sorting exercises to calculate each indicator needed (e.g., the proportion of children 6-10m who are receiving solid or semi-solid food). This information is then used to make line graphs, target coverage charts (see Tool #2), or tables such as the one on the following page.

Aside from being useful for monitoring key indicators, the behavior box can increase the usefulness of the growth chart in that it documents the *mother's behavior and child's illness pattern during the child's first year of life*. Some of these elements (e.g., breastfeeding) are recorded by some organizations on the face of the growth chart (above the curve) along with other services or supplements the child has received (e.g., vitamin A, deworming), but do not provide a set of questions that helps to prompt the CHW as to what main questions should be used during the diagnostic part of the process.

This tool could be adapted to agricultural by monitoring monthly or quarterly adoption of agricultural practices during contact with farmers (e.g., tilling, weeding, user of fertilizer, pesticide application or IPM activities, and other improved agricultural methods).



Other Attributes:

- Given that only children who show up for growth monitoring are included in the sample, there is an **inherent selection bias <u>if</u> the results are generalized to all program beneficiaries**, and the rigor of this method is compromised. However, this is not unusual: Service data for program participants are routinely used to monitor the progress towards population-level objectives, realizing that the picture is incomplete.
- This tool would be **optimally used in an area where the coverage level with growth monitoring is very high** (i.e., where most children are weighed on a regular basis).
- This tool can be somewhat **participatory** if indicators are calculated at the community level (by the CHW), and the information for a given indicator is reported back at the community level. Community members can then be involved in brainstorming solutions to increase indicator levels.
- This best way to assure that this tool continues to be used after a project is completed is to convince the MOH of the value of it (involving them in the training), and to have the growth charts printed with the box on them. MOH staff are sometimes reticent to make any change to the growth chart.

References / Sources of Training and Technical Assistance

Contact Amy Metzger (focasamy@aol.com), Tom Davis (tdavis@fhi.net), or Claire Boswell (cboswell76@hotmail.com), MAP, International for more information or training on this tool.

Other Tools/Methods for Measuring Acquisition of Knowledge by Staff and Program Participants

In order to measure acquisition of knowledge and skills of staff (but not of clients), **OICI** uses annual staff performance appraisal forms and forms to record participation in technical conferences and workshops. OICI also uses pre- and posttests for staff trainings, but headquarters staff was unaware of whether there were specific, written guidelines used to develop pre- and posttests in the countries in which they are working. (No guidelines are given in their M&E guide for Ghana.)

Africare has done extensive work on the measurement of community capacity for sustainable food security. Their monitoring of that is largely based on standardized observation by project supervisors. Africare is now standardizing that observation process across its Title II programs. The system is currently most fully-developed in French-speaking countries. Africare has worked with their Title II countries to do a SWOT analysis of the different tools that have been used for this purpose, but they do not have further information available on these tools at this time.

In Cape Verde, **ACDI/VOCA** (and presumably other organizations) uses *oral exams* to assess whether microfinance clients have understood the contents of training sessions on loans and loan management. The oral exam is given once clients have undergone two training sessions. The test is one page long, and includes seven open-ended questions. (See **Annex I** for a copy in Portuguese.)

Other Tools/Methods for Monitoring Adoption of Practices (Techniques/Behaviors)

In many Title II programs, changes in health and agriculture practices (adoption rates) are measured by using a knowledge, practice, and coverage questionnaire – usually annually -- with a sample of program beneficiaries (using various sampling methods). The most common sampling methods used appear to be 30-cluster sampling, systematic sampling, and random sampling of program participants. In agriculture, this survey is often done through extension visits during the growing season.

OICI conducts a mini-survey every six months to look at certain practice indicators. The survey is conducted using a five-page questionnaire and is done with a random sample of 35-45[58] people in households that participated in OICI trainings.

ACDI/VOCA and other organizations measure client adoption of practices during their annual survey. Their survey includes measurement of income and dietary diversification using a 10-page questionnaire. (See **Annex J** for a copy.)

World Vision and other organizations are using Microsoft Excel® to track key program activities. However, some organizations are moving away from Excel for monitoring of activities, and plan to use Microsoft Access® or another database in which data can be manipulated, and reports can be generated, more easily. One important aspect of WV's monitoring sheets is that many items where people are counted have a **breakdown by gender** (i.e., two columns for reporting, one for women and one for men). ***This small but important detail allows an organization to monitor the involvement of women in its projects.***

Other organizations use qualitative tools to gain a better understanding of what changes have been made in practices. For example, in CARE's Flood Proofing Project, one of the interventions is aimed at reducing diarrhea among children under 5 years of age. Monitoring of changes in practices is attempted through use of direct observation and focus group discussions in Mother's Clubs. As part of CARE's SHABGE project (in Bangladesh), farmers are taught improved farming techniques for selected crops in a Farmers Training School. In this program, CARE attempts to assess changes in behavior through direct observation and focus group discussions at the field level.

There are many limitations, however, to using focus group discussions and direct observation for monitoring of practices. Focus groups (when used properly) are intended to provide descriptive, qualitative data rather than being intended to measure changes over time. Thus they are not very helpful for measuring changes in the adoption of techniques/behaviors. The reasons for this are manifold:

- A *convenience sample* of like-minded individuals (e.g., all women 18-25 years of age, farmers who have had pest problems in the past year) is generally used for focus groups rather than a representative sample of program beneficiaries. Because a convenience sample is used, the results cannot be extrapolated to a larger group.

[58] With a simple random sample, a sample size of 43 yields a precision of approximately 15% with a 95% confidence interval.

- Given the group setting for focus group discussions, one person's response can greatly affect the other group members' responses.
- Focus groups can provide *descriptive* information on how a given group of people thinks or how they do things. Being qualitative, they are not intended, though, for measuring the level of change in knowledge, practices, or coverage. Sometimes one can hypothesize that a change has occurred in a given group of people, but one cannot measure the *level* of change or even substantiate that a quantitative change has occurred.

As stated in CARE/Uganda's *Guidelines to Monitoring & Evaluation*,[59] "While [direct] observation has the advantage of relying on physically observed phenomena, it is subjective and can generate mistaken conclusions based on the interpretation of the observer." Direct observation is often done with a convenience sample, as well, decreasing its rigor (and usefulness) in monitoring changes in a project area. The table on the following pages summarizes some of the characteristics of quantitative versus qualitative methods.

The FAM Local Capacity Building Working Group has begun a project on measurement of capacity building. The group will develop a compendium of capacity building indicators, while investigating and describing some effective tools for their measurement in a compendium. One of the methods it will likely investigate will be the Africare work on development of community capacity for sustained food security. The work, which has just begun (at time of this document's publication) is due for completion within the next 12 to 18 months. For more information, contact the FAM Local Capacity Building Working Group or visit the Local Capacity Building working group page on the FAM website at www.foodaid.org.

[59] Tom Barton, Creative Research and Evaluation Centre, Consultant to the M&E Task Force of CARE International in Uganda, 17 Mackinnon Road, Nakasero, P.O. Box 7280, Kampala, Uganda

For what purposes are Qualitative Methods useful?	Examples	For what purposes are Quantitative Methods useful?	Examples
To sense (without measuring) emotion and attitudes.	To know which is more important to mothers: *When* she introduces food or *how* she introduces food (Attitudes are not black and white: gray.)	To measure changes (when the terms are already defined).	To detect a change in agricultural production. To detect a change in the percentage of children taken to a clinic when they have cough and rapid or difficult breathing/
To get a feel for a situation rapidly and at low-cost. ("quick and dirty")	To know -- through a two day process -- the main crops that the farmers are using in an area (without a high level of precision.	To answer "how many" and "how often" type questions with varying degrees of precision.	To determine the average number of animals that each family has at the beginning and end of a project. To know how many times during the day mothers feed their children.
To answer "why" type questions. To better understand unanticipated results found during a KPC survey or other quantitative study.	To know the *reasons* why people are not using oral rehydration solution or fertilizer (without necessarily knowing the *principal* reason). To know why nobody said they went to a traditional healer.	To answer "when" questions with precision.	To know when (at which age) the mother begins to give their children food other than breastmilk. To know when farmers are planting a particular crop. (Averages, before a certain time, quartiles, etc.)

For what purposes are Qualitative Methods useful?	Examples	For what purposes are Quantitative Methods useful?	Examples
To determine most of the possible answers for a question that you plan to use in a questionnaire. To make lists. To identify new needs and situations. To shorten the amount of time interviewers spend writing out responses during a survey.	To know all the common responses to the question, "From where do you buy seeds?"	To answer "Who" type questions precisely.	To know what portion of the deliveries in an area were attended by a qualified health worker. (But you may need to use qualitative methods -- e.g., interviews or checklists -- to know if a particular type of Health Worker is, in fact, qualified.)
To adapt a questionnaire and assure that the terms used in the questionnaire are understandable and the best possible ones. (Note: You do not want your KPC interviewers "explaining" questions!)	Asking health workers, "What terms do people here use for weaning? For bottle feeding?" Or for farmers: "What terms do people here use for erosion? For white fly?"	To measure knowledge, practice, and coverage levels.	To determine the percentage of farmers using an improved agricultural technique. To determine the percentage of children who have received the third dose of DTP.
To better understand a cultural system (= *ethnography*) or social norms / image regarding something.	To understand the hot-cold food system in order to know what to tell pregnant women they should be eating. To understand how farmers feel about using animal vs. mechanized plowing.		

Examples of Qualitative Methods:

- Semi-structured interviews
- Key informant interviews
- Participatory Rapid Appraisal (usually self-selecting participants).
- Participant (direct) observation (e.g., in cane harvest).

Examples of Quantitative Methods:

- Questionnaires applied in a study (with the whole population or a correctly-drawn sample)
- Counts (e,g, of the number of latrines, water sources, animals)
- Monitoring of prices and/or levels (e.g., prices mentioned for crops on the radio or from secondary data).

Other Characteristics of Qualitative Methods:

- The questions are *broad*, *rich*, and encourage *elaboration*.
- The group of participants are not necessarily representative of their community. (The opposite is true of quantitative methods.)
- You cannot easily compare the results before and after a project. You cannot measure changes (e.g., changes in attitudes or practices).
- The replies given are *richer*, *deeper*, and *more descriptive*.
- One participant's response may affect another participant's response (which is sometimes a positive thing). This should not be true of quantitative methods.

IV. Other General References / Tools for Use in Development of a Monitoring System

Several good, general references that have been used by PVOs to develop a monitoring system include:

- "Toolkits, A Practical Guide to Assessment, Monitoring, Review and Evaluation". Save the Children. Reprinted in 1999. (This can be ordered online from the ITT bookstore in London: http://www.itpubs.org.uk.)
- "Tools to Measure Performance of Nutrition Programs," September 1999, available from the Human Development Network at the World Bank. This book was developed by professors at Tufts University, and is regularly used in their Nutrition M&E course which is held annually. Some Title II programs have found it very difficult to order this from the World Bank, however. Title II project staff are encouraged to contact Dorothy Scheffel at World Vision for information on ordering this book.
- A UNICEF Guide for Monitoring and Evaluation, (http://www.unicef.org/reseval/mander.html)
- Performance Monitoring and Evaluation TIPS: Preparing a Performance Monitoring Plan, USAID Center for Development Information and Evaluation, 1996(7). Available at: http://www.usaid.gov/pubs/usaid_eval/pdf_docs/pnaby215.pdf
- A FAM guide for development of monitoring and evaluation plans is available at: http://www.foodaid.org/worddocs/meplan.doc

Sentinel sites were developed by WHO for surveillance of communicable diseases and first used in the campaign to eradicate smallpox. They are especially appropriate for monitoring situations in which rapid changes are possible (e.g., epidemics, where trends can be logarithmic rather than linear), and those changes would then provoke fast action of some sort to confront the problem. Sentinel surveillance does not attempt to detect all cases of a given problem or disease. High sensitivity and quality of data are generally the goals. Development workers at selected sites (e.g., farms or health facilities) collect and report information (e.g., cases of target child diseases, plant diseases/insect infestations, or services provided). The data reach headquarters much more quickly than comprehensive routine reporting, and are analyzed to monitor such things as disease trends and program efficacy and impact. The system can be used to supplement routine reporting systems. However, care must be exercised in selecting sentinel sites and in making generalizations based on data obtained from sentinel sites since they may not be representative of the district or country's population as a whole.[60]

The number of sentinel sites chosen should be based upon a rough measure of the number of people (or farms, etc.) in the area who are at risk of the problem/disease being tracked. A heavy concentration of farms in a given area should prompt the organization to use more than one farm as a sentinel site in that area. If a choice exists in selecting a sentinel site from among several in the same area, it may be better to select the site with the highest risk of exposure to the problem. However, other criteria must be considered when selecting a site, such as the facility's willingness to

[60] A UNICEF Guide for Monitoring and Evaluation, Section IV (http://www.unicef.org/reseval/mander.html)

participate. A small facility (or farm) that enthusiastically and consistently participates as a sentinel site will provide data that are more useful for comparative purposes, as opposed to a larger facility that participates only intermittently.

Sample size, in general, is an issue when using sentinel sites or a portion of project beneficiaries. The Epi-Table module of Epi-Info software[61] allows the user to calculate the sample size needed based on:

- the desired precision of results,
- expected prevalence (use 50% when unsure or measuring multiple things), and
- design effect (1.0 is used for simple random sampling, 2.0 is generally used for nutrition and Expanded Program of Immunization (EPI) studies, 5.0 for diarrhea prevalence studies).

Other online resources are available for calculating sample size, as well.[62] Workshop materials from the FAM, "Sampling for Managers Workshop," is available for download from: http://www.foodaid.org/samplingwkshp.html

Annex K contains a table showing the relationship of the monitoring tools in this guide to the Title II Generic Indicators. Some of the tools listed there can be used to directly monitor the generic indicator itself (e.g., % of crops lost to pests or environment), while others can be used to monitor processes related to the generic indicator (e.g., quality of educational sessions in which IPM is promoted).

