Working with Individuals, Families and Communities to Improve Maternal and Newborn Health

A Toolkit for Implementation

Module 5:
Finalizing, Monitoring and Evaluating the IFC Action Plan

World Health Organization

Enfants du Monde

Pan American Health Organization

World Health Organization Americas

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Contents: Module 1: An overview of implementation at national, province and district levels; Module 2: Facilitator's guide to the orientation workshop on the IFC framework; Module 3: Participatory community assessment in maternal and newborn health; Module 4: Training guide for facilitators of the participatory community assessment in maternal and newborn health; Module 5: Finalizing, monitoring and evaluating the IFC action plan.

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TABLE OF CONTENTS

ACRONYMS

ANC	Antenatal care
CHW	Community health worker
DHS	Demographic and Health Survey
ICT	Information and communications technology
IFC	Individuals, Families and Communities (in reference to the World Health Organization's framework for Working with Individuals, Families and Communities to Improve Maternal and Newborn Health)
HIV/AIDS	Human immunodeficiency virus infection/acquired immunodeficiency syndrome
MICS	Multiple Indicator Cluster Surveys
MOU	Memorandum of understanding
MNH	Maternal and newborn health
NGO	Non-governmental organization
PCA	Participatory community assessment
PNC	Postnatal care
TBA	Traditional birth attendant
ToR	Terms of reference
WHO	World Health Organization

Tell us what you think!

All comments on this document are welcome. Please let us know if you find the content useful, your experience in using this guide, if there is any information missing, if there is anything else you would add to this guide. Please send all comments to the Department of Maternal, Newborn, Child and Adolescent Health (MCA), World Health Organization (WHO), Geneva, to mncah@who.int.

THE STORY OF THE TOOLKIT

In 2003, The World Health Organization (WHO) published a concept and strategy paper entitled *Working with individuals, families and communities to improve maternal and newborn health*,[1] herein referred to as the "IFC framework".

The IFC framework was developed in response to the observation that a robust and systematic health promotion component was largely absent from most maternal and newborn health (MNH) strategies in countries.

Soon after its publication, countries began to ask how to implement the Framework and how to operationalize the key themes of empowerment and community participation. This is where the story of the five modules included in this document, *Working with individuals, families and communities to improve maternal and newborn health: a toolkit for implementation*, begins.

The work of all five modules was done under the technical supervision of Anayda Portela, WHO/Department of Maternal, Newborn, Child and Adolescent Health (WHO/MCA) in Geneva. The modules related to the participatory community assessment (PCA) were developed under the guidance of Anayda Portela, Carlo Santarelli of Enfants du Monde and Vicky Camacho, then the Regional Advisor on Maternal Health to the Pan American Health Organization (PAHO). Each module has a series of authors, reviewers and country experiences.

We have attempted to mention all the teams and moments involved below. Some individual names may not be cited, however we wish to convey our gratitude to every person and country team who has contributed, and regret any contributions which may have been overlooked or not specifically mentioned.

The first work on the PCA and the corresponding *Guide to train facilitators* began in 2005. In response to country requests in Latin America, Vicky Camacho proposed an adaptation of earlier MotherCare work and of the Strategic Approach developed by WHO/Department of Reproductive Health and Research. Veronica Kaune, a consultant from Bolivia, developed the first guide for PCA, which was reviewed by an expert group including Fernando Amado, Angela Bayer, Lola Castro, Colleen B. Conroy, Julio Córdova, Luís Gutiérrez, Martha Mejía, Rafael Obregón, and Marcos Paz.

A meeting was held in El Salvador in September 2005 to review the PCA with representatives from Bolivia, El Salvador, Honduras, and Paraguay. After the first pilot experiences in El Salvador and Paraguay, the PCA was modified to simplify the process and reporting to ensure that a country could integrate it into its ongoing planning processes.

Kathryn Church, a consultant supported by funding from Enfants du Monde and PAHO, then went to El Salvador to support the national IFC committee in a next country experience. The MIFC committee included representatives of the Ministerio de Salud Pública y Asistencia Social (MSPAS), Concertación Educativa de El Salvador (CEES), Fundación Maquilishuat (FUMA), CREDHO, and PAHO EL Salvador. The PCA was conducted in Izalco and Nahuizalco with support from local facilitators, the health units and the SIBASI of Sonsonate.

[1] Please see http://www.who.int/maternal_child_adolescent/documents/who_fch_rhr_0311/en/

Special mention is made of the work in El Salvador who was a pioneer in leading the IFC implementation in the Americas Region, and the PCA was subsequently reformulated on the basis of these experiences.

The El Salvador team included: Jeannette Alvarado, Tatiana Arqueros de Chávez, Carlos Enríquez Canizalez, Luís Manuel Cardoza, Virgilio de Jesús Chile Pinto, Hilda Cisneros, Morena Contreras, Jorge Cruz González, William Escamilla, Jessica Escobar, Elsa Marina Gavarrete, Melgan González de Díaz, Edgar Hernández, María Celia Hernández, Pedro Gonzalo Hernández, José David López, José Eduardo Josa, Carmen Medina, Emma Lilian Membreño de Cruz, Ana Dinora Mena Castro, Ana Ligia Molina, Sonia Nolasco, Xiomara Margarita de Orellana, Ever Fabricio Recinos, Guillermo Sánchez Flores, Lluni Santos de Aguilar, Luís and Valencia. Maritza Romero of PAHO was instrumental in supporting the process.

Kathryn Church was subsequently hired by WHO Geneva to work with Anayda Portela to simplify the PCA based on the El Salvador experience; thereafter what are now Modules 1, 3 and 4 were produced.

Carlo Santarelli of Enfants du Monde also provided important input into this work. Subsequent experiences led to further refinement of these Modules: 1) in Moldova and Albania with the support of WHO Europe and Isabelle Cazottes as a consultant, and 2) in Burkina Faso with the support of the Ministry of Health (Minstère de la Santé), Enfants du Monde and UNFPA.