An excellent resource for readers who would like to learn more about **health and nutrition baseline research methods** is Patricia Haggerty's, "Review of Health and Nutrition Project Baseline Research Methods of Title II Funded PVOs.[63]" Some of the methods mentioned in that document may also be useful, once modified, for monitoring purposes. This document is available for download from FAM's website: http://www.foodaid.org/worddocs/moneval/HNSurveyReviewWeb.doc. An excellent guide for readers who would like to learn more about **agricultural baseline surveying methods** is Patricia Bonnards, "Review of Agriculture Project Baseline Surveying Methods of Title II-Funded PVOs: Part 1, Socio-economic Methods." Some of these methods may also be useful for monitoring. The document is available for download at: http://www.foodaid.org/pdfdocs/moneval/agriculturalbaseline.pdf. Other FAM monitoring and evaluation documents are available at: http://www.foodaid.org/mne3.htm

---

61 Available free of charge at: http://www.cdc.gov/epiinfo/

62 For example, http://www.dssresearch.com/SampleSize/use_pct.asp or http://www.surveysystem.com/sscalc.htm

63 *Op cit.*

ANNEXES FOR
Review of Health and Agriculture Project Monitoring Tools for Title II Funded PVOs

Annex A

Contributors to the Title II Monitoring Toolbox

Seth Abu-Bonsrah (ADRA)
Irene Abdou (Counterpart)
Alisa Alano(Counterpart)
Paul Amevor (OICI)
David Ameyaw (ADRA)
Mary Arimond
Chris Bessenecker (PCI)
Bart Burkhalter (QAP)
Susan Bolman
Judy Bryson (Africare)
Ben Campbell (WV)
Alfsonso Contreras (BASICS II)
Lew Dick (FHI)
David Evans (FHI)
Cecilia Fernandez (SCF)
Susan Gearon (PCI)
Brett Gresham (WV)
Lisa Howard-Brabman (SCF)
Carol Jenkins (WV)
Ben Kauffeld (IRC)
Adugna Kebede (FHI)
Lisa Kuennen (CRS)
John Lundine (Worldshare)
Scott McNiven (ADCI-VOCA)
Gail Montano (PCI)
Mugo Muita (CARE)
Adrian Ng'asi (ACDI/VOCA)
Victor Pinga (OICI)
Carol Puzone (ARC)
Jolee Reinke (QAP)
Mara Russell (FAM)
Rene Salgado (BASICS II)
Dorothy Scheffel (WV)
Trish Schmirler (FAM)
Suzanne Schwoebel (ACDI/VOCA)
Eric Swedberg (SCF)
Anne Swindale (FANta)
Youssef Tawfik (SARA Project/AED)
Ange Tingbo (Africare)
Kristen Turra (ACDI/VOCA)
Joseph Valadez (NGO Networks for Health)
Bill Weiss (JHU)
Keith Wright (FHI)
Steve Zodrow (FAM)

Annex B

Verbal Case Review Form (Form A).xls [10 pages] and
Verbal Case Review Form (Form B).xls [14 pages])

BASICS Nigeria

Form A: Verbal Case Review for Management of Child Illness

(One form for every child less than 5 years old who was sick during the previous 2 weeks with Diarrhea, ARI or Fever/Malaria and his/her family sought care/advice outside the home or purchased medicine)

Form Serial Number:_____ | SerialN ☐☐☐

Date: _____ | Survdate / /

Interviewer's name:: _____ Interviewer's ID:_____ | SurvID ☐☐

Field Supervisor: _____ Supervisor ID:_____ | SupID ☐

Location: _____ | Location ☐

Distance from household to nearest health facility (HC, HP, health hut) | Hfdist ☐
(circle one)

1.< 5 kilometres

2. ≥ 5 kilometres

Respondent Information ***(NB-Respondent should be the person who took care of the child during this sickness)*** | outcare 1

1- Respondent's name: _____

2- Is Respondent? ***(circle the answer)*** | RespID ☐

1. Mother
2. Father
3. Grandmother
4. Grandfather
5. Other:_____

3- Father's name (of sick child): _____

4- Age of respondent: _____ | Respage ☐

5- Education of Respondent: ***(circle highest level completed)*** RespEdu ☐

1. Illiterate
2. literate (can read and write, but did not complete primary school)
3. Completed, primary education (finished class 5)
4. Completed, secondaty education (finished class 10)
5. Higher than secondary school

Household Information

("household" = persons who eat at the same table/from the same dish)

6- Total number of people living in the household, by age:

1. ≥ 15: _____ people Hhadult ☐
2. 5-14 years: _____ people Hhteen ☐
3. < 5 years: _____people HHchild ☐
4. Total number living in the household: _____ people Hhtotal ☐☐

7- What was the total household income during the last 3 months? HHincome ☐☐☐

_____Naira

____ don't know

8- How much did this household spend on food/drinks during the last 3 months? HHfoodex ☐☐☐

_____Naira

____ don't know

9- How much did this household spend on medicine/treatment during the last month? HHmedex ☐☐☐

_____Naira

_____ don't know

10- Interviewer's assessment of the household's economic standard: ***(circle one)*** ecstand ☐

Note to interviewer: observe the family environment to determine the approximate economic level.

1. High
2. Medium
3. Low

11- Is this household in an urban or rural area? Urb/rural

1. Urban
2. Rural

Sick Child Information

12- Sick child's name: _____ Sick child serial N° :_____ ChildID

13- Age in months: _____ ChildageM ChildageY
(if less than one month of age, write '0')

14- Male or Female? Childsex

1. Male
2. Female

15- Birth order of child among sistersbrothers: ***(circle one)*** Childord

1. 1st child
2. 2nd child
3. 3rd child
4. 4th child
5. 5th child
6. 6th child
7. 7th child
8. 8th child

16- Child sickness: (for all sickness during past 2 weeks)

(circle all applicable responses)

1. Diarrhea — Diar ☐

   If yes, bloody stools? — DSang ☐

   yes

   no

2. Cold/flu/runny nose — Cold ☐
3. Cough — Cough ☐
4. Difficult breathing — Dbreath ☐
5. Fever/malaria — Fever ☐
6. Vomiting — Vomit ☐
7. Sweating at night — Sweat ☐
8. Shivering at night — Shiver ☐

17- Date of onset:_____/____/_____ — Onset __/__/__

18- Is child still sick? — StillS ☐

1. Yes
2. No
3. Deceased

If no, date of recovery:____/____/____ — Recovery __/__/__

19- ***Interviewer: verify the number of days the child was sick.*** _____ days — DSick ☐

20- What symptoms or signs made you realize that the child is sick? ***(circle answers)***

1. Change in appetite	Appet	☐
2. Change in activity--play less, tired	Lessact	☐
3. Fever	Rfever	☐
4. Loose stool	lostool	☐
5. Frequent stool	frstool	☐
6. Blood in stool	blstool	☐
7. Vomiting	vomit	☐
8. Cough	Rcough	☐
9. Runny nose	Rrnose	☐
10. Ear discharge/earache	ear	☐
11. Trouble breathing	Tbreath	☐
12. Rapid breathing	Fbreath	☐
13. Other:_____		

21- ***Ask:*** In your opinion, was the child's sickness: severity ☐

1. Severe?
2. Moderate?
3. Mild?
4. Don't know?

If Severe, ask question 22; if not, go to question 23.

22- What symptoms/signs made you realize the child's sickness is severe?
(circle all answers given)

1. Not able to eat or drink — noeatdr ☐
2. Change in activity--play less, tired — lethargy ☐
3. High fever — Hifever ☐
4. Loose stool — slostool ☐
5. Frequent stool — Sfrstool ☐
6. Blood in stool — Sblstool ☐
7. Repeated vomiting — Rvomit ☐
8. Strong cough/frequent cough — Srcough ☐
9. Convulsions — convuls ☐
10. Ear discharge/earache — Sear ☐
11. Trouble breathing — Stbreath ☐
12. Rapid breathing — Sfbreath ☐
13. Other: _____

23- Normally how many times per day is the child fed/breastfed? — bdietfr ☐

_____ times/day (***i.e., before the sickness)***

24- During the sickness, was the child fed/breastfed: ***(circle answer)*** — DietFr ☐

1. The same as usual?
2. Less often?
3. More often?

25- During the sickness, how many times per day was the child fed/breastfed? — dDietfr ☐

_____ times/day

26- After the sickness, how many times per day was the child fed/breastfed? — sdietfr ☐

_____ times/day

_____ Child is still sick

27- In general, what symptoms/signs make you believe that your child could be seriously sick?
(write answer/s)

_____

_____

_____

(circle all symptoms and signs mentioned in the above answer)

1. Severe vomiting (repeatedly)	gsvomit	☐
2. Blood in stool	gbldstl	☐
3. Child is lethargic (very tired and not active as usual)	gletharg	☐
4. Convulsions	gconv	☐
5. Child does not eat/drink	gneat	☐
6. High fever	gfever	☐
7. Trouble breathing	gdbreath	☐
8. Rapid breathing	grbreath	☐

9. Other: _____

Care Outside Home

Interviewer: Ask the respondent to tell the story of the child's sickness
Describe symptoms noticed and when they were noticed. If any action was taken at home, who took care of the child and what treatment was given? Who made decisions regarding treatment and the purchase of medicines? What happened outside the home and who took the child for outside care/treatment? Did the respondent accompany the child to the care providers?

28- You mentioned earlier that you sought outside home care/advice about the child's sickness. From whom did you seek care/advice or purchase medicines?

Indicate all providers/sources consulted during this sickness.

(circle all answer/s and write name and address/location of care providers; refer to practitioner list to specify type of provider.)

1. Relative/neighbor:_____ Relative ☐
2. Traditional healer:_____ Thealer ☐
3. Non-government health facility (NGO):_____ NGOFac ☐
4. Religious group-run health facility: _____ Religfac ☐
5. Drug seller (Western medicine): _____ DSellerW ☐
6. Pharmacist: _____ Pharm ☐
7. Drug seller (traditional/herbal): _____ DSellerH ☐
8. Private doctor: _____ MBBS ☐
9. Private nurse: _____ Nurse ☐
10. Hospital/health centre/health post/health hut: _____ MOHcl ☐
11. Weekly market: _____ markt ☐
12. Marabou: _____ marab ☐
13. Dispensary: _____ Munic ☐
14. Other: _____

29- Total number of outside care sources consulted: _____ NSources ☐

30- Whom did you consult:

1. first? _____
2. second? _____
3. third? _____

31- Did you buy medicines for this sickness? Pmed ☐

1. Yes ***If yes, dontinue with Q32***
2. No ***If no, go to Q34***

32- Where did you buy medicine?

1. Relative/neighbor:_____ MRelative ☐
2. Traditional healer:_____ MThealer ☐
3. Non-government health facility (NGO):_____ MNGOFac ☐
4. Religious group-run health facility: _____ MReligfac ☐
5. Drug seller (Western medicine): _____ MDSellerW ☐
6. Pharmacist: _____ MPharm ☐
7. Drug seller (traditional medicine/herbs): _____ MDSellerH ☐
8. Private doctor: _____ MMBBS ☐
9. Private nurse: _____ MNurse ☐
10. Hospital/health centre/health post/health hut: _____ MMOHcl ☐
11. Weekly market: _____ Mmarkt ☐
12. Marabou: _____ Mmarab ☐
13. Dispensary: _____ M Munic ☐
14. Other: _____

33- Who advised you to buy medicine for the sick child?

1. Relative/neighbor:_____ cRelative ☐
2. Traditional healer:_____ cThealer ☐
3. Non-government health facility (NGO):_____ cNGOFac ☐
4. Religious group-run health facility: _____ cReligfac ☐
5. Drug seller (Western medicine): _____ cDSellerW ☐
6. Pharmacist: _____ cPharm ☐
7. Drug seller (traditional medicine/herbs): _____ cDSellerH ☐
8. Private doctor: _____ cMBBS ☐
9. Private nurse: _____ cNurse ☐
10. Hospital/health centre/health post/health hut: _____ cMOHcl ☐

11. Weekly market: _____ cmarkt ☐

12. Marabou: _____ cmarab ☐

13. Dispensary: _____ cMunic ☐

14. Other: _____

34- What made you seek outside care/advice for the illness of the child? Youtcare ☐

(Write answers below)

_____

_____

_____

_____

_____

_____

BASICS Nigeria

Form B: Verbal Case Review for Management of Child Illness
(one form per child <5 years sick during past 2 weeks with diarrhea, ARI or fever/ malaria and his/her family did not seek outside care/advice and did not buy medicine)

Form Serial Number:_____ SerialN

Date: _____ Survdate __/__/__

Interviewer's name: _____ Interviewer's ID: _____ SurvID

Field Supervisor: _____ Supervisor ID: _____ SupID

Site: _____ Location

Distance from household to nearest health facility (HC, HP, health hut) Hfdist
(circle one)

1.< 5 kilometres

2. ≥ 5 kilometres

Respondent Information ***(NB-Respondent should be the person who took care of the child during this sickness)*** outcare 2

1- Respondent's name: _____

2- Is Respondent? ***(circle the answer)*** RespID

1. Mother
2. Father
3. Grandmother
4. Grandfather
5. Other:_____

3- Father's name (of sick child): _____

4- Age of respondent: _____ Respage

5- Education of Respondent: ***(circle highest level completed)*** RespEdu

1. Illiterate
2. literate (can read and write, but did not complete primary school)
3. Completed, primary education (finished class 5)
4. Completed, secondaty education (finished class 10)
5. Higher than secondary school

Household Information

("household" = persons who eat at the same table/from the same dish)

6- Total number of people living in the household, by age:

1. ≥ 15: _____ people Hhadult
2. 5-14 years: _____ people Hhteen
3. < 5 years: _____people Hhchild
4. Total number living in the household: _____ people Hhtotal

7- What was the total household income during the last 3 months? HHincome

_____Naira

____ don't know

8- How much did this household spend on food/drinks during the last 3 months? HHfoodex

_____Naira

_____ don't know

9- How much did this household spend on medicine/treatment during the last month? HHmedex

_____Naira

_____ don't know

10- Interviewer's assessment of the household's economic standard: ***(circle one)*** ecstand

Note to interviewer: observe the family environment to determine the approximate economic level.

1. High
2. Medium
3. Low

11- Is this household in an urban or rural area? Urb/rural

1. Urban
2. Rural

Sick Child Information

12- Sick child's name: _____ Sick child serial N° :_____ ChildID

13- Age in months: _____ ChildageM ChildageY
(if less than one month of age, write '0')

14- Male or Female? Childsex

1. Male
2. Female

15- Birth order of child among sistersbrothers: ***(circle one)*** Childord

1. 1st child
2. 2nd child
3. 3rd child
4. 4th child
5. 5th child
6. 6th child
7. 7th child
8. 8th child

16- Child sickness: (for all sickness during past 2 weeks)
(circle all applicable responses)

1. Diarrhea Diar
   If yes, bloody stools? DSang
   yes
   no
2. Cold/flu/runny nose Cough
3. Cough Cold
4. Difficult breathing Dbreath
5. Fever/malaria Fever
6. Vomiting Vomit
7. Sweating at night Sweat
8. Shivering at night Shiver

17- Date of onset:_____ Onset __/__/__

18- Still sick? StillS

1. Yes
2. No
3. Died

Si no, date of recovery:____/____/____ Recover __/__/__

19- ***Interviewer: verify the number of days the child was sick:*** _____ days DSick ☐

20- What symptoms/signs made you realize that the child is sick? ***(circle answer/s)***

1. Change in appetite Appet ☐
2. Change in activity--plays less, tired Lessact ☐
3. Fever Rfever ☐
4. Loose stool lostool ☐
5. Frequent stools frstool ☐
6. Blood in stool blstool ☐
7. Vomiting vomit ☐
8. Cough Rcough ☐
9. Runny nose Rrnose ☐
10. Ear discharge, earache ear ☐
11. Trouble breathing Tbreath ☐
12. Fast breathing Fbreath ☐
13. Other:_____

21- ***Ask:*** In your opinion, was the child's sickness: severity ☐

1. Severe?
2. Moderate?
3. Mild?
4. Don't know

If Severe, ask question 22; if not, go to question 23.

22- What symptoms/signs made you realize the child's sickness is severe?
(circle all answers given)

1. Not able to eat or drink — noeatdr ☐
2. Change in activity--play less, tired — lethargy ☐
3. High fever — Hifever ☐
4. Loose stool — slostool ☐
5. Frequent stool — Sfrstool ☐
6. Blood in stool — Sblstool ☐
7. Repeated vomiting — Rvomit ☐
8. Strong cough/frequent cough — SRcough ☐
9. Convulsions — convuls ☐
10. Ear discharge/earache — Sear ☐
11. Trouble breathing — Stbreath ☐
12. Rapid breathing — Sfbreath ☐
13. Other: _____

23- Normally how many times per day is the child fed/breastfed?

_____ times/day (***i.e., before the sickness)*** — bdietfr ☐

24- During the sickness, was the child fed/breastfed: ***(circle answer)*** — DietFr ☐

1. The same as usual?
2. Less often?
3. More often?

25- During the sickness, how many times per day was the child fed/breastfed? — dDietfr ☐

_____ times/day

26- After the sickness, how many times per day was the child fed/breastfed? — sdietfr ☐

_____ times/day

_____ Child is still sick

27- In general, what symptoms/signs make you believe that your child could be seriously sick?
(write answer/s)

_____

_____

_____

(circle all symptoms and signs mentioned in the above answer)

1. Severe vomiting (repeatedly) gsvomit ☐
2. Blood in stool gbldstl ☐
3. Child is lethargic (very tired and not active as usual) gletharg ☐
4. Convulsions gconv ☐
5. Child does not eat/drink gneat ☐
6. High fever gfever ☐
7. Trouble breathing gdbreath ☐
8. Rapid breathing grbreath
9. Other: _____

Home Care Practice

Ask respondent and write answer here:
What did you do to take care of the child's illness? What did you give him/her during the illness?

(Ask specifically, if not mentioned, whether the sick child received ORS/tablets/syrup/ injection and write answer above.)

Based on the above answer, circle below the action/s of care taker during the child illness.

1- Home Care for Fever:

1. Child did not have fever — ***if no fever, circle here and go to 'home care of diarrhea'*** — nofever ☐
2. Put more clothing on — mcloth ☐
3. Put less clothing — lcloth ☐
4. Gave tablets for fever: _____ — ftablet ☐
5. Gave antibiotics: _____ — fantib ☐
6. Gave injection: _____ — finject ☐
7. Gave herbal/traditional medicine: _____ — fherbal ☐
8. Gave other medicine/treatment: _____

2- Home Care for Diarrhea: *(circle answer/s)*

1. Child did not have diarrhea — ***if no diarrhea, circle here and go to 'home care for cough/cold/trouble breathing'*** — nodiar ☐
2. Gave ORS — ORS ☐
3. Gave sugar-salt solution — SSS ☐
4. Gave fluids — fluids ☐
5. Gave herbal/traditional medicine: _____ — herbs ☐
6. Gave tablets/syrup:_____ — Tabsyrup ☐
7. Gave injection:_____ — injection ☐
8. Gave other medicine/treatment: _____

3- Home Care for Cough/Cold/Trouble Breathing *(encercler réponse/s)*

1. Child did not have cough/cold/trouble breathing — nocough ☐
   circle here if child did not have cough/cold/ trouble breathing and go to 'Source of ORS/Medicine/ Injection'
2. Gave cough medicine: _____ — coughmed ☐
3. Gave pain/fever medicine: _____ — fevermed ☐
4. Gave antibiotic: _____ — antib ☐
5. Gave injection: _____ — inject ☐
6. Gave herbal/traditional medicine: _____ — herbal ☐
7. Gave other medicine/treatment: _____

Source(s) of ORS/Medicine/Injection:

Interviewer: Verify from above answers if any ORS, medicine (tablets/syrup) or injection were given to the sick child

if yes, continue
if no, go to Q7

4- You mentioned that you gave (child's name) ORS/tablets/syrup/injection, when did you buy them? whenmed ☐

1. During the child's current illness ***(If you circled here, you should not be using Form B; you should use Form A)***
2. Had it before the child's current illness. ***(continue with Form B)***

5- Where did you buy/get them? ***(circle answer/s)***

1. Relative/neighbor Drelativ ☐
2. Traditional healer Dthealer ☐
3. NGO-run facility DNGOFac ☐
4. Religious group-run facility DRelgfac ☐
5. Drug seller (Western medicine) DDSellrW ☐
6. Pharmacist DPharm ☐
7. Drug seller (traditional, herbal) DDSellrH ☐
8. Private doctor DMBBS ☐
9. Private nurse DNurse ☐
10. Hospital/health centre/health post/health hut DMOHcl ☐
11. Market DMarkt ☐
12. Marabou DMarab ☐
13. Dispensary DMunic ☐
14. Other: _____

6- ***If injection was given, ask the following questions:***

1. How many injections did the sick child actually receive during the current sickness? Ninjtk ☐

   _____ injections

2. Where was the injection given? injsite ☐

   1. At home
   2. Outside home; if yes, where?:_____

3. Who actually gave the child the injection? whoinj ☐

1. Family member living in the same household
2. Other family member/neighbor
3. Other: _____

4. What kind of syringe was used? syringe ☐

1. Plastic
2. Glass
3. Don't know

5. If plastic syringe was used, was it new (taken out of a sealed package)? Syrinew ☐

1. Yes
2. No
3. Don't know

6. What was done with it after use? Syrdisp ☐

1. Kept for future use
2. Boiled
3. Thrown away dispwhr ☐
   If yes, where??
   1. Garbage can
   2. Outside home
   3. Don't know
4. Don't know

7. If glass syringe was used, did you boil the syringe before use? Syrboil ☐

1. Yes
2. No
3. Don't know

7- Why have you decided not to seek outside home care for your sick child? ***(circle answer/s)***

1. Child was not seriously sick nserious ☐
2. Child conditions could be treated at home, no need for outside care noneed ☐
3. No good health services accessible nogood ☐
4. Outside home care is costly nomoney ☐
5. Other: _____

8- Have you recently (within last 6 months) sought health care outside home for the same child? prevcare ☐

(circle answer/s)

1. Yes
2. No
3. Don't know

If yes, what made you decide to seek care outside home then? ***(circle answer/s)***

1. Child was more sick — moresick ☐
2. Child had different sickness: — diffsick ☐

   If mentioned, what was the child's sickness? (circle answer/s)

   1. Diarrhea — pdiar ☐
   2. Cough — pcough ☐
   3. Cold/flu/runny nose — pcold ☐
   4. Difficulty breathing — pdbreath ☐
   5. Fever — pfever ☐
   6. Other: _____
3. I could afford it then — pmoney ☐
4. There was a good health provider available then — pgoodc ☐

Bed Nets and Handwashing

1- Do you have bed nets at home? bednet ☐

1. Yes bednet ☐
2. Baby-size only
3. None ***(go to Q2)***

If yes, can I see it? bdntprst ☐

1. Present

total number present _____

condition bdntcond ☐
(circle answer based on observation by interviewer)

good

some holes

bad

2. Not present
3. Couldn't see

When did you buy the bed net? ___/___/___ bdntdate ☐

Where did you buy the bed net? bdntbuy ☐

1. Market
2. NGO
3. Other: _____

How much did it cost? _____ Naira bdntcost ☐☐☐

Who slept under the bed net last night? ***(circle answer/s)*** bdntuser ☐

1. No one
2. Father
3. Mother
4. Grandparent/s
5. Child/ren < 5 years old
6. Older child/ren
7. Other: _____

Has your bed net ever been treated/dipped with insecticide? nttreat ☐

1. Yes
2. No ***(go to Q2)***
3. Don't know ***(go to Q2)***

If yes, when was it treated last? ***(circle answer)*** treatwhn ☐

1. In the past 6 months (< 6 mos)
2. 6 months-1 year ago
3. More than 1 year ago
4. Don't know

Where did you get the treatment? treatwhr ☐

1. Market
2. Pharmacy
3. NGO
4. Other: _____

2- Do you have at home any mosquito/insecticide spray or coil? spraycoil ☐

1. Yes
2. No ***(go to Q3)***
3. Don't know ***(go to Q3)***

If yes, what? ***(circle all answers given)*** wmosprod ☐

1. Spray
2. Tablet
3. Coil
4. Herbs/leaves
5. Other _____

3- How much have you paid for mosquito/insecticide products combined during the last 3 months? sprycost ☐☐☐

1. _____ Naira
2. Don't know

4- Do you have soap at home? soap ☐

1. Yes
2. No ***(go to Q5)***

If yes, can I see it? soappr ☐

1. Present
2. Not present
3. Couldn't see

5- During the last 24 hours (since yesterday), have you washed your hands? handwash ☐

1. Yes
2. No ***(go to Q7)***

If yes, how many times?: _____ handwashn ☐

What occasion? whenwash ☐

1. Before preparing food
2. Before eating
3. Before feeding the child/ren
4. After bathroom
5. When hands got dirty
6. Other: _____

6- Show me: How did you wash your hands last time?
Interviewer observes and circle answers:

Use soap? usesoap ☐

1. Yes
2. No

Rub hands to wash front and back? washback ☐

1. Yes
2. No

Wash between fingers? wshfingr ☐

1. Yes
2. No

7- Is there a syringe at home? syrhouse ☐

1. Yes
2. No ***(end of questionnaire)***
3. Don't know ***(end of questionnaire)***

If yes, what type of syringe? wsyrh ☐

1. Plastic
2. Glass
3. Don't know

If plastic, is it new? newsyrh ☐
(Interviewer should see if still in sealed package)

1. Yes
2. No
3. Couldn't see

When was the syringe last used? whensyrh ☐

1. In the past 3 months (< 3 mos)
2. 3-6 months ago
3. 7 months-1 year ago
4. More than 1 year ago

Where did you get this syringe? whersyrh ☐

1. Bought it
2. Care provider
3. Relative/neighbor
4. Don't know

Annex C
Consultant Training Skills Matrix

Consultant[64]	HFA	Exit Interviews	Key Informant Interviews	Focus Groups	Pre/ Posttests	KPC Surveys	LQAS	Languages spoken (fluent)
Ibrahim Bani	No	No	No	Yes	No	Yes	No	Arabic, English
Deborah Bender	No	No	Yes	Yes	Yes	Yes	No	English, Spanish
Karabi Bhattacharyya	No	Yes	Yes	Yes	Yes	Yes	No	English
Dennis Cherian	No	Yes	Yes	Yes	Yes	Yes	No	English, Hindi
Lily Clement	Yes	Yes	Yes	Yes	Yes	Yes	No	English, Spanish
Tom Davis	Yes	Yes	Yes	Yes	Yes	Yes	Yes	English, Spanish, Haitian Creole
Valerie Flax	No	No	No	Yes	Yes	Yes	Yes	English, French
Ruth Garcia de Sylva	No	No	No	Yes	Yes	Yes	Yes	Spanish, English
Gul-e-rana Ghori	Yes	Yes	Yes	Yes	Yes	No	Yes	Turkish, Urdu, English, Hindi
Stephen Gloyd	No	No	Yes	Yes	Yes	Yes	No	English, Portuguese
Maria Valencia-Gutierrez	No	No	Yes	Yes	No	No	No	Spanish, English
Bonnie Kittle	No	No	Yes	No	No	No	No	English, French
Nicaise Kojogbe	No	No	No	No	No	Yes	No	English, French, Fon, Mina
Ruth Kornfield	No	Yes	No	Yes	No	Yes	No	English, French
Thomas Murray	No	Yes	No	No	No	No	No	English, French, Spanish
Marydean Purves	No	Yes	Yes	Yes	Yes	Yes	No	English, French, Portuguese
Marcie Rubardt	No	Yes	Yes	Yes	Yes	No	No	English, French, Spanish
Adam Slote	No	No	No	No	No	Yes	No	English
Suresh Sundar	Yes	Yes	Yes	No	Yes	Yes	No	English
Florence Tienzo	No	No	No	Yes	No	Yes	No	English, Filipino
Karunesh Tuli	No	No	No	No	No	Yes	Yes	English, Hindi
Armand Utshudi-Lumbu	Yes	Yes	Yes	No	Yes	No	No	English, French, Lingala

[64] Consultants listed are from the CORE Consultant DB. See http://www.coregroup.org/consult_search/consultants2.cfm for more information on each of these consultants, or click on a name.

Annex D

FHI's FOCUS GROUP TRAINING NOTES

By Tom Davis, MPH (tdavis@fhi.net)

(USE overhead.)

After this section of the workshop, you should:

- Be able to select a proper sample of people as participants in a focus group.
- Understand how to choose participants for a focus group.
- Select a place to do a focus group and know how to set it up.
- Understand what materials are needed to run a focus group.
- Understand how to facilitate a focus group.
- Understand some options for analyzing focus group data.