Isabelle Cazottes was then hired by WHO Europe to work with WHO Geneva (Anayda Portela and Cathy Wolfheim) to develop an Orientation Workshop for the IFC framework and implementation, which served as the basis for what is now Module 2.

The workshop was based on training guides developed for the introduction of the IFC framework and implementation process used in regional workshops in Africa, Europe, Eastern Mediterranean, the Americas and Southeast Asia (workshops organized by the WHO Regional Offices of Africa, America, Europe, Eastern Mediterranean, South East Asia and Western Pacific). Module 2 was subsequently finalized by Janet Perkins, consultant to WHO, Anayda Portela, and Ramin Kaweh. A version was tested by the Enfants du Monde team with the local IFC committee in Petit-Goâve, Haiti.

Module 5 was begun by the health team at Enfants du Monde including Cecilia Capello, Janet Perkins and Charlotte Fyon, working with Anayda Portela of WHO. Carlo Santarelli and Alfredo Fort, Area Manager for the Americas Region, WHO Department of Reproductive Health and Research at the time, provided inputs. Different sections of the module were subsequently reviewed by the regional coordinators of Enfants du Monde, the national MIFC committee in El Salvador, Ruben Grajeda of PAHO, Aigul Kuttumuratova of WHO/EURO, Raúl Mercer and Isabelle Cazottes. The module was finalized by Janet Perkins as a consultant to WHO Geneva.

Janet Perkins, as a consultant to WHO Geneva, did a final technical review and edit to harmonize all five modules. Jura Editorial copyedited Modules 1, 3 and 5. Yeon Woo Lee, an intern with WHO/MCA, updated the references to ensure compliance with the WHO style guide. Pooja Pradeep, an intern with WHO/MCA, reviewed all the modules after the editor changes were incorporated. Amélie Eggertswyler, intern with Enfants du Monde, and Hanna Bontogon, intern with WHO/MCA, reviewed the layout of Module 1. Francesca Cereghetti, also intern with Enfants du Monde, reviewed the layout of Modules 1 and 5, and Saskia van Barthold, intern with Enfants du Monde, reviewed the layout of Modules 2, 3 and 4.

The toolkit, in different stages of development and in various degrees, has been used in the following countries: Albania, Bangladesh, Burkina Faso, Colombia, El Salvador, Guatemala, Haiti, Kazakhstan, Lao People's Democratic Republic, Paraguay and the Republic of Moldova. We have learned from each of these experiences and have tried to incorporate the learning throughout the toolkit's development.

Such a document can only be useful if it is adapted to each context, and we have intended for it to be a living document – that improves with each use and each reflection. Thus this story will continue.

Financial support for the development of the modules over the years has been received from Enfants du Monde, WHO, PAHO, WHO/EURO, the EC/ACP/WHO Partnership and the Norwegian Agency for Development Cooperation.

INTRODUCTION TO MODULE 5

This document is the fifth module of a series entitled *Working with individuals, families and communities to improve maternal and newborn health: a toolkit for implementation*, designed to support the implementation of the World Health Organization (WHO) framework *"Working with individuals, families and communities (IFC) to improve maternal and newborn health"*,[2] herein referred to as the "IFC framework."

The IFC framework, originally elaborated in 2003, was developed in response to the observation that a robust and systematic health promotion component was largely absent from most maternal and newborn health (MNH) strategies in countries. Grounded on the foundational principles of health promotion as outlined in the Ottawa Charter,[3] the framework and the interventions it proposes were formulated based on an examination of evidence and successful experiences in working with individuals, families and communities to improve MNH.

This evidence was updated in 2015 and we refer the reader to the publication *WHO recommendations on health promotion interventions for maternal and newborn health*, available at http://who.int/maternal_child_adolescent/documents/health-promotion-interventions/en/.

To date, the IFC framework has been implemented in a number of countries spanning the six world WHO regions, including: Bangladesh, Burkina Faso, Colombia, El Salvador, Guatemala, Haiti, Kazakhstan, Lao People's Democratic Republic and the Republic of Moldova. The aim of the toolkit is to support public health programmes in launching a process to work with and empower individuals, families and communities to improve MNH.

[2] See the following strategic document: Working with individuals, families and communities to improve maternal and newborn health, WHO, 2010.
[3] See WHO, 1986.

The implementation toolkit contains five modules, as described in the following table:

Module	Description
Module 1: An Overview of Implementation at National, Province and District Levels	An introduction to the process of initiating implementation of the IFC framework at national, province and district levels.
Module 2: Facilitators' Guide to the Orientation Workshop on the IFC Framework	A resource guide for conducting a workshop to orient national, province and district actors to the key concepts, processes and interventions of the IFC framework.
Module 3: Participatory Community Assessment in Maternal and Newborn Health (PCA)	An overview on conducting the PCA, a participatory tool designed to support district-level actors to assess the MNH situation and needs and to identify priority interventions for IFC implementation.
Module 4: Training Guide for Facilitators of the Participatory Community Assessment (PCA) in Maternal and Newborn Health	A guide to support training of facilitators to conduct the PCA.
Module 5: Finalizing, Monitoring and Evaluating the IFC Action Plan	**A guide to support the finalization of the IFC action plan based on the PCA, including suggestions for monitoring and evaluation.**

As outlined in the above table, the fifth module provides an orientation to finalizing an action plan for IFC implementation based on the results of the participatory community assessment (PCA). It is designed to provide MNH actors, in collaboration with other actors and sectors, the tools to organize and implement the IFC component effectively and efficiently and to develop a plan for monitoring and evaluation.