(30 minutes)

1. OVERVIEW OF FOCUS GROUPS

a. WHAT is a focus group?

- Focus groups are a type of **group interview** whereby a small group of **about 6-15 people** has a conversation about a given topic.
- The conversation is **guided by one person** who is called the "moderator" or "facilitator."
- A focus group usually **lasts between 30 minutes and two hours**.
- The facilitator **asks open-ended questions** and then "probes" the participants with smaller questions.
- ***The facilitator is the learner not the teacher.*** The facilitator leads a discussion, but the purpose is to learn from the participants, not to teach them anything. Focus groups can be ruined if the person leading them switches into their "educator" or "promoter" roles. It's very difficult for us to just listen sometime, without too much comment or suggestions. Good listening is essential for focus groups, though.
- **The problem with using questionnaires or forms alone** (and reporting forms are really a type of questionnaire) **is that people are forced into fitting their way of thinking into someone else's categories** as they are listed on the questionnaire form. People sometimes talk about whether a questionnaire is "grounded" or "ungrounded." Ungrounded means that it does not fit with the respondent's way of thinking. Grounded means that it does fit. The information that you get from an "un-grounded" questionnaire can be meaningless. You have to try to make the questions that you use fit with the way people think. You often need to do this with your education and your project in general, as well. That's not always very easy, but focus groups can help you to do that.

b. Demonstrate a focus group.

[Explain the setup: I would greet each participant as they came in, have each one tell a little bit about themselves then ask the question and facilitate a discussion. Ask the question on the following page and facilitate a discussion of the question using good facilitation techniques.]

"You know, I have been working with [*name of your organization*] for only about five months. I still don't have a very good idea of the ways in which [*name of your organization*] is different from other private voluntary organizations. Let's talk about that for a while**. In what ways is [*name of your organization*] different from other organizations working in international development? What do you think its strengths are relative to other organizations? What really sets it apart?** Let me repeat that question , , , (***repeat the question***).

Probes: In what ways do you feel [*name of your organization*] is different from other organizations in terms of:

- …its philosophy of development?
- …its organizational structure?
- ... the way the offices in developed countries relate to the offices in the field?

SUMMARIZE their statements, then use a transition: Now let's talk about the areas where Food for the Hungry needs to grow.

c. Discuss the Example

(ASK participants:) "What are some of the things that you noticed about *the question* I asked that may have made participants more likely to respond?" (reread the question):

- I expressed **naiveté (ignorance about the subject).**
- I used a series of **open-ended questions**.
- I used a **longer question** and **repeated** it.

(ASK participants:) "What are some of the things that I did while I facilitated the group to get a lot of information out of the group?"

- I used **probes** (small questions).
- I **asked specific people** what their opinion was.
- I **watched body language.**
- I **limited some people's answers** after a point so all could participate.
- **I brought about a true group discussion. (In many settings, focus groups often turn into "interviews done in groups" where each person in the group gives an answer to a question that is unrelated to what the last person said in the group. This is not the intent of the methodology.** The discussion in a focus group should be a free-flowing *discussion* amongst the participants where the facilitator plays a smaller and smaller role once the question is understood by the participants. Responses by participants are made in reference to the original question, but are also made in response to comments made by other participants in the group.)
- We will discuss others later during the facilitation skills part of this training.

(10 minutes)

2. Advantages of using focus groups.

(USE overhead and discuss)

a) They **cost less** than other qualitative methods.

b) They are especially **useful for** collecting information from certain age **groups or populations that are difficult to interview** one-on-one, such as teenagers. (This may be true of the very poor as well.) This is because **interviews between people from**

different classes often do not yield as good of results as when the interviewer is of the same status and class. Focus groups **take the emphasis off of the interviewer** since the interviewer in a focus group [the"facilitator"] talks less of the time --s/he is "outnumbered". When a person is in a group of people like his or herself, s/he is has the security needed to talk more freely about her opinions and ideas .

c) Focus groups **allow for more community involvement** in the generation of ideas and materials useful to projects. For example, in some countries development workers have found that putting a picture of a child and a loving mother on an ORS packet meant that more mothers would buy them. Or *flavoring* the ORS made more people use it. They found these things out by using focus groups.

d) Focus groups can **encourage people to speak honestly** more easily than in a one-to-one interview. Individuals sometimes feel more comfortable in talking about their beliefs and practices in a group of people who share their beliefs and opinions. (This often happens to "new" Christians who feel much more comfortable talking about their faith in church than they do talking about it with their non-Christian friends.) This is why focus groups have been used extensively for learning about family issues. Home interviews do not provide the "balance-of-power" that is needed.

e) Focus groups can be **useful in defining problem areas and new concerns** which need to be addressed in detail with a survey (as mentioned earlier), problems that you may not have known existed had you started with a closed-ended questionnaire.

(10 minutes)

3. Disadvantages of focus groups.

(USE overhead and discuss)

1. **Harder to interpret** the data than other methods.
2. **Less control over the course of discussion** than other methods. A good facilitator needs to keep people on track so that all questions are answered.
3. The **setting is less natural** than some methods.
4. **Recruitment of participants is more difficult** than for many other methods.
5. Sometimes it is **difficult to achieve "anonymity"** (a goal of focus groups) where people feel like they can say what they want. Power relations and hierarchies can affect and distort the results if some of the participants know each other very well -- which is almost inevitable to a certain degree in small villages.

(10 minutes)

4. Organizing a Focus Group and Selecting People to Participate in Focus Groups

a) Characteristics of good focus group participant selection.

1. Homogenous according to salient characteristics.

The respondents should share characteristics that most likely influence attitudes towards the focus group topic. (This may be hard to determine ahead of time.) These may include:

- age
- race
- education
- sex

- income level
- people that share a particular problem (e.g., birds eating their sorghum; children who won't gain weight).
- people that are trying to modify or add a behavior (e.g., using terracing; exclusive breastfeeding).

Some researchers screen potential respondents to ensure homogeneity of the group: They look for people ahead of time who meet certain criteria.

2. **6-15 people (8-12 best in most places).**

3. **Preferably, you want people who are acquaintances or less. (Difficult.)** This can be a problem. Focus groups are not as effective within an club or organization where people are often more than acquaintances and there are chains of command that can greatly affect people's responses in a group (e.g., people following the leader's response). You would not want to do a "focus group" using a community organization. That's not a focus group. It's just a group discussion. And it might end up being a speech by the group's leader!

4. **Ideally, do at least two focus groups (best 4-5) per grouping of people (e.g., Lead Farmers) per subject.**

5. **Do 3-5 groups per theme -- like erosion prevention methods or child health.**

6. ***Select participants somewhat randomly if possible (within a category).***
   * **Not** essential, but helpful.
   * Consider using a door-to-door invitation in the morning for an afternoon focus group, selecting every third house, etc.
   * Consider ease of selection vs. "purity" of sample.

7. ***Naïve Participants***
   Participants should not be told the questions they will be discussing before the focus group begins. You do that so that people will say what is on their mind (be spontaneous), be more honest, and give non-divisive answers. You can mention the general topic to the participants ahead of time (e.g., agriculture or health), but do not talk about specifics of the focus group or the planned project. (And when I ask questions about needs, I start with very open-ended questions, then ask specifically about the topic that interests me most [health].)

(3 minutes)

5. Selecting the focus group site.

The focus group site should be:

* **Quiet.** It is hard to exclude observers sometimes, but at least get them not to talk or distract participants. Don't shut out others (e.g., shutting windows) unless participants want that.
* **Comfortable** for participants
* "**Neutral**" or on "their turf." It should be a place where they feel fairly comfortable (e.g., a public meeting place rather than a church or a mosque).
* **Accessible**

(3 minutes)

6. Materials Needed for a Focus Group

* **Room** (or area near a reflecting wall -- put tape recorder in middle).
* **Table**, a **circle of chairs**, or a **square of benches**.
* **Refreshments**.
* Block of **paper and pen** to record responses.
* (Facilitator and **someone to record** DETAILED responses.)
* **Tape recorder** and fresh **batteries** (optional)

(3 minutes)

7. The Facilitator's Role

- **Greet** participants.
- Deliver **introductory statement**.
- Have participants **introduce** themselves.
- Keep people **speaking from their own experience**. (NOT, "I think my neighbors don't …, but "I don't …)
- **Encourage participants**, letting them know that their ideas and opinions are important ("I never thought of that!", "That's very helpful", etc.).
- **Guide the discussion** using proper facilitation skills.
- **Record key insights** after sessions and **assign someone (or two people, taking turns) to take detailed notes during the entire session**.

Desired (not mandatory) criteria for selection of facilitators (all can be learned):

- Able to listen.
- Skilled in group dynamics.
- Not too shy.
- Non judgmental.
- Knowledgeable and prepared on the focus group topic.
- If possible, not a major stakeholder in the project (hard sometimes and not all that important if you can remain objective).

(30 minutes)

8. Facilitation Skills

(Go through each of these skills and give examples.)

a) Type of interaction desired.

- Relaxed
- Allow conflicting ideas to exist. AGREEMENT (CONSENSUS) IS *NOT* THE GOAL!

b) Guidelines

Generally:

- **Sit in the circle** with everyone else, not further in or further out.
- **Dress** as you expect the participants will dress if that is appropriate (e.g., not too formal; wear jeans if they were jeans; a tie if they wear ties [e.g., physicians]).
- Generally, **do not interrupt,** especially when someone speaks slowly or has trouble expressing his- or herself.
- **Laugh with people,** but NOT at them!
- **Small talk** with people before the focus group begins, but not about the subject of the focus group.

- **Limit dominator's answers.** Tactics: **(*ASK participants*:)** What are ways that we can do this without offending people? ***(ADD:)*** Asking to hear from someone else instead, "Ms. Ledford has lived here a bit longer than you; let's give her a chance to respond to that question"; not giving them eye contact after a point; act bored with them?; etc.)
- **Keep participants focussed.**
- **Get quiet people to respond.** Tactics: **(ASK participants for suggestions. Then ADD:)** Pulling them out, complimenting them more, etc.
- **Handle controversy, but don't stifle it** (intervene if necessary, "everyone has opinions"; "you and I can talk more about that before you leave, if you want, but we really need to move on now.")
- **Watch for body language** cues:
  - Body positioning (folded arms, leaning back, covering their mouth, etc.)
  - People laughing., smiling, or looking irritated by others answers.
  - Tone of voice.
- **Allow for some silences** (puts pressure on people to respond to a certain degree).
- **Use probes**
- **Make summaries** of what has been said.
- **Use transitional statements** (provided in the question guide) so that people know you are finished with one question and are going to something different; and
- **Use humor.**

(20 minutes)

9. Developing a Questions Guide for Focus Groups

(USE overheads)

1. <u>Characteristics of Good Questions / Probes</u>

- **Start off with a "sharing" questions**; use early (e.g., could you each tell me a little bit about yourself, who you are, how many children you have and their ages?")
- **Use open-ended questions**. That's what FGs are made for. If you mainly want to use closed-ended questions, then you shouldn't be using focus groups.
- **Use questions that help you to discover people's attitudes, opinions, and that get participants to talk about their own experiences.**
- **Consider using list-building questions.**
- **Use longer questions to encourage longer answers** that draw on the participants' ideas, experience, or beliefs. (Longer questions often generate longer answers.) You can use more than one question at a time.
- **Consider using "What if" probes**, hypothetical situations (e.g., "If we had the meetings every month instead of every week, would you be more likely to attend?") . . . but don't promise anything you are not ready to provide and do not believe everything that you hear! **Information about future activities is very unreliable.**
- Can use some probes that provoke **humorous responses** to lighten the atmosphere.

  ***(Give an example of a good question: Note length of question, expressed naivete, "you're the experts," etc..*)**

  "I have only been living in Marsabit for about two years now so I don't know about a lot about the health facilities here in this area like you do. What I would like to know is, what has been your experience with the public health centres in Marsabit?. Have you ever visited them? How were you treated when you went there? Are they good health centres or do they need a lot of improvements? Tell me about your experiences with the public health centres in Marsabit.

2. <u>Delivery of Questions / Probes</u>
(USE overhead)

- **Read the questions, but you can elaborate from memory**.
- **Preface sensitive questions**. (Give an example: "People often feel a little uncomfortable talking about teenage pregnancy. But if we want to help prevent it, we need to talk about it more and understand why it happens.")
- **Always repeat questions to give people time to think**. Ask if anyone needs to have the question repeated a third time. You don't want to start the discussion before everyone understands the question (since they would be left out for about 10 minutes otherwise).
- **Pace yourself so that the whole session lasts the amount of time you have allotted.** There's no benefit of finishing early, but you DON'T want to end late unless everyone is having a great time!

3. <u>Sequencing of Questions</u>

- **Put objective, descriptive, less personal questions before subjective, value-oriented, personal ones**.
- Begin with **sharing-type question**.
- **Start with easy questions and proceed to hard ones then back to easy**.
- Be **somewhat flexible** about the sequence.
- **End with a question that make people feel good about themselves** and the focus group experience. (A touchy-feely question, e.g., "dreams for the future.")

(60 minutes)

10. Small Group Exercise in Writing a Question Guide

[Have the participants divide into groups to develop a question guide (max. five questions) for a current need of theirs (e.g., client satisfaction with extension services, finding out about current agricultural practices, program fit, etc.). Have participants present their question guides, and give each group coaching in plenary.]

(2.5 hours)

11. Small Group Exercise in Facilitating Focus Groups

[For each group of 8 people, have people take turns facilitating the group discussion using a question guide provided to them (relevant to their work). Workshop facilitators should rotate among groups and give coaching to each facilitator.]

- Tell participants that we will have about 5-10 minutes per question during this exercise, then explain what has happened already: Participants have been welcomed and are sitting waiting for FG to begin.
- One of the training facilitators does the introductory statement then another person does the sharing question (where participants can introduce themselves).
- One of the training facilitators does the first question and facilitates discussion of that question. Then the second person in the group takes over (becoming a facilitator rather than a focus group member). Workshop facilitators should sit behind each person as they are facilitating and whisper coaching hints to them (e.g., "pay attention to who is *not* talking to," "use probes to get more information there," "get people to talk to each other, not you").

- **After each question/facilitator, have the group give feedback to the person who last facilitated the group.**
  - What did s/he do well?
  - What can s/he do to improve her facilitation techniques?
  - Any other suggestions or comments?

- **Have a "plant" for certain questions** -- go whisper directions to people as the moderator facilitates the group. Tell the "plant" to do the following:
  - On one question, have someone **dominate** (talking on and on, one story after another);
  - on another, have someone **be shy** and not say a word;
  - on another question, have someone **try to block the process** with a concern (e.g., "you're just here to get us all sterilized" or "you want to steal our land");
  - on another question, have **someone talk about other people's experiences** all the time, but never his or her own experiences

12. Analysis of Focus Group Data[65] (30 minutes)

[Discuss analysis options with the workshop participants.]

After each session, the team should finish their notes and prepare a summary of what was learned. During an analysis workshop, these summaries can be read all at one time. Potential trends and patterns and strongly held or frequently aired opinions can be written on newsprint. If transcripts are made, participants can divide into groups and highlight key sections of the transcript to share with in plenary. At this point, information on each question asked can be analyzed separately. Participants can divide into small groups with each group analyzing a particular question or set of questions, and write a summary statement that describes the discussion. When analyzing the results, the team should consider:

- *Words*. Weigh the meaning of words participants used. Can a variety of words and phrases categorize similar responses?
- *Framework.* Consider the circumstances in which a comment was made (context of previous discussions, tone and intensity of the comment).
- *Internal agreement*. Figure out whether shifts in opinions during the discussion were caused by group pressure.
- *Precision of responses*. Decide which responses were based on personal experience and give them greater weight than those based on vague impersonal impressions.
- *The big picture*. Pinpoint major ideas. Allocate time to step back and reflect on major findings.
- *Purpose of the report.* Consider the objectives of the study and the information needed for decision-making. The type and scope of reporting will guide the analytical process. For example, focus group reports typically are (1) brief oral reports that highlight key findings; (2) descriptive reports that summarize the discussion; and (3) analytical reports that provide trends, patterns, or findings and include selected comments.

(*Overheads are provided on the following pages.*)

[65] Taken from Performance Monitoring and Evaluation TIPS: Conducting Focus Group Interviews, USAID Center for Development Information and Evaluation, 1996(10). Available for download at: http://www.usaid.gov/pubs/usaid_eval/pdf_docs/pnaby233.pdf

AFTER THIS SECTION YOU SHOULD:

- **Be able to organize and select a proper group of people as participants in a focus group.**
- **Be able to set up a focus group site.**
- **Understand what materials are needed to run a focus group.**
- **Understand how to facilitate a focus group using good facilitation skills.**
- **Understand some options for analyzing focus group data.**

ADVANTAGES OF USING FOCUS GROUPS

1) They cost less than other qualitative methods.

2) They are especially useful for collecting information from certain age groups or populations that are difficult to interview one-on-one.

3) Focus groups allow for more community involvement in the generation of ideas and materials useful to projects.

4) Focus groups can often encourage people to speak honestly more easily than in a one-to-one interview.

5) They can be useful in defining problem areas and new concerns that need to be addressed in detail with a survey.

DISADVANTAGES OF FOCUS GROUPS

1. **Harder to interpret the data than other methods**

2. **Less control over the course of discussion than other methods**

3. **Setting is less natural than some methods.**

4. **Recruitment of participants is more difficult.**

5. **Sometimes difficult to achieve anonymity.**

CHARACTERISTICS OF GOOD FOCUS GROUP PARTICIPANT SELECTION

1. **Participants are homogenous according to relevant ("salient") characteristics.**

2. **There are 6-20 people (8-12 best in most places) per focus group.**

3. **Preferably, the participants are acquaintances "or less." (Difficult.)**

4. **Ideally, you have at least two focus groups (best 4-5) per grouping of people (e.g., Lead Farmers) per subject.**

5. **You have 3-5 focus groups per theme.**

6. **Randomly chosen (if possible)**

7. **"Naive."**

POSSIBLE SALIENT CHARACTERISTICS

- Age
- Race or cultural group
- Sex
- Educational level
- Income level
- People who share a particular problem
- People who are trying to modify or try out a behavior

SELECTING A GOOD FOCUS GROUP SITE

The focus group site should be:

- **Quiet**
- **Comfortable** for participants
- "**Neutral**" or on "their turf."
- **Accessible**

MATERIALS NEEDED FOR A FOCUS GROUP

- Room (or area near a wall).
- Table (round if possible), circle of chairs, or square of benches.
- Refreshments.
- Block of paper and pen to record responses.
- Tape recorder and fresh batteries (optional)
- (Facilitator and someone to record DETAILED responses.)

THE FACILITATOR'S ROLE

- **Greet participants.**
- **Deliver introductory statement.**
- **Have participants introduce themselves.**
- **Keep people speaking from their own experience.**
- **Encourage participants, letting them know that their ideas and opinions are important**
- **Guide the discussion using proper facilitation skills.**
- **Record key insights after session and assign someone (or two people, taking turns) to take detailed notes during the entire session.**

Desired (not mandatory) criteria for selection of facilitators (all can be learned):

- **Able to listen.**
- **Skilled in group dynamics.**
- **Not too shy.**
- **Non judgmental.**
- **Knowledgeable and prepared on the focus group topic.**
- **Neutral relative to group (hard sometimes).**

FACILITATION SKILLS

Type of interaction desired:

- **Relaxed**
- **Conversational: NOT going around the circle in a fixed pattern**
- **Allow conflicting ideas to exist. CONSENSUS IS NOT THE GOAL!**

Guidelines:

- **Sit in the circle with everyone else, not further in or further out**
- **Dress as you expectant the participants will dress if that is appropriate**
- **Bring about a true group discussion, not an individual interview in a group setting.**
- **Generally, do not interrupt**
- **Laugh with people, but NOT at them!**
- **Small talk with people before the focus group begins**

Guidelines (cont.)

- **Limit dominator's answers**
- **Keep participants focused**
- **Get quiet people to respond.**
- **Handle controversy, but don't stifle it**
- **Watch for body language cues**
- **Allow for some silences**
- **Use probes (small questions)**
- **Make summaries of what has been said**
- **Use transitional statements**
- **Use humor**

Characteristics of Good Questions / Probes

- Start off with a "sharing" type question
- Use open-ended questions
- Use questions that solicit attitudes and opinions and keep participants speaking from their own experiences
- Consider using list building questions
- Use longer questions to encourage longer answers that draw on participants ideas, experience, or beliefs.
- Consider using "What if" probes, hypothetical situations
- Consider using some probes that provoke humorous responses to lighten atmosphere.

Delivery of Questions / Probes

- ❖Read the questions (but elaborate from memory)
- ❖Preface sensitive questions
- ❖Repeat questions
- ❖Pace yourself

Sequencing of Questions

- ❖Use objective, descriptive, less personal questions before subjective, value-oriented, personal ones
- ❖Begin with a sharing type question
- ❖Start with easy questions, proceed to hard ones, then end with easy ones.
- ❖Be somewhat flexible about sequence.
- ❖End with a question that make people feel good about themselves and the focus group experience.

Annex E

FHI's Training Notes: Using Pre- & Posttests in Trainings

(by Tom Davis, MPH, Food for the Hungry, International)

1. ***(ASK:)*** What are the different ways that you can evaluate whether the education that you do is effective? **(Note their responses on newsprint, then hand out Handout #4A, "Choosing Appropriate Training Techniques." Take them through the table, focusing on the last column.)**
   - Skills should be measured using a QIV checklist.
   - Attitudes and values can be observed indirectly on the job, and recorded in a journal.
   - Facts and information, though, should be evaluated using written or oral exams. We call these examinations or tests or quizzes, pre- and posttests. When the evaluation is done at the beginning of a training, it's a pretest. When it is done at the end of a workshop, it's called a posttest.

2. ***(ASK:)*** Is it generally better to give participants a test before they have been trained, after they have been trained or both? ***(ADD:)*** Both, especially if it is part of a more formal training. This will allow you to see to what degree participants' knowledge or skills have changed as a result of the training. Without a pretest, you cannot be sure how much information or what level of skills the participants had on the topic prior to the training. Also, you can review pretest results early in a training in order to see which topics and individuals may require more attention and training time.

3. ***(ASK:)*** When you are developing a written pre/posttest, what are some of the things you think you should keep in mind?
   a. **It should generally not be more than about one and one-half pages per day of workshop**.

   b. **If you are using it with a group that meets very regularly, and especially if there are people in the group who do not read and write, the posttest should be given orally and individually.** ***(ASK:)*** Why should it be given individually rather than during a group interview? ***(ADD:)*** Without an individual interview, you only get an idea of what *some* people in the group have learned, usually the more vocal ones, but you cannot evaluate each learner independently. Maybe 20% of the people learned 95% of the material, but the other 80% of the people only learned about 10% of the material. Who do you think will speak up when you ask the group a question?
   c. The participants should be able to **complete it in a reasonable amount of time**, generally less than one hour for a written pre or posttest.

- **For written pre/posttests, you should use question formats that are easy to complete rapidly** (e.g., fill in the blank, multiple choice, matching), but avoid formats that are easy to guess (e.g., True/False type questions). In the beginning, you will have to spend time explaining how to fill out the posttest (e.g., how to mark multiple choice questions properly). After the participants have done it once or twice, however, they probably will not need help in filling out the written form.
- **Verbal pre/posttests should be shorter** since you have to use them individually, with each person. If there are 20 people in a group and you have two trainers, structure the verbal pre/posttest so that it takes no more than about three minutes for each person. It is a good idea to include questions on the key messages only for verbal pre/posttests.

d. **The pre/posttest should be able to be scored easily and quickly.** When the pre/posttest is very complicated, for example, having tables that have to be filled in, it can become difficult to score them. Use basic question formats that are easy to score. Avoid using too many open-ended questions since they are harder and more time-consuming to score. Develop a "key" prior to use of the pretest, a filled-in questionnaire that has all the correct responses on it. Assure that everyone grading the pre/posttests has a copy of the key and is following it.

e. **Once the pre and posttest scores are calculated, compare them.** Take an average of the pretests and an average of the posttest scores. You can calculate what percentage of the scores was above and below certain levels (e.g., what percentage was below 50%). You should generally expect that the average posttest score of a well-done training would be greater than 75%. Rarely will you find that everyone has a score over 95%. In order to assure that people know more than 75% of the material that you have taught, you may need to use refresher courses and use Quality Improvement and Verification Checklists.

f. **Consider reporting the results in terms of *changes in a performance index*.** Often, changes from a pretest to posttest score are reported in terms of *absolute percentage increases*. For example, an increase from 20% to 40% of correct responses would be reported as a 100% increase using the formula:

$$\frac{\textit{Posttest score} - \textit{Pretest score}}{\textit{Pretest score}} = \frac{40 - 20}{20} = \frac{20}{20} = 100\% \text{ increase}$$

While this is an acceptable way of reporting changes in an indicator, it can be misleading when posttest scores are low: a participant who goes

from a score of 20% to a score of 40% may not be as significant to an organization as a participant who goes from 50% to 100% (despite the fact that both experience a 100% increase). **One way around this problem is to calculate increases using a *performance index*.**[66] The *performance index* is the proportion of the gap between the baseline level and the ceiling of 100 percent that is eliminated during a training or educational session. The *performance index* is calculated as the reported increase between the baseline and final level divided by the maximum possible increase (100 percent minus the baseline percentage value). Thus, to calculate a change from 20% at pretest to 40% at posttest, the formula used for this is:

$$\frac{\text{Posttest Score} - \text{Pretest Score}}{100 - \text{Pretest Score}} = \frac{40 - 20}{100 - 20} = \frac{20}{80} = 25\%$$

For a participant who goes from a score of 50 to 100%, the performance index would be 100% (100-50/100-50).

<u>Example of a Good Pre/Posttest</u>
(Show the overhead of the Sample Pre/Posttest, Nutrition. Discuss how it fits the criteria.)

<u>Exercise</u>
(Have the participants divide into their teams and develop a written pre/posttest to go with their lesson plan. They should do this on overhead transparency so they can show it to the rest of the participants. They do not have to finish their pre/posttest, just get it started.)

---

[66] This methodology is explained in Weiss W., Storms D., Winch P. 1998. "Performance of Private Voluntary Organizations in Increasing Population Levels of Child Survival Behaviors and Knowledge in Developing Countries" in Weiss W. (ed.), <u>In Search of Results: Report of the KPC Final Analysis</u>. PVO Child Survival Support Program, The Johns Hopkins University School of Public Health. Baltimore, MD.

Sample Pre/Posttest, Growth Monitoring/Promotion

(In the part below, circle the best answer for each question. There is only one correct answer for each question.)

1. **When you are weighing a child to see how he is growing, what clothes can the child be wearing?**
   a. He can wear shoes and a diaper only.
   b. He can wear a T-shirt, a diaper and shoes only.
   c. He can wear a dry diaper only.
   d. He can wear anything.

2. **When should a child first be weighed by the Promoter?**
   a. As soon after birth as possible.
   b. After he is about 3 months old.
   c. After he is about 6 months old.
   d. When he begins to lose weight.

3. **At what height should the balance be placed when you weigh a child?**
   a. At the height of your chest.
   b. At the height of your face.
   c. Just above your head.
   d. It does not matter.

4. **If a child is too little to hold up its head, what should you use to weigh the child?**
   a. a bucket.
   b. a piece of plastic.
   c. a diaper.
   d. the same thing you use for older children.

5. **On the "Road to Health" growth chart of a healthy child, what direction should the growth curve go?**
   a. it should rise each month.
   b. it should go down each month.
   c. it should stay level each month.
   d. it should rise each month for 4 months, then go down until one year of age.

6. **On the Road to Health chart, what does it mean if a child's weight falls below the road to health?**
   a. The child is healthy.
   b. The child is malnourished.
   c. The child is overweight.
   d. The child is anemic.

7. **You weigh a child who is 6 months old in October and he weighs 7 kilos. His weight falls in the middle of the Road to health. You weigh him again in November and he weighs 6 kilos, still within the Road to Health. What should you do?**
   a. Congratulate the mother -- Her child is still well nourished.
   b. Tell the mother that her child is not doing well, but you do not need to give her advice on how to make him grow.
   c. Find out why the child did not gain weight and give the mother advice on how to make him grow.
   d. Do not say anything to the mother. Wait until the child's weight falls outside of the Road to Health to tell the mother (so as not to startle her).