This module describes the processes of planning, monitoring and evaluating the IFC component in two different scenarios: (1) when the IFC framework is introduced in a country or province for the first time and is being implemented in the initial district(s); and (2) after a country or province has experience in IFC implementation and is scaling up the framework to new districts. Some elements will be adapted when moving from this initial experience to a phase of scaling-up; therefore we distinguish between initial implementation sites and expansion sites throughout this module. For example, while planning in the initial implementation sites will generally be based on a full PCA, it may be advisable to use a simplified participatory planning process in the expansion sites. Additionally, in the initial implementation districts we advise that programmes include plans for a rigorous impact evaluation, while this may not be necessary or feasible in the expansion sites.

Who should use this module?

This module is designed to be studied by MNH programme coordinators and committee members at national, province and district levels in order to acquaint them with the steps and considerations to effectively plan, monitor and evaluate the IFC component. It is not intended to be an exhaustive resource on the general programme cycle, emphasizing rather those considerations to be made in the context of the IFC framework.

IFC committee members (or MNH committee members) at the national and province levels will find this guide useful as they support the districts in IFC implementation and work toward institutionalization of the IFC framework at their respective levels. Their role is critical as they plan national/province level actions to facilitate work at the district level, assist the district in planning and implementing activities, coordinate monitoring and evaluation systems in the different districts, and monitor and evaluate the contribution of the IFC component within the national MNH strategy.

IFC committee members at the district level will be able to use this guide to understand more concretely how they can move ahead in planning IFC activities, monitoring their progress and evaluating their results once the PCA team has provided a preliminary plan for interventions.

Readers of this module at all levels will benefit from having a thorough understanding of the fundamentals of the IFC framework. This may involve having previously studied the IFC framework strategic document that provides its theoretical underpinnings, as well as Module 1 of this toolkit that offers an overview of the IFC implementation processes. Previous participation in a workshop introducing the IFC framework (see Module 2) would be advantageous. Familiarity with the PCA process (Modules 3 and 4) would also be beneficial, as this module completes the continuum of implementation phases following this essential step. These preliminary efforts are important as they provide a foundation and global perspective of the IFC framework.

Further assistance

Planning, monitoring and evaluation are complicated processes. As such, this module is not expected to respond to all the planning, monitoring and evaluation needs of any project or programme because contexts vary significantly and processes need to be adapted accordingly. Also, the processes will need to take into account and compensate for the varying levels of expertise and experience of the actors participating in IFC implementation. Experience has shown that IFC committees often lack experience in the areas of planning, monitoring and evaluation, and they benefit from external assistance. When members of the IFC team have limited experience, we strongly encourage IFC coordinators to seek the support of external experts and consultants during key moments, such as during the development of an action plan following the PCA. As IFC committees increasingly build their capacities, their reliance on external consultants will decrease accordingly.

Adapting the process

The processes outlined in this guide are suggested processes — they will need to be reviewed and adapted within each country to suit the national and local contexts, and in consideration of available resources. The IFC component is a complex system that is being introduced into an already complex MNH system, which is embedded in a broader complex social system. Each country must take into account and adapt the processes according to its ongoing strategies and initiatives, the coordination efforts between these different initiatives, as well as the implementation environments.

Structure of the module

Section 1 provides an overview of finalizing an IFC action plan and monitoring and evaluating IFC activities; it underscores the principles of participation of the community and other actors in these processes.

Section 2 describes the process of finalizing the IFC action plan by elaborating a logical framework and detailed activities plan.

Section 3 presents some core elements of monitoring and evaluating the IFC component.

Section 4 provides considerations for documenting lessons learnt throughout the implementation process.

Section 5 describes the process of disseminating and using monitoring and evaluation results.

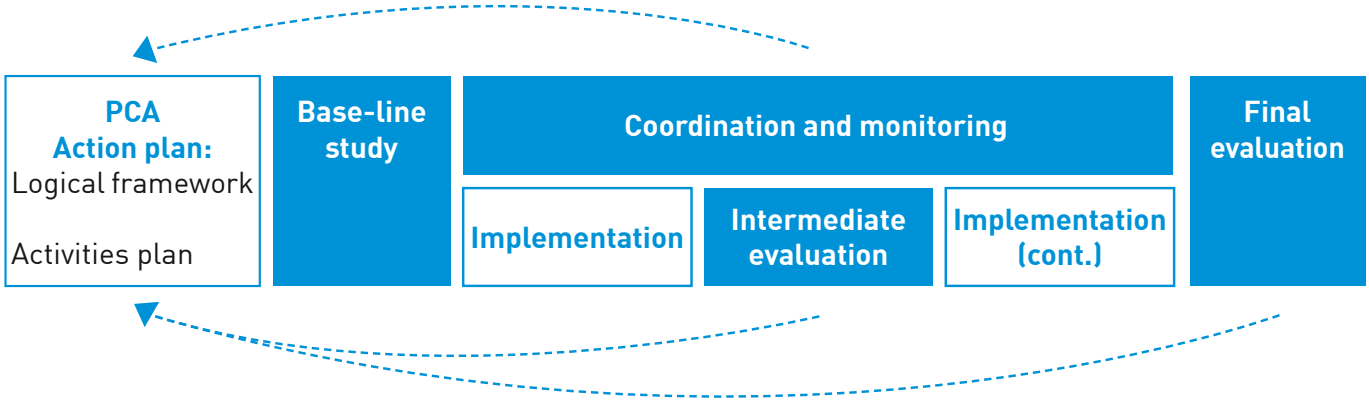
The **annexes** provide sample tools and guides for planning, monitoring and evaluating the IFC component.

1. IFC PLANNING, MONITORING AND EVALUATION OVERVIEW

1.1 POST-PCA PHASES OF THE IFC IMPLEMENTATION FRAMEWORK

Once the IFC framework has been introduced in a country or province and the PCA completed, the district IFC committee moves into the next phases of the IFC implementation consisting of the joint planning process, participatory implementation and participatory evaluation. The PCA provides the foundation for planning IFC interventions by generating many ideas for improving MNH within the context of the IFC framework. The joint planning process is undertaken to organize the PCA results and determine how priority interventions will be implemented in practice. It also lays the groundwork for effective monitoring and evaluation. These processes feed back into each other, as monitoring and evaluation are used to adjust current plans and guide future planning – they are therefore, more appropriately viewed as a complex trajectory with transactions and decision-making processes at each stage of the process (see Fig. 1.1).

Fig. 1.1: Planning, monitoring and evaluating the IFC component

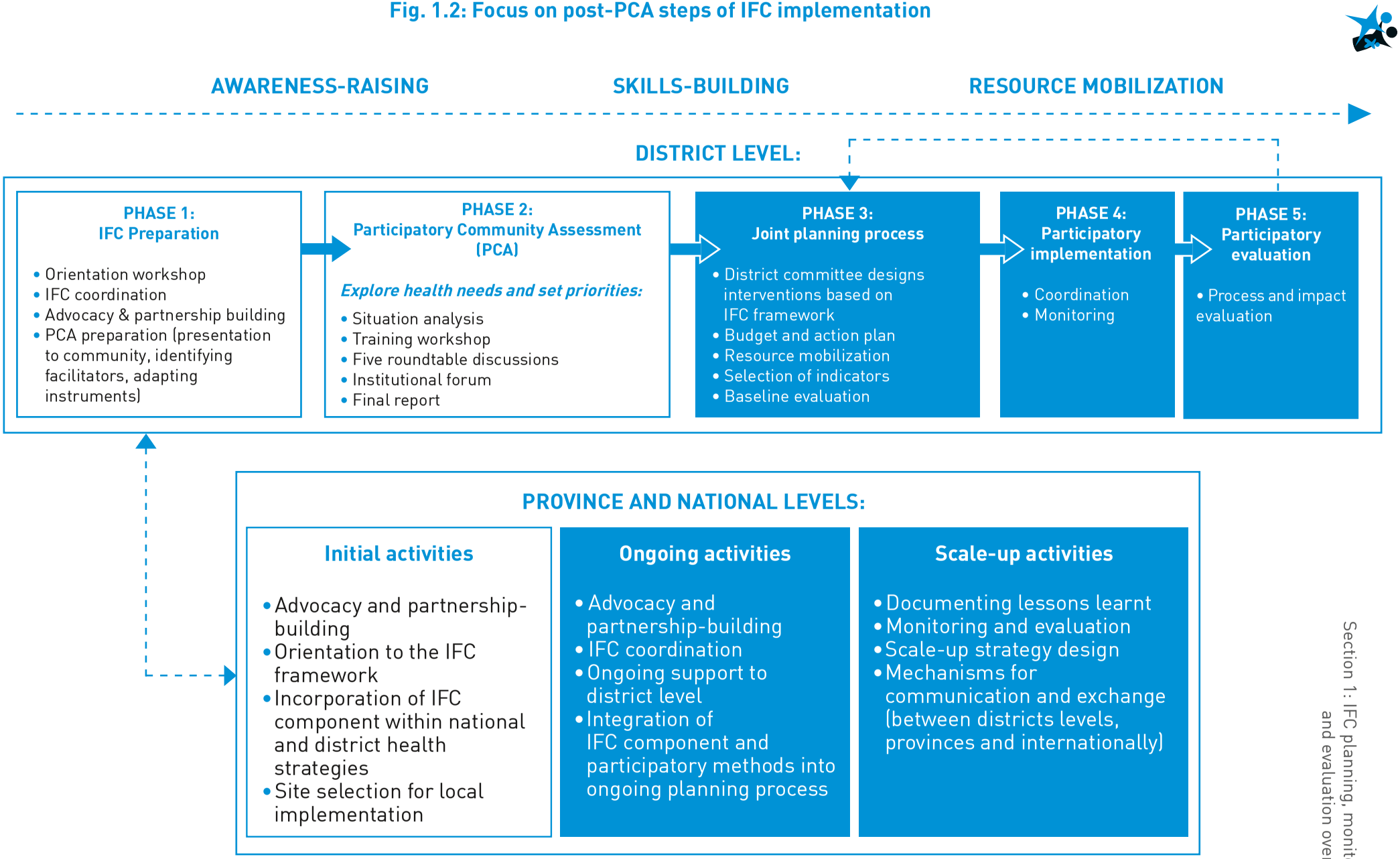


Meanwhile, national and province level MNH actors continue to provide support to the district; strengthen coordination among partners; bridge communication among the different districts implementing the IFC component; monitor and evaluate activities at these respective levels; and work towards scale-up of the IFC framework in the country. Activities at all levels are complementary; the districts receive support from national and province levels while also providing the evidence necessary and lessons learnt to guide scale-up of the framework.

Fig. 1.2 highlights the steps of the IFC implementation process at the national, province and district levels that are addressed to varying degrees in this manual.

It is important to note that the sequence between monitoring and evaluation, knowledge generation, dissemination and policy-making for scaling-up is not a straightforward process. It is subjected to many contingencies (e.g. political will, windows of opportunity). It is important for IFC partners to try to account for this during the planning process, particularly considering the lack of continuity among administrations and the need to ensure means for sustainability of the process.