8. **What is more important to mention to a mother, whether or not her child is gaining weight or whether or not he is on the Road to Health?**
   a. Whether or not he is gaining weight.
   b. Whether or not he is on the Road to Health.
   c. Neither is very important.

9. **After birth and before a child is 3 months old, which foods should he eat?**
   a. Breast milk and other liquids in a baby bottle.
   b. Breast milk, Juice, and foods mashed up very well.
   c. Breast milk and water only.
   d. Breast milk only.

10. **When should a mother start giving solid or semi-solid food to her baby?**
    a. shortly after birth.
    b. at 2 months of age.
    c. at 4 months of age.
    d. at 6 months of age.

11. **What is the best way to give a child his first semi-solid food?**
    a. Using a baby bottle.
    b. Using a hose or long-handled shovel.
    c. Using a cup and clean spoon.
    d. Using your hands.

12. **For how long can you store cooked food for a small child (without refrigerating it)?**
    a. No more than 15 minutes.
    b. About 2 hours, not more.
    c. About 5 hours, not more.
    d. One day if the food is not in the sun.

13. **When is a child most likely to become anemic?**
    a. Between 0 and 6 months of age.
    b. Between 6 and 18 months of age.
    c. Between 18 and 36 months of age (1.5 - 3 years old).
    d. From 5 - 10 years of age.

14. Should a woman continue to breastfeed her child when he has diarrhea?

a. Yes.
b. Yes, but only if the child is not dehydrated.
c No.

15. When should a child begin eating almost everything that the other members of the family normally eat?

a. at 3-6 months of age
b. at 7 months of age
c. at 18 months of age
d. at 24 months of age

16. How many times a day should a two-year-old child eat?

a. 1-2 times a day
b. 2-4 times a day
c. 4-6 times a day
d. 6-8 times a day

17. What is the best thing to add to a child's food to make it have more calories?

a. sugar
b. salt
c. rice or corn
d. margarine or oil

(Fill in the blanks.)

18. What are the 5 steps in Growth Monitoring and Counseling?

a. _____
b. _____
c. _____
d. _____
e. _____

19. On the growth chart, why do we fill in all of the boxes with the child's birthdays before filling in the other boxes?

_____

20. Besides the dots that represent a child's weight, what should you write on the vertical lines on the growth chart?

_____

21. What is the purpose of doing growth monitoring and counseling?

_____

22. What are 4 questions that you would ask a mother to determine why her child lost weight?

a. _____

b. _____

c. _____

d. _____

23. Name two foods mentioned during the workshop that contain lots of Vitamin A:

a. _____

b. _____

Annex F

Note: ***Print on Legal***

INFORMAÇÃO SEMI-ANUAL DE CONHECIMENTO E PRÁCTICA

Comunidade _____ Promotor _____ Chefe de Saúde _____

Número do Grupo _____ Data _____

Nome da criança	Data de nascimento	Quantos meses tem?	Dá peito?		Dá mais alguma coisa?		Come 3 vezes ao dia ou mais?		Dá óleo nas papas enriquecidas?		Últimas Duas Semanas: Teve diarréia?		Aumentou líquidos?		Aumentou comida?		Deu mais quantidade de leite materno?		Deu líquido apropriado?*		Recebeu DPT3?		Quantas sinais de desidratação conhece a mãe?*		Tomou cápsulas de Vitamina A nos últimos seis meses?		Tomou comprimidos de Mebendazole nos últimos seis meses?		A criança comeu alguma coisa rica em Vitamina A ontem?*		A criança teve malaria nas Ultimas duas semanas?		Quando recebeu tratamiento? n=nunca 0 = mesma dia 1 =1 dia depois 2 = 2 dias depois
			S	N	S	N	S	N	S	N	S	N	S	N	S	N	S	N	S	N	S	N	0-1	2-8	S	N	S	N	S	N	S	N	

*Líquidos Apropriados- Pacote de UNICEF, àgua de arroz, soro caseiro, papas liquidas, sumos liquidos, agua de lanho ou coco, cha

*Sinais de desidratação- falta de lagrimas, pouca orina, sede, olhos encovados, fontanella deprimida, prega cutanea

*Rico em Vitamin A- cenoura, manga, papaia, ovo, folhas verdes oscuras, figado, abobora, batata doce amarella

Annex G
Study on Mothers' Use and Reaction to the MCH Calendar

INFORME SOBRE PERCEPCION Y MANEJO DEL CALENDARIO MATERNO INFANTIL

I. INTRODUCCION.

Project Concern International (PCI) está realizando proyectos de atención primaria en salud con las comunidades organizadas y el MINSA desde el año 1991 en Nicaragua (Acahualinca 1991-1994; Distrito IV Managua 1994-1997), su quehacer está centrado en facilitar procesos educativos en salud, favoreciendo los vínculos entre el MINSA y la Comunidad y aumentando los conocimientos y habilidades en los prestadores de servicios y las comunidades.

Desde el año 1997 está ejecutando en cuatro municipios de Jinotega, proyectos de salud materno-infantil y alimentación complementaria, con amplia participación comunitaria.

Dentro de sus estrategias de trabajo está contemplado implementar un Sistema de Información en Salud que integre la información de las comunidades y de las unidades de salud del MINSA, lo que posibilitaría apropiar a las comunidades de su propia situación de salud y búsqueda organizada de alternativas, así como proporcionar al Ministerio de Salud toda aquella información que se queda en la comunidad y que les permitiría tener una mejor valoración y actuación ante los problemas de salud.

Como paso previo a la implementación del Sistema de Información Comunitario en Salud, se sometió a pilotaje uno de sus instrumentos principales de trabajo: el Calendario Materno Infantil, en 38 comunidades de cuatro municipios de Jinotega, durante un período de cuatro meses.

En el presente documento se presentan los resultados de la investigación operativa ¨Percepción, manejo y utilización del Calendario Materno Infantil por las madres de niños menores de 1 año y embarazadas¨.

II. OBJETIVOS.

⇒ Conocer qué percepción tienen las madres y embarazadas sobre el Calendario Materno Infantil.

⇒ Identificar qué logros o limitaciones tienen las madres y embarazadas en el manejo y utilización del Calendario Materno Infantil.

III. PROCEDIMIENTO.

A fin de obtener información acerca de la percepción, manejo y utilización del Calendario Materno Infantil durante el período de validación del mismo (meses de Mayo, Junio, Julio y Agosto del año

1988), se encuestaron un total de 151 madres de niños menores de un año y embarazadas, quienes recibieron el CMI durante el mes de Mayo.

El instrumento de recolección de la información fue un cuestionario con 15 preguntas abiertas y cerradas y la técnica utilizada fue la entrevista. Las entrevistas fueron realizadas por los Promotores de salud de PCI, en las comunidades que ellos atienden.

IV. RESULTADOS.

1. Características de las entrevistadas.

Se entrevistaron un total de 151 mujeres, de los 4 municipios del área del proyecto.

MUNICIPIO	NUMERO	PORCENTAJE
CONCORDIA	24	15.9%
PANTASMA	48	31.8%
SAN RAFAEL DEL NORTE	24	15.9%
YALI	55	36.4%
TOTAL	151	100.0%

El grupo de mujeres entrevistadas tiene un promedio de 25 años. La edad de la madre más joven es de 15 años y la de mayor edad 45 años.

El 10% (15) de las mujeres entrevistadas son mujeres embarazadas y un 90% (136) son madres de niños menores de 3 años.

El 99% (149) de las mujeres entrevistadas tienen tarjeta de control de crecimiento y desarrollo o de control prenatal.

El 77% (105) de los niños son menores de 1 año y un 23% (31) mayores de un año. El promedio de edad de los niños es de 9 meses.

2. Visitas de brigadistas a las mujeres entrevistadas en la comunidad.

La mayoría de las mujeres entrevistadas, un 83% (125) han sido visitadas en sus casas por un brigadista de salud durante el período evaluado. El 17% (26) no ha recibido visitas de un voluntario de la comunidad.

VISITAS DE BRIGADISTA	NUMERO	PORCENTAJE
SI	125	82.8%
NO	26	17.2%
TOTAL	151	100.0%

En cuanto al número de veces que han sido visitadas las mujeres entrevistadas, el 26.4% (33) de ellas ha recibido una visita mensual, el 24% (30) una visita bimensual y el 9% (11) dos visitas mensuales.

NUMERO DE VISITAS	NUMERO	PORCENTAJE
Una trimestral	16	12.8%
Una bimensual	30	24.0.%
Una mensual	33	26.4%
Cuatro en 3 meses	22	17.6%
Cinco en 3 meses	11	8.8%
Dos mensuales	11	8.8%
Sin respuesta	2	1.6%
TOTAL	125	100.0%

La mayoría de las mujeres entrevistadas, 87% (131) consideran que las visitas del brigadista les han sido útiles, fundamentalmente porque les brindan orientaciones.

¨Ellos nos explican y revisan las tarjetas y si nos falta el control nos mandan al centro. Le explican cómo es el uso del cereal y el aceite¨.

Al preguntarles a las mujeres entrevistadas si es importante que un brigadista de salud las visite, todas ellas expresaron que era de mucha importancia porque les brindan orientaciones de salud, ayuda o apoyo.

¨Nos dan consejo para cuidar al niño, porque nos orientan dar suero oral cuando hay diarrea y qué hacer cuando el niño tiene tos y fiebre¨.

¨Porque le dicen qué remedios caseros les puede hacer uno a los niños y porque le hago preguntas de salud¨.

En cuanto a la frecuencia de las visitas a los hogares, el 42% (64) expresó que a ellas les gustaría que un brigadista de salud las visite mensualmente y un 26% (39) quincenalmente.

FRECUENCIA DE LAS VISITAS	NUMERO	PORCENTAJE
Ninguna	2	1.3%
Mensual	64	42.4%
Quincenal	39	25.8%
Cada 10 días	3	2.0%
Semanal	15	9.9%
Cuando quieran	11	7.3%
Todos los días	17	11.3%
TOTAL	151	100.0%

3. Consejos de salud brindados por el brigadista.

El 88% (133) de las mujeres entrevistadas expresaron que han recibido consejos u orientaciones de salud por parte de los brigadistas de salud de su comunidad.

RECIBIO CONSEJOS DE SALUD	NUMERO	PORCENTAJE
SI	133	88.1%
NO	18	11.9%
TOTAL	151	100.0%

El 60% (79) de las entrevistadas refirieron que las orientaciones que han recibido han versado sobre diferentes temas, en cambio a un 32% (41) de ellas solamente les han hablado sobre un tema, a un 6% (8) sólo le han brindado orientaciones sobre el retiro de alimentos o invitaciones a actividades educativas y un 2% (3) no recuerda de qué temas les han hablado.

En relación a los contenidos de los consejos de salud, los principales temas que trasmitieron los brigadistas a las mujeres entrevistadas fueron sobre diarrea, higiene e infecciones respiratorias agudas.

TEMAS	NUMERO
Diarrea	59
Higiene	54
Infección Respiratoria Aguda	40
Lactancia Materna	23
Nutrición	19
Control Prenatal	19
Control Crecimiento y Desarrollo	18
Inmunizaciones	9
Planificación Familiar	2

¨Nos enseña de que los niños cuando tengan diarrea hay que darles suero y me dice que la leche materna no se la quite, que cuando tiene más de 6 meses le enseñe a comer al niño¨.

4. Calendario Materno Infantil (CMI)

- *Procedimientos en el llenado del CMI*

El 100% (151) de las mujeres entrevistadas recibieron el Calendario Materno Infantil y todas ellas manifiestan que los brigadistas de salud les explicaron cómo debía llenarse el calendario.

El procedimiento que describen es que se debe de colocar una X en la figura correspondiente a la enfermedad o acción de salud que se realice con el niño o que realice la embarazada cada mes. Muy pocas entrevistadas explicaron cómo se debe de llenar la lactancia materna.

¨Que marcara en los cuadritos con una equis cuando llevaba al niño a control, o cuando voy a control del embarazo marco con una equis en el cuadrito¨.

- *Utilidad del Calendario Materno Infantil*

Las entrevistadas consideran que el Calendario Materno Infantil les ha servido, principalmente porque les sirve como registro y para marcar las acciones, sin embargo es importante destacar que casi la mitad de ellas mencionan que el CMI les ha servido para mejorar los cuidados de salud, para recibir mensajes de salud, para actuar ante las primeras señales de enfermedad, para prevenir y como recordatorio de las acciones de salud a realizar.

UTILIDAD DEL CMI	**NUMERO**	**PORCENTAJE**
Mejorar cuidados	24	16.1%
Consejos de salud	16	10.7%
Actuar	4	2.7%
Prevención	2	1.3%
Registro	44	29.5%
Marcar las acciones	35	23.5%
Recordatorio	24	16.1%
Total	149	100.0%

¨Para llevar el control del niño en el mes, de la alimentación y también se observa cómo y cuántas veces se me enferma el niño al mes. También me sirve en el cuadro de las vitaminas, para saber qué verduras debo darle al niño¨.

Al preguntarles a las mujeres entrevistadas si el CMI les sirve para controlar mejor su salud o la salud del niño, un 99% (150) expresó que sí.

Ellas consideran que el CMI les sirve de registro, para valorar la salud del niño o de ellas, como recordatorio, a través de éste reciben orientaciones por los brigadistas de salud, actúan ante situaciones de alarma y se sienten ayudadas o apoyadas por los brigadistas.

UTILIDAD DEL CMI	NUMERO	PORCENTAJE
Registro	54	38.5%
Valorar la salud	26	18.6%
Recordatorio	21	15.05
Orientaciones	21	15.0%
Actuar	16	11.4%
Ayuda	2	1.4%
Total	140	100.0%

¨Bueno, porque allí tiene todo lo que tiene uno que hacer, lo que tiene que darle de vitaminas, que tiene que tenerlo en control y las vacunas¨.

5. Charlas impartidas por los brigadistas de salud

El 89% (134) de las entrevistadas han recibido charlas de salud impartidas por brigadistas. Solamente un 11% (17) de las entrevistadas no ha recibido charlas, los motivos principalmente son: llega tarde al puesto de distribución de alimentos, no tiene con quien dejar a los niños, falta de tiempo, no dan charlas en su comunidad, no la invita el brigadista a las charlas; una madre menciona que no ha querido asistir. Como se puede observar las madres que no asisten a las charlas, es una minoría y los motivos expresados d}son de mucha validez.

HA RECIBIDO CHARLAS	NUMERO	PORCENTAJE
SI	134	88.75%
NO	17	11.25%
TOTAL	151	100.0%

En relación con las orientaciones o mensajes que han recibido en las charlas el 77% (100) de las entrevistadas mencionan que han recibido varios temas de salud, el 61% (80) solamente un tema, un 3% (4) orientaciones sobre actividades a realizar y un 1% (2) no recuerda los temas.

En cuanto a los contenidos de los consejos de salud, los temas principales que trasmitieron los brigadistas a las mujeres entrevistadas en la charlas fueron sobre diarrea, infecciones respiratorias agudas y nutrición.

TEMAS	NUMERO
Diarrea	79
Infección Respiratoria Aguda	66
Nutrición	40
Control Prenatal	39
Higiene	35
Lactancia Materna	28
Control Crecimiento y Desarrollo	13
Inmunizaciones	3
Planificación Familiar	2

6. Recomendaciones de las mujeres entrevistadas para mejorar las charlas y visitas domiciliares

En cuanto a las visitas domiciliares recomiendan que continúen los brigadistas realizando las visitas y que sean con mayor frecuencia.

Respecto a las charlas, sugieren que continúen las charlas, que avisen con anticipación la fecha de las charlas y tener un día y horario fijo, dar dos charlas por mes, en el Puesto de distribución dar las charlas más cortas, dar charlas los fines de semana, abordar los temas de planificación familiar y remedios caseros, entrega de plegable posterior a la charla, que sean más participativas, que se den más recomendaciones, entrega de recetario de CSB y reunir a las madres para darles charlas.

También recomiendan que se realicen reuniones con las madres y reuniones comunitarias para abordar los problemas de salud de la comunidad y el trabajo de los brigadistas.

V. CONCLUSIONES.

⇒ Generales

Las mujeres entrevistadas, madres de niños menores de un año y embarazadas tienen una percepción positiva sobre el Calendario Materno Infantil, consideran que el CMI les ha servido, fundamentalmente para mejorar los cuidados de salud de sus hijos o de ellas mismas.

Se demostró que el CMI es un instrumento sencillo, fácilmente llenado e interpretado por las madres, ellas sienten un mayor vínculo con el Proyecto.

⇒ Específicas:

Las mujeres entrevistadas, en su mayoría son jóvenes, lo que permite una mayor apropiación de nuevas ideas y contenidos de salud.

En cuanto a los requisitos de entrega del CMI, en su mayoría se han cumplido: mujeres embarazadas y madres de niños menores de 1 año. Solamente una minoría de los brigadistas seleccionó madres con niños mayores de 1 año.

La mayoría de las mujeres tienen tarjeta de control de crecimiento y desarrollo de su hijo pequeño y las embarazadas cuentan con tarjeta de control prenatal, ésto es indicativo de que esta población está receptiva a las orientaciones que los brigadistas están realizando en cuanto a la promoción de asistencia a los programas preventivos y de control de salud.

A pesar de que la mayoría de las mujeres entrevistadas han sido visitadad en sus hogares por brigadistas de salud, aún no hay una uniformidad en la frecuencia de visitas programadas mensualmente. Solamente una cuarta parte de las entrevistadas fueron visitada mensualmente como está establecido, habría que revisar con los brigadistas involucrados, qué elementos intervinieron en la no visitar regular.

Existe una valoración positiva de las madres alrededor de las visitas domiciliares realizadas por el brigadista, consideran que les han sido útiles, fundamentalmente porque reciben orientaciones de salud y están interesadas en que este tipo de actividad educativa continúe.

Las principales opciones de las madres en relación con la frecuencia de las visitas a los hogares, son visitas mensuales o quincenales.

La mayoría de las mujeres entrevistadas han recibido consejos u orientaciones de salud por parte de los brigadistas de salud de su comunidad, los consejos han sido fundamentalmente sobre la diarrea, higiene e infecciones respiratorias agudas. Lo que está en concordancia con las capacitaciones que ellos han recibido y con los principales problemas de salud en la comunidad.

Todas las mujeres entrevistadas recibieron el Calendario Materno Infantil y conocen los procedimientos para el llenado del mismo. Una limitante es que aún no está claro cómo se debe anotar en el CMI la lactancia materna y la lactancia materna exclusiva.

La mayoría de las entrevistadas han recibido charlas de salud impartidas por brigadistas, los principales temas abordados fueron diarrea, infecciones respiratorias agudas y nutrición.

Las razones por las cuales las entrevistadas no han recibido charlas se centran sobre todo en aspectos que las limitan a asistir a éstas (llegadas tarde al puesto de distribución de alimentos, no tiene con quien dejar a los niños, falta de tiempo, no imparten charlas o no las invitan).

Las recomendaciones brindadas por las madres para mejorar las visitas domiciliares y charlas se centran en continuar con este tipo de actividad y que sean más frecuentes, así como realizar reuniones con las madres y con la comunidad para abordar los problemas de salud de la comunidad y el trabajo de los brigadistas.

VI. RECOMENDACIONES.

Enseñar a todas las madres de niños menores de un año y embarazadas cómo el Calendario Materno Infantil puede contribuir en el mejoramiento de los cuidados de salud de sus hijos o de ellas mismas en el hogar.

Implementar el Censo de embarazadas y niños menores de 1 año en cada comunidad y captar continúamente beneficiarios para el CMI.

Establecer que las visitas domiciliares por los brigadistas de salud sean sistemáticas, de preferencia mensual, si la embarazada o el niño son inasistentes a los Programas del Ministerio de Salud, realizar la visita quincenal.

Valorar con promotores y brigadistas de salud, los factores que incidieron para que las visitas domiciliares no fueran sistemáticas durante el período de validación del CMI.

Elaborar programación de contenidos para las visitas domiciliares mensuales y que éstos sean los mismos temas que se abordan en las charlas mensuales. Que los brigadistas además, brinden consejos de salud de acorde a la situación o problema de salud que encuentren en el hogar en el momento de la visita.

En las entregas de CMI a la población objetivo explicar más claramente el procedimiento para el llenado de la lactancia materna y la lactancia materna exclusiva.

Revisar y analizar los motivos por los cuales no se están brindando charlas o no están invitando a las madres en algunas comunidades.

Realizar reuniones con las madres y con la comunidad para abordar los problemas de salud de la comunidad y dar a conocer el trabajo realizado por los brigadistas.

Febrero de 1999

Annex H
Grain Storage Silos Maintenance Questionnaire

MINISTERIO DE AGRICULTURA Y GANADERIA
AGENCIA SUIZA PARA EL DESARROLLO Y LA COOPERACION
UNIDAD COORDINADORA POSTCOSECHA DE EL SALVADOR

CO SUDE

ENTREVISTA SOBRE MANEJO DEL GRANO ALMACENADO EN SILO METALICO

Fecha de visita				No BOLETA
	Día	Mes	Año	

I. INFORMACION GENERAL				
1. Nombre del agricultor:				
2. Capacitador:	Técnico ( )	Artesano ( )	Lider campesino ( )	Nadie ( )
3. Institución de apoyo:				
4 Ubicación:	Caserío			Cantón
	Municipio			Departamento
II. MANEJO DEL SILO METALICO				
5 Año de compra del silo metálico:			6. Grano almacenado:	
7. Mes y año de almacenamiento del grano:		8. ¿Ha tenido pérdidas de grano en el SM?		
		si ( )	no ( )	
9. Razón (es) de las pérdidas:				
10. Tiempo de secado del grano antes de almacenarlo:	- 3 días ( )	3 días ( )	+ de 3 días ( )	No asolea ( )
11. ¿Antes de almacenar el grano, realiza las actividades de?			Selección	si ( ) no ( )
			Limpieza	si ( ) no ( )
			Enfriamiento	si ( ) no ( )
12. ¿Revisa el estado del SM antes de utilizarlo?			si ( )	no ( )
13. ¿En qué consiste la revisión?		Limpieza	( )	
		Ubicación de agujeros	( )	
		Corrosión	( )	
14. ¿Utiliza Fosfamina para la fumigación del grano almacenado?			si ( )	no ( )
Nº de aplicaciones efectuadas:	¿Fecha última aplicación?		Si la respuesta es no, ¿Qué utiliza?	
Si utiliza fosfamina, ¿Qué dosis utiliza?		Volumen del SM ____ qq		Dosis:_____ pastillas
15. ¿Dónde coloca las pastillas?	Arriba del grano ( )	Entre el grano (	¿En que coloca la pastilla?	
16. ¿Sella su silo metálico?	si ( )		no ( )	
¿Qué utiliza para sellar?				
17. Tiempo de espera para romper el sello del silo:	- 10 días ( )	10 días ( )	+ 10 días ( )	
18. Realiza revisión del grano almacenado?		si ( )		no ( )
Frecuencia de revisiones:	- 1 mes ( )	1 mes ( )	+ 1 mes ( )	
19. ¿Cómo vacía o vaciará los últimos quintales del SM?		Con azada ( )		Inclinado ( )
20. ¿Tiene argollas para candado el SM?		si ( )	no ( )	Bien ubicadas: Si ( ) No ( )
21. ¿Quién tiene a su cargo en el hogar el vaciado del SM		Hombre ( )	Mujer ( )	Ambos ( )
22. ¿Desearía comprar otro silo metálico? si ( ) no ( )		23. ¿El afiche que tiene su silo le ha servido? si ( ) no ( )		

MINISTERIO DE AGRICULTURA Y GANADERIA
AGENCIA SUIZA PARA EL DESARROLLO Y LA COOPERACION
UNIDAD COORDINADORA POSTCOSECHA DE EL SALVADOR

VERIFICACION VISUAL DEL SILO METALICO Y EL GRANO ALMACENADO

CONDICIONES DEL SILO METALICO			OBSERVACIONES
Ubicación:	bajo techo ( )	a la intemperie ( )	
[redacted]			
Protegido de la lluvia:	si ( )	no ( )	
[redacted]			
[redacted]			
Condiciones del SM:	abollado ( )	picado ( )	
Buenas Condiciones ( )	oxidado ( )	roto ( )	
[redacted]			
¿Está sellado correctamente?	si ( )	no ( )	
[redacted]			
Porcentaje de humedad del grano (bh):			
Menor del 15% ( )	*Mayor del 15% ( )*		
[redacted]			
[redacted]			
CONDICIONES DEL GRANO ALMACENADO			**OBSERVACIONES**
Apariencia del grano:	sano ( )	dañado ( )	
	limpio ( )	sucio ( )	
[redacted]			
Olor del grano:	normal ( )	anormal ( )	

Annex I
ACDI Oral Posttest Questions for Microfinance

Exame Oral

Nome do Cliente _____ Cln Nº _____ Grupo Nº _____

1. Se O Sr(a) _____ não pagar a sua prestação, Quem pagará no seu lugar?

_____

2. Quais são as vantagens do totocaixa?

_____

3. Que pensa do grupo? _____

_____

4. Quais são as vantagens da associação funerária? _____
_____

5. Quais são os requisitos necessários para obtenção de um empréstimo?

_____

_____

6. Se um empréstimo for de _____, quanto é o fundo de garantia? _____

Qual é o juro? _____, E a cota? _____.

7. Se um dos elementos não pagar a dia, quem Responsabilizará? _____.

Data da 1ª Formação _____

Data da 2ª Formação _____

Assinatura do Cliente _____

Data da 3ª Formação _____

Annex J

ACDI/VOCA's Client Adoption of Practices Questionnaire Form

ID # _____ **Rúbrica do Inquiridor**_____

1) Nome da Pessoa Inquirida _____ 2) Data do Inquérito_____

3) Ilha _____ 4) Ribeira _____ 5) Localidade _____

6) Nome do(a) chefe de família _____
(não é necessáriamente a pessoa da lista fornecida pela ACDI/VOCA)

7) Sexo de Chefe: Homen Mulher 8) Idade de Chefe _____ 9) Estado civil _____

10) # Adultos (13-64 anos) _____ # Idosos (>= 65 anos) _____ # Crianças (<= 12 anos) _____

I. CARACTERÍSTICAS DEMOGRÁFICAS DAS PESSOAS DA CASA - AGREGADO
(incluir o chefe da familia na primeira linha)

Nome dos membros da família	Relação ao Chefe	Sexo	Idade	Obs.
	Chefe			

II. RECURSOS EM 2000

11) **Acesso a terrenos Agrícolas**

Tipo de Exploração	**SIM/ NÃO**	**Nº de Parcelas**	**Área Total (em Litros)**
Sequeiro			
Regadio - Irrigação Tradicional			
Regadio - Irrigação Gota-a-Gota			

12) Tem terras que outra pessoa trabalha e que dá rendimento? SIM NÂO

13) **Efectivo Pecuário**

	Adultos	Cria	Venda	Perdido/Oferta/ Roubado	Consumido
Bovinos					
Equinos					
Caprinos					
Suinos					
Aves					
Outros					

Actividades Remuneradas

14) O Inquirido ou alguém do agregado familiar recebeu ajuda monetárias ou sociais durante 2000?

Pôr um circulo na resposta: SIM NÃO

15) Que tipo de Ajuda?

Tipo de Ajuda	**Escudos Caboverdianos/MΛs (a)**	**# Vezes em 2000 (b)**	**Total/Ano (a) x (b)**
Dada pelo pai, mão, outra pessoa em Cabo Verde mas for a do agregado			
Remessas			
Serviços Sociais			
Pesão de Reforma			
Associação			

(se recebeu só uma vez, escreve somente na colunta de "total/ano")

16) Se recebe comida quais são as-quantidades de:

Item	**Quantidade/Mês (a)**	**# Vezes/Ano (b)**	**Quantidade Total por Ano (a) x (b)**
Milho			
Lentilha (Pinto)			
Oleo			
Açúcar			
Camoca			
Outra			

(se recebeu só uma vez, escreve somente na colunta de "total/ano")

17) O Inquirido ou alguém do agregado familiar exerce actividades remuneradas (Frentes de trabalho, trabalhador em propriedade de outros, actividade doméstica, etc) ?