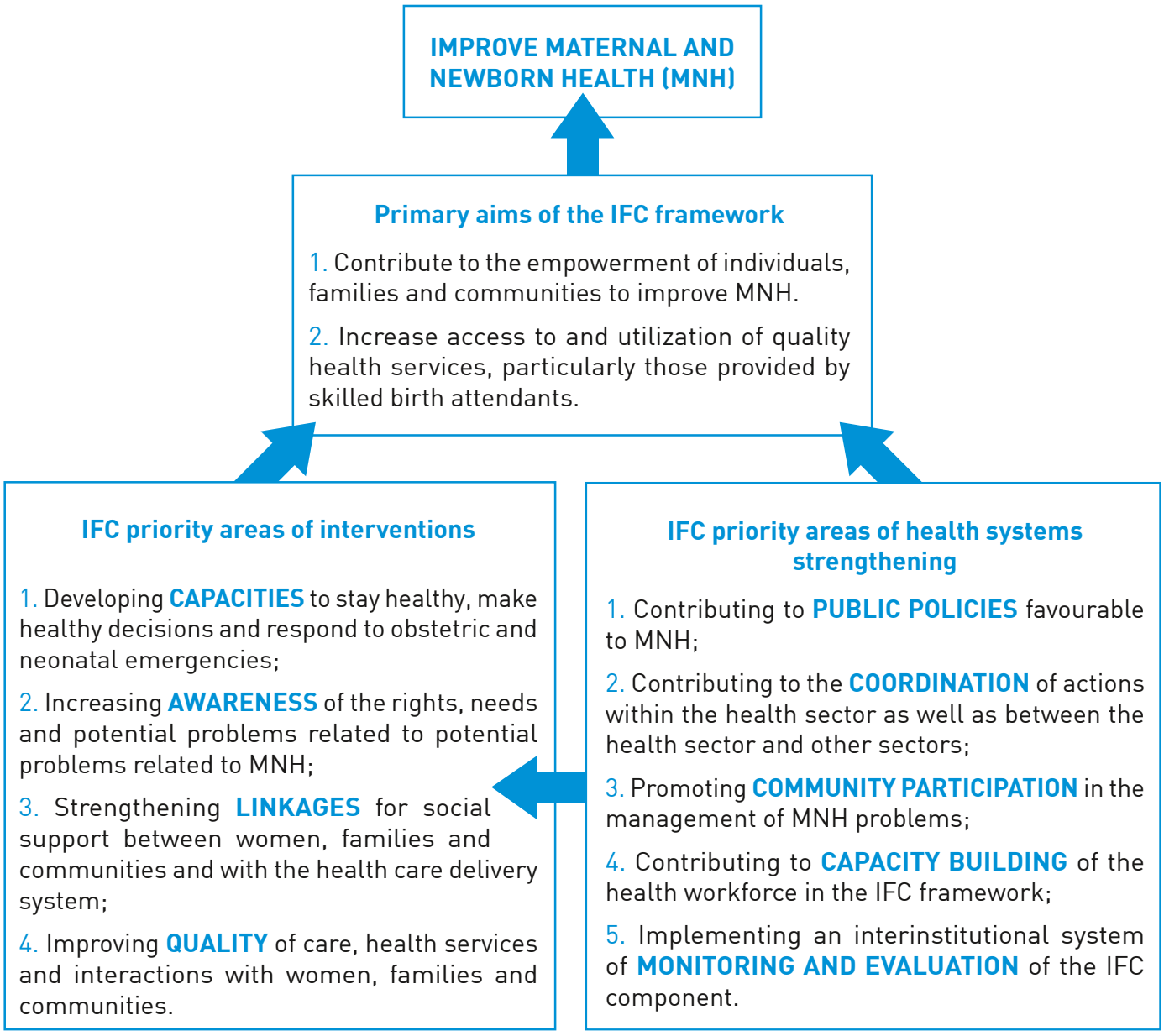
Fig. 1.2: Focus on post-PCA steps of IFC implementation



See Module 1, Fig. 2.1

As the IFC framework is designed to form a complementary health promotion component of a broader MNH strategy, it is difficult to measure the specific contribution of the framework to the overall improvement of MNH. An ultimate, measurable improvement in MNH will be the result of the complex interplay of multiple factors, including the availability and performance of health services, policy considerations and, to a large extent, the socioeconomic and cultural context.

Fig. 1.3: IFC framework objectives and priority areas



Implementation of the IFC framework intends to directly impact the four priority areas of intervention outlined in the conceptual framework as well as the five priority areas of health systems strengthening, which also serve to strengthen the foundation for implementing actions within the priority areas of intervention. The combination of actions within these nine areas is intended to contribute to the primary aims of the IFC framework, which in turn are expected to contribute to improving MNH (see Fig. 1.3).

IFC coordinators will want to assess the process of IFC implementation and how implementation may be influencing change in the aims and priority areas of the framework. Effectively carrying out these assessments will be facilitated by designing appropriate tools and outlining a plan for monitoring and evaluation at the outset of implementation.

1.2 RELATIONSHIPS BETWEEN PLANNING, MONITORING AND EVALUATION

As in any programming cycle, IFC planning, monitoring and evaluation are inextricably linked components of the implementation process (see Box 1.1).

Planning can be defined as the process of setting goals and objectives, developing strategies to reach these goals and objectives, outlining the arrangements for implementation of interventions, and identifying and allocating resources.

Monitoring is the ongoing process by which stakeholders gather information to determine whether actions are being implemented as planned and progress is being made toward reaching the stated objectives.

Evaluation is the rigorous assessment that broadens the understanding of the contribution of the IFC component to change in the primary aims and priority areas of intervention and health systems strengthening of the IFC framework, and how and why IFC implementation is influencing change.

Planning, monitoring and evaluation are distinct yet closely interrelated processes. Together they play a major role in enhancing the effectiveness of the IFC component and its interventions. Optimal planning helps actors focus on achieving the identified objectives within the priority areas. A clear plan facilitates monitoring and evaluation, while monitoring and evaluation provide evidence to inform decision-making throughout the intervention and for scaling-up, both "horizontally" (i.e. to other districts and provinces) and "vertically" (through greater institutionalization) (see Module 1, sections 2.15 and 2.16).

Box 1.1: Links between planning, monitoring and evaluation

- Without proper planning and clear articulation of intended results, it is not clear what should be monitored and how; hence monitoring cannot be done well.
- Without effective planning (i.e. developing clear frameworks), the basis for evaluation is weak; hence evaluation cannot be done well.
- Without careful monitoring, the necessary data are not collected; hence evaluation cannot be done well.
- Monitoring is necessary, but not sufficient, for evaluation.
- Monitoring facilitates evaluation, but evaluation uses additional data collection and different frameworks for analysis.
- Monitoring and evaluation of interventions will often lead to changes in planning. This may mean further changing or modifying data collection for monitoring purposes.

Source; UNDP, 2009.

1.3 PARTICIPATION IN PLANNING, MONITORING AND EVALUATION

As in all other phases of the IFC implementation, planning, monitoring and evaluation of the IFC component is intended to be undertaken with the participation of actors from various sectors and institutions, with special attention given to community participation. Active and meaningful participation is not only consistent with the principles of health promotion, but fundamental to a rights-based approach and necessary for empowerment. To participate, people (women, their partners and families) need to be informed and empowered. This requires establishing transparent and democratic rules to govern the planning, monitoring and evaluation processes.

While particular aspects of participation will be highlighted throughout this module, this section provides an overview of these participatory processes and the guiding principles that may be kept in mind in order to lay the groundwork for assuring participation.

Participation in planning

Participation in planning is initiated during the PCA. The PCA promotes the active participation of community members, leaders and IFC partners in working together to define MNH priorities and propose activities to address these priorities. This participation initiates a process of empowerment as women, families and communities are directly involved in making decisions and designing actions that are meant to benefit them. The PCA is a particularly beneficial tool for promoting participation as it not only builds the capacities of community members to participate, but also the capacities of actors within the health system to institutionalize participatory processes.

This participation continues following the PCA as the IFC committee elaborates the action plan, detailing how interventions will be implemented, monitored and evaluated. This action plan is developed with input from stakeholders, including the community, and is shared with all stakeholders before activities are implemented. In addition, monitoring and evaluation results are shared with the community throughout the implementation timeframe allowing community members to provide input on how plans can be adjusted to better respond to their needs. This ensures a natural continuum of participation throughout all phases of IFC planning.

Participation in monitoring and evaluation

The emphasis on participation in the IFC framework is also maintained in monitoring and evaluation. Preserving this participation necessitates some fundamental variations from more conventional approaches to monitoring and evaluation. Box 1.2 highlights some of the major differences between participatory monitoring and evaluation and traditional monitoring and evaluation. In order to ensure these distinctions, monitoring and evaluation of the IFC component is underpinned by the broader principles of participatory monitoring and evaluation.

These are:

- Participation: Monitoring and evaluation of the IFC component emphasizes the participation of various stakeholders in the process. This principle is facilitated by IFC committees, in which different sectors and actors are represented. All stakeholders, including community representatives, can participate in developing and providing input on tools for monitoring and evaluation, organizing and supporting the process, and analysing and using results. Moreover, monitoring and evaluation of IFC interventions is ideally conducted in collaboration with both internal (e.g. IFC committee members, community members) and external (e.g. research institutions, external consultants) actors. This ensures that the interventions are assessed from the viewpoints of both those directly

involved in the component and those with a more independent position.

- Learning: Participatory monitoring and evaluation stresses practical and action-oriented learning throughout the process. Monitoring and evaluation of the IFC component is an "educational experience" for all stakeholders. Participating actors, including community members, become aware of what is working and where weaknesses lie, contributing to empowering them to create conditions conducive to change and action.

- Negotiation: Participatory monitoring and evaluation is a social process in which participating actors negotiate between varying needs, expectations and worldviews. This approach recognizes the complex interrelationships between stakeholders. It is intended to contribute to the empowerment of those stakeholders who are traditionally less likely to have their needs and expectations included in decision-making processes, with an emphasis on community members, particularly marginalized groups (minorities, indigenous people, poor people, people with disabilities, elderly people, among others).

- Flexibility: In order for monitoring and evaluation to be participatory, it needs to be approached with flexibility. Monitoring and evaluation of the IFC component will need to be adjusted to the specific context of the implementation district, province and country, ensuring that the process itself responds to stakeholder's needs and expectations.

When using a participatory approach, monitoring and evaluation contributes to the primary aim of the IFC framework to empower women, their partners, families and communities to improve MNH. It also strengthens collaboration and increases trust among IFC partners, reinforcing coordination to improve MNH. Moreover, it contributes to ensuring transparency and accountability, which are central to a rights-based approach, throughout the implementation process as all stakeholders are consistently informed of developments and progress within the IFC component.

While the potential benefits of participatory approaches to monitoring and evaluation are great, all actors involved should be aware that such an approach generally requires a greater time commitment, particularly as more actors are involved, and they will want to account for this when outlining plans and timelines.

Box 1.2: Characteristics of participatory monitoring and evaluation

In contrast to traditional methods of monitoring and evaluation, participatory monitoring and evaluation is:

- focused on processes and measurement, rather than exclusively on measurement;
- oriented towards the needs of intervention participants and community members, rather than exclusively on funders and policy-makers;
- promotes a relationship between evaluators and participants, rather than objectivity and distance; and
- conducted for the purpose of empowering participants, implementers and beneficiaries alike, rather than simply judging shortcomings.

Source: Estrella, M and Gaventa J, 1997.

Using visual tools for participation in planning, monitoring and evaluation

In many cases, community members will not have experience with the tools used for planning, monitoring and evaluation and will not be comfortable with abstract concepts such as rates and proportions. One way to bridge differences in experience and background and allow for meaningful participation of all actors is to use visual tools. Tools that allow for the visual representation of concepts or data can contribute to creating a common platform where all actors are able to share an understanding and provide meaningful contributions.

Graphs, such as histograms and pie charts can be useful for sharing data with community members. A histogram, or bar chart, can help participants understand how the situation is changing over time. For example, it could be used to assist community members to understand changes in the number of maternal and newborn deaths or in the utilization of health services (see Fig. 1.4).

Fig. 1.4: Example histogram

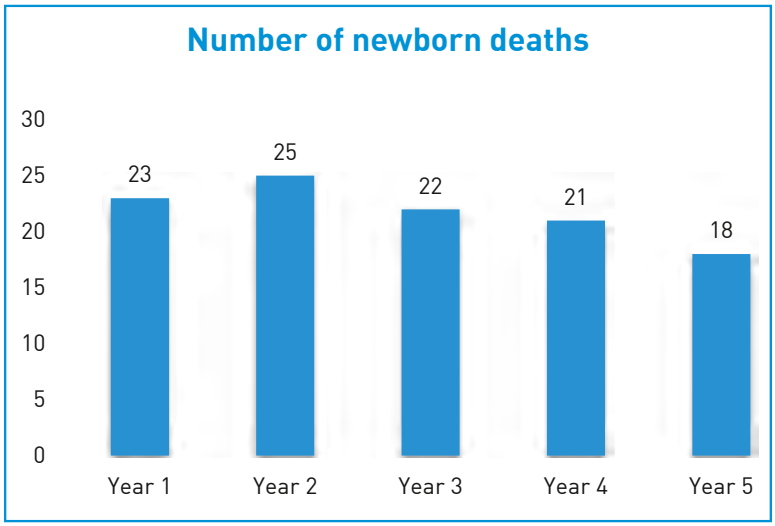
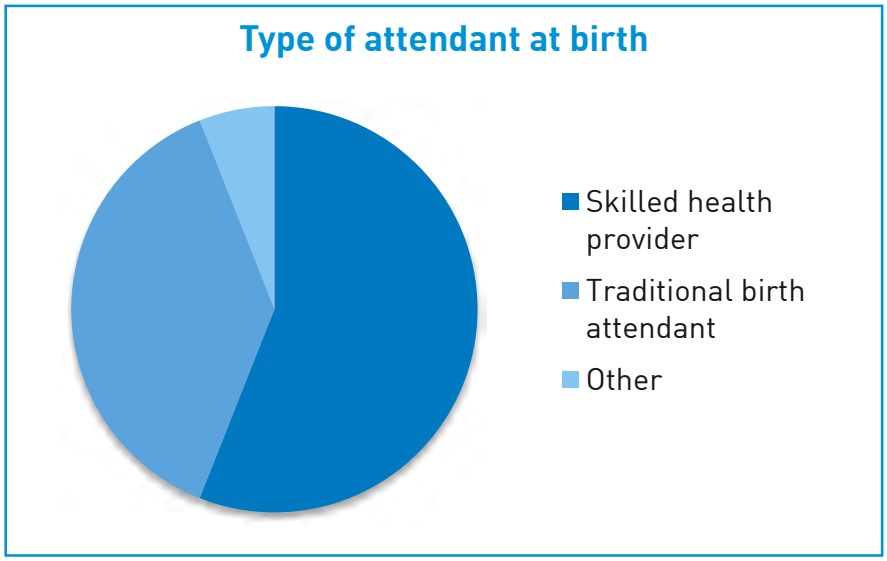
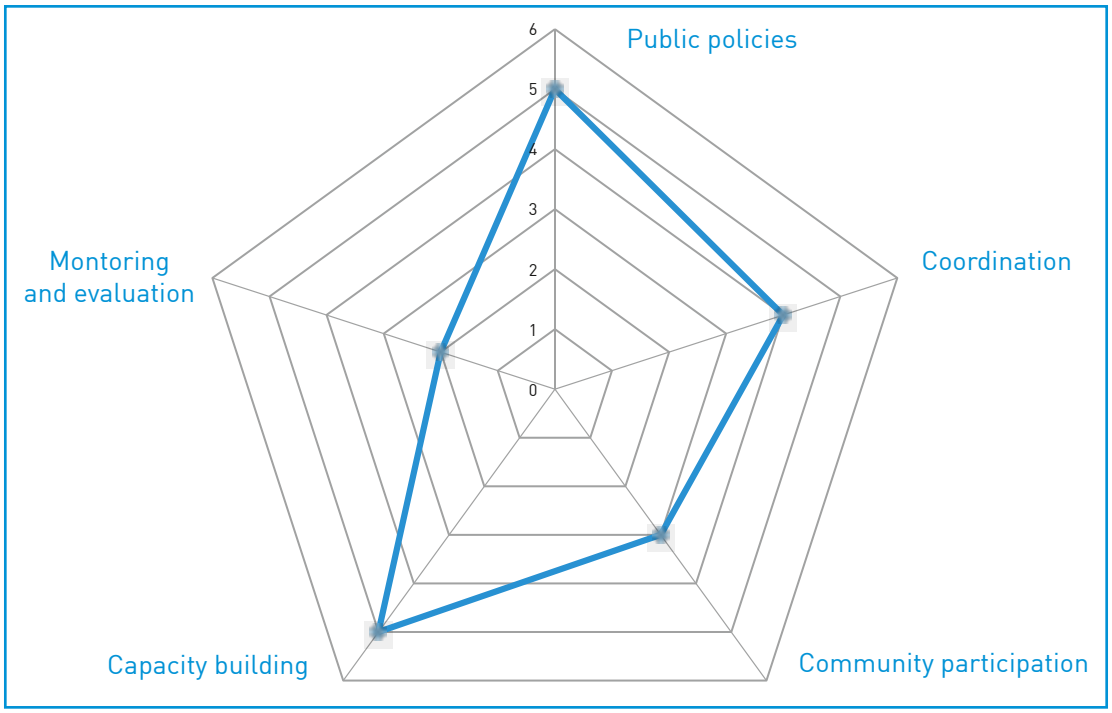


Fig. 1.5: Example pie chart



A pie chart can help people visualize the situation at a given point in time. They can be especially useful when presenting information on percentages, such as the percentage of women or newborns receiving skilled care (see Fig. 1.5 for an example).

While these graphs provide a visual representation of the current situation or specific indicators, other tools can visually represent processes. A spider diagram or "spidergram" (see Fig. 1.6) can be useful in this regard[4]. For example, a spidergram could be used by stakeholders to examine the processes of IFC implementation within the priority areas of health systems strengthening. In order to do this, participants could examine each priority area of health systems strengthening and select a score ranging from 1-6 (1 corresponding to little development and 6 corresponding to a high degree of development), plotting this on the line corresponding to the appropriate area. They can then connect the scores with a line. The "web" that it creates illustrates the current status of processes in these areas with a broader web indicating greater progress and a narrower web indicating less progress. These can also be plotted over time to represent changes throughout the implementation timeframe. This exercise can help programme partners identify strengths and areas for improvement.



Using the IFC priority areas of health systems strengthening is simply one example of how a spidergram may be used to chart processes. The IFC committee can agree to use it to plot any processes that are relevant to their particular context.

IFC coordinators and committee members will be in the best position to determine which visual tools will be most beneficial for promoting the participation of a diverse array of stakeholders. Ideally this will be done in collaboration with representatives of the target audience. We suggest approaching these exercises with creativity and developing tools that respond to the local realities.

[4] Adapted from Rifkin et al. 1988.

2. FINALIZING THE IFC ACTION PLAN

2.1 THE DISTRICT IFC ACTION PLAN

Completing the district IFC action plan in the initial implementation site

During the institutional forum of the PCA, participants develop a priority list of problems and a draft list of solutions aiming to address these problems. The local coordinator and district committee use this draft plan as the foundation to develop a detailed district action plan, generally for the following 3–5 years. Ideally, IFC coordinators will be able to directly integrate the IFC interventions into the MNH programme at the district level, or will use the planning tools that are accepted and utilized in the country and at the respective level to elaborate a plan for IFC interventions. It is important that IFC coordinators use the tools that will facilitate an integrated approach to implementation of the IFC component and that they are comfortable using the selected tools. However, if standardized tools are not currently being used, the matrices proposed in Annexes 1 and 2 of this module may be adapted and adopted. These matrices are illustrative; they contain the fundamental components of an IFC action plan (described in detail below). Regardless of the particular tools utilized, the district IFC coordinator is responsible for ensuring that all the basic elements of a strong plan for the IFC component are in place. A strong plan will facilitate a shared vision among stakeholders, lay the groundwork for smooth implementation and contribute to ensuring accountability and transparency.

The planning method for the IFC component that we suggest in this module involves elaborating two central tools: the **logical framework (logframe)** and the **activities plan**. These are complementary instruments that facilitate the implementation, monitoring and evaluation of interventions. These tools are particularly useful for the management of IFC implementation and can help to build consensus among partners, promote a shared vision of what is planned and contribute to promoting accountability.

However, in proposing these tools, it is also necessary to stress their limitations. The IFC component is a complex health initiative that is introduced into an already complex MNH system, which is itself embedded in its own complex social system. These tools tend to imply a linear cause-and-effect relationship between inputs and outputs/outcomes, while in reality change processes are generally non-linear, and inputs can contribute to change while not mechanistically causing it per se. They also are by necessity overly simplistic and are unable to capture all the factors that will come into play that lie beyond the scope of the planned initiative.

In order to compensate to some degree for these limitations, when using these or similar tools, it is important for partners to clearly recognize that they are not in fact dealing with a self-contained system and that the tools provide an overly simplistic, one dimensional view of a complex reality. Rather, partners are managing a complex initiative intervening in a complex social system on the basis of a simplified logical model. The benefits of the tools are therefore optimized when they are used flexibly and are adapted on an ongoing basis to respond to unforeseen changes in the context and to experience. In addition, it is also important to seriously consider the assumptions that the models are based on and their inherent risks. Finally, they will ideally be used as learning tools for all actors rather than for judgement and criticism.

To plan the objectives and activities of the IFC component, the team refers to the results of the PCA. Throughout the course of the institutional forum the participants ideally will have selected

one to two priority interventions to implement within each of the four IFC areas of intervention. The district team can review the plans and verify that the plan is focused, feasible and that the interventions are appropriate and well adapted to the objectives of the IFC framework. They will also want to verify that the IFC planned interventions are coherent with the district MNH programme. With these considerations in mind, they will be able to modify the plan generated through the PCA as necessary (see Module 3, sections 4 and 5).

In addition, IFC coordinators and partners will generally want to identify actions to implement and measure within the IFC priority areas of health systems strengthening. When implementing the IFC component for the first time, it may be beneficial to determine actions for each of these areas, though this may not be necessary in future implementation.

The IFC action plan in the expansion sites

Planning in the IFC expansion districts will be very similar to the process conducted in the initial implementation sites. The primary difference will be that planning in these districts will generally not be based on a full PCA. Rather, the IFC committees in these sites may instead base intervention planning on alternatively agreed upon methods (see Module 1, section 2.16). A validation workshop may be conducted with district actors to review the results of PCAs previously conducted in similar sites and to base the planning on relevant results. Otherwise, IFC committee members may agree on other methods, such as meetings with local actors. In all cases, partners will need to work together to determine how to maintain the core principles of the IFC framework. This will include keeping the principles of participation at the forefront of the planning processes and ensuring that the voices of various actors and community members in particular are represented. The district IFC committee may proceed to develop an action plan based on the results surfacing during these alternative discussions and planning processes. They will also want to include actions within selected priority areas of health systems strengthening based on needs identified by partners.

2.2 DEVELOPING THE DISTRICT IFC LOGFRAME

A logframe, or similar tool, outlines the "logic" of the interventions, demonstrating the way in which interventions are expected to lead to certain results in order to contribute to the objectives (see Annex 1 for a proposed logframe). In sum, the logframe provides a coherent and cohesive summary of key elements of the interventions. While