Pessoas do Agregado / Familiar	**Actividade**	**Se está na Frente da Associação CSA pôr um √**	**Salário ou Rendimento por Dia/Mês (a)**	**# de Dias por Mês (b)**	**# de Meses em 2000 (c)**	**Total (a)x(b)x(c)**

(Incluia todas as pessoas que tenha rendimento)

18) Outras Actividades Econ∴micas

ACTIVIDADES	**RECEITAS POR MÊS (a)**	**DESPESAS POR MÊS**	**# VEZES EM 2000 (b)**	**TOTAL (a) x (b)**
Rabidante / Comerciante				
Produção Hortícola (por conta propria)				
Venda de Animais				
Venda de Produtos de Animais (leite, manteiga, queijo, ovos, pele)				
Micro empresa/Indústria				
Outras				

III. SITUAÇÃO DENTRO DO MOVIMENTO DAS ASSOCIAÇÕES

(Pôr um circulo à volta da resposta. Tem a certeza que as perguntas 22 E 23 estão marcadas. Verifique se a resposta da 23 corresponde à resposta da pergunta 17. Exemplo: Se disse que tem uma pessoa na frente da associação mas não indicou nenhum salário na pergunta 17)

22) O inquirido ou alguém do agregado é sócio duma associacão empreiteira de obras? SIM NÃO

Se **SIM**, qual é o nome da associação? _____

Se **NÂO**, porquê? _____

23) O inquirido ou alguém do agregado trabalha numa das frentes da associação? SIM NAO

Nome da associação: _____
Função (ões): _____

24) Quais os benefícios de ter uma associação dentro da ribeira?

(Deixe a pessoa falar`a vontade - Marcar com um X os itens que o inquirido mencionar. Não perguntar o inquirido se ele/ela está de acordo com cada um dos itens em baixo)

a) Oportunidade de **emprego** ____
b) Ter **obras** de CSA na sua **propriedade** ____
c) Poder **participar na planificaHνo** das obras ____
d) Receber uma A**gratificacao** se houver produtividade no trabalho ____
e) **Melhorar a zona** com obras de conservacao de solo e água ____
f) A AssociaHvo garante a **qualidade das obras** que ela constrúi ____
g) **Pagamento** de salário **atempadamente** ____
h) Oportunidade de **trabalho seis dias** por semana (segunda até Sábado) ____
i) Poder **trabalhar perto** de casa ____
j) Acesso a **crédito** através da associacao ____
k) A associacao dá **apoio social** aos moradores ____
l) **Desenvolvimento das aptidτes** dos moradores da ribeira ____
m) Outro(s) beneficio(s)? Especifique ____

25) Quais as responsabilidades ou obrigacoes duma associacao?(Marcar com X os itens que o inquirido mencionar)

(Deixe a pessoa falar à vontade - Marcar com um X os itens que o inquirido mencionar. Não perguntar o inquirido se ele/ela está de acordo com cada um dos itens em baixo)

a) Assegurar a **produtividade** ____

b) **Produzir** obras de boa **qualidade** ____

c) **Assumir** as **responsabilidades de manutencao** das obras feitas pela associacao ____

d) **Informar** aos sócios dos **balancos contabilísticos** da associacao ____

e) **Pagar a jóia, quota** e percentagem do **contrato** a **OASIS** para servicos técnicos e de reparacao ____

f) **Cumprir contrato** de execucao de obras **CSA** com a **DGASP** ____

g) **Assegurar** que os trabalhadores recebam os **salários atempadamente** ____

h) Assegurar que **uma pessoa por família** tem direito a trabalhar nas frentes de ASSOCIACOES, dando **prioridade as famílias mais carénciadas** ____

i) Nvo mexer na **politica** ____

j) Manter os **sócios envolvidos nas actividades** das associacaes (levar a cabo **assembleias gerais** e outros **encontros** conforme as necessidades) ____

k) Garantir que todos os s∴cios e agricultores do zona **participem** nas actividades anuais de **planificacao de obras** a serem contractadas com a DGASP ____

l) Assegurar que todos os orgaos sociais da associacao estao a trabalhar e que as pessoas eleitas svo **competentes** para empreender o cargo designado

____

m) Assegurar que haja uma **distribuicao equitativa** entre os sócios e moradores dos benefícios das obras CSA a serem construídas ____

n) Quando houver **ganho** nos trabalhos contractados, **fazer distribuicao** duma parte aos trabalhadores ____

o) **Apoiar** aos sócios na **procura de empréstimos** de investimentos produtivos ____

p) Outro (especifique) _____

(Se a pessoa não souber, escreva "não sabe". Nunca deixe o espaço em branco.)

26) Como é que os lideres e sócios da associacao determinam o tipo e localizacao das obras a serem feitas?

_____

27) Para as obras que sao executadas pela associacao, o inquirido ou alguém do agregado foi consultado sobre:

Ano	Tipo de Obra	LocalizaHvo da Obra
Ano passado (2000)	Sim Nao	Sim Nao
Para este ano (2000)	Sim Nao	Sim Nao

28) Como é que a associacao pode melhorar os seus serviços e contribuicaes em benefícios dos sócios?

_____

IV. ACTIVIDADES DE CONSERVAÇÃO DE SOLOS E ÁGUA

29) Na sua opinião, existem beneficios na utilização das seguintes prácticas agrícolas?

(Use os códigos abaixo na Justificação. Não é necessário escrever toda a resposta. Nunca deixe sem resposta. Se a pessoa não souber, ou não quer responder, indica.)

Prática Agrícola	Sim	Não	Não Sabe	Justificação
A. Armazenamento / Utilização de estrume				
B. Plantação de feijão Congo				
C. Foice para cortar palha				
D. Barreiras vivas plantadas em contorno				
E. Plantação de carrapatos carriços nas linhas de água				
F. Construção de arretos				
G. Construção de diques				
H. Plantação de árvores				

A.1: Adubo A.2: Retém humidade do solo A.3: Aumenta de produção agrícola

B.1: Controla erosão do solo B.2: Aumenta fertilidade do solo B.3: Produção das plantas (grão, palha, lenha, etc.)

C.1: Controla erosão do solo C.2: Recuperação mais rápida da pastagem

D.1: Controla erosão do solo D.2: Maior retenção da humidade no solo D.3: Aumenta de produção agrícola

E.1: Diminuição de velocidade de escoamento de agua E.2: Maior infiltração de agua E.3: Maior retenção do solo

F.1: Controla erosão do solo F.2: Maior infiltração de agua F.3: Maior retenção de humidade no solo
F.4: Maior produtividade

G.1: Controla erosão do solo G.2: Maior retenção da humidade no solo G.3: Aumenta de produção agrícola

H.1: Controla erosão do solo H.2: Protege o solo H.3: Produção de lenha

V. CONSUMO ALIMENTAR

(a. Entrevista a mulher da casa porque ela tem mais conhecimento das informções requeridas)
(b. Pôr um circulo à volta do "sim" se foi comido ou do "não" se não foi comido)

Nome da Pessoa Inquérida _____

19) Indique se consumiu e qual foi a composição **DE ONTEM** de

a) Pequeno Almoço (sim / não)

a1) Composição/ingredientes
_____

_____

_____

b) Almoço (sim / não)

b1) Composição/ingredientes _____

_____

_____

c) Jantar (sim / não)

c1) Composição/ingredientes _____

_____

_____

d) Lanche (sim / não)

d1) Composição/ingredientes _____

_____

20) Quantas vezes consumiu **em Janeiro 2000**, **o mês passado**, os seguintes produtos:

a) Carne _____
b) Peixe _____
c) Ovos _____
d) Leite _____

e) Banana verde _____

21) Categoria Alimentar Consumidas na Casa **(<u>ONTEM</u>)**

(Depois, verificar com as refeições comidas ontem e clarifica qualquer confusão. exemplo: se a pessoa disse que comeu cachupa ontem mas não disse que come milho em baixo)

Categoria	**(x)**	**Produto**	**(x)**
a) Cereais		Milho	
		Arroz	
b) Produtos derivados de cereais		Pão / bolacha / bolo	
		Massa	
c) Legumes		Feijão	
		Mancarra	
d) Carne & Peixe		Carne de vaca	
		Carne de Porco	
		Galinha	
		Peixe	
e) Produtos de animal		Leite	
		Queijo / Manteiga	
		Ovos	
f) Açúcar		Açúcar	
g) Produtos transformados		Caldo Galinha (Knorr)	
		Sumo em pó	
h) Gorduras & óleo		Gordura (banha)	
		Óleo	
i) Hortaliças		Cebola	
		Tomate	
		Alho	
		Couve	
		Cenoura	
		Repolho	
		Abóbora	
		Pimentão	
i) Frutas		Banana Verde	
		Banana Madura	
		Manga	
		Papaia	
		Melancia	
		Goiaba	
		Tamarindo	
		Sumo de Fruta	
j) Tubérculos		Batata Inglesa	
		Batata Doce	
		Mandioca	

Annex K
Relationship of Monitoring Tools to Title II Generic Indicators

Category	Level	Indicator (note: SUMMARY definition below)	Suggested Tools for Monitoring the Generic Indicator or Related Processes
Health & Nutrition	Impact	% infants breastfed w/in 8 hours of birth	**Tools #1, #3, #4 and #6 (see below); #9; #10; #12; #13; #15**
		% infants under 6 months breastfed only	**Tools #1, #3, #4 and #6 (see below); #9; #10; #11; #12; #13; #15**
		% infants 6-10 months fed complementary foods	**Tools #1, #3, #4 and #6 (see below); #9; #10; #11; #12; #13; #15**
		% infants continuously fed during diarrhea	**Tools #1, #3, #4 and #6 (see below); #9; #10; #11; #12; #13; #15**
		% infants fed extra food for 2 weeks after diarrhea	**Tools #1, #3, #4 and #6 (see below); #9; #10; #11; #12; #13;**
	Annual monitoring	% eligible children in growth monitoring/promotion	**Tools #10; #12; #13; #15**
		% children immunized for measles at 12 months	**Tools #1, #2; #10; #12; #13;**
		% of communities with community health organization	**Tool #9**
		% children in growth promotion program gaining weight in past 3 months by gender disaggregated)	**Tools #1, #3, #4 and #6 (see below); #9; #10; #12; #13; #15;**
Water and sanitation	Impact	% infants with diarrhea in last two weeks	**Tools #10; #11; #12; #13; #15**
		liters of household water use per person	**Tools #10; #11; #12; #13**
		% population with proper hand washing behavior	**Tools #1 and #6 (see below); #9; #10; #12; #13**
		% households with access to adequate sanitation (also annual monitoring)	**Tools #1 and #6 (see below); #10; #12; #13; #14 (modified); #15**
	Annual monitoring	% households with year-round access to safe water	**Tools #10; #11 (modified for Ag.); #12; #13; #15**
		% water/sanitation facilities maintained by community	**Tool #14 (modified)**
HH food consumption	Impact	% households consuming minimum daily food requirements	**Tool #5 (modified)**
		number of meals/snacks eaten per day	**Tool #1, #3, #4 and #6 (see below); #10; #11; #12; #13; #15**

Category	Level	Indicator (note: SUMMARY definition below)	Suggested Tools for Monitoring the Generic Indicator or Related Processes
		number of different food/food groups eaten	**Tools #1, #3, #4 and #6 (see below); #10; #11; #12; #13; #15**
Ag. Productivity	Impact	annual yield of targeted crops	**Tools #1 and #6 (see below);**
		yield gaps (actual vs. potential)	
		yield variability under varying conditions	
		value of agricultural production per vulnerable household	
		months of household grain provisions	**Tools #10; #12; #13; #15 (modified for Ag.)**
		% of crops lost to pests or environment	**Tools #9; #10; #11 & #12 (modified for Ag.); #13; #15 (modified for Ag.)**
	Annual monitoring	annual yield of targeted crops	**Tools #1 and #6 (see below);**
		number of hectares in which improved practices adopted	**Tools #10; #14 & #15 (modified for Ag.)**
		number of storage facilities built and used	**Tools #2; #10; #11 & #12 (modified for Ag.); #13; #15 (modified for Ag.)**
Natural resource management	Impact	imputed soil erosion	**Tool #9**
		imputed soil fertility	**Tool #9**
		yields or yield variability (also annual monitoring)	
	Annual monitoring	number of hectares in which NRM practices used	**Tools #9; #10; #11 & #12 (modified for NRM); #13; #14 & #15 (modified for Ag.)**
		seedling/sapling survival rate	**Tools #6 (used in HH), #9; #10; #12; #13; #15 (modified for Ag.)**
FFW/CFW roads	Impact	agriculture input price margins between areas	**Tool #5 (modified)**
		availability of key agriculture inputs	**Tools #5 (modified); #10; #11 & #12 (modified for Ag.); #13; #15 (modified for Ag.)**
		staple food transport costs by seasons	**Tools #5 (modified); #10; #11, #12, #13, & #15 (modified for Ag.)**
		volume of agriculture produce transported by households to markets	**Tools #2; #10; #11, #12, #13, and #15 (modified for Ag.)**

Category	Level	Indicator (note: SUMMARY definition below)	Suggested Tools for Monitoring the Generic Indicator or Related Processes
		volume of vehicle traffic by vehicle type	**Tool #2**
	Annual monitoring	kilometers of farm to market roads rehabilitated	**Tool #2**
		selected annual measurements of the impact indicators	**Tools #2; #10; #11 & #12 (modified for Ag.); #13**

Other Tools and Their Relationship to the Title II Generic Indicators:

- **Tools #1 and #6, Quality Improvement and Verification Checklists, and Exit Interview Suing Negative Response Cases:** Tool #1 (QIVCs) could be used to monitor the *quality* of many tasks associated with many of these indicators (e.g., the quality of nutrition education to improve exclusive breastfeeding). Tool #6 (Exit Interviews) could be used to measure the quality of certain services, and to identify opportunities for improvement of those services (e.g., tree nurseries, water sources, trainings/educational sessions).

- **Tools #3 and #4, Verbal Case Review for IMCI Clinical Practices, and Integrated Health Facility Assessment:** The implementation of integrated management of childhood illnesses (IMCI) protocols generally leads to health professionals doing a better job of screening for malnutrition and counseling of mothers on breastfeeding and other feeding practices (including feeding during illnesses). In that way, implementation of IMCI contributes to Title II health program indicators by improving food utilization. Tools #3 and #4 are helpful in measuring how successfully IMCI and C-IMCI has been carried out.

- **Tools #7 and #8, Key Informant Interviews and Focus Groups:** Both of these tools can be useful in answering qualitative questions (e.g., “why” questions) related to many of the generic indicators. These are not noted in the table above, since they may be useful in monitoring each and every one of the indicators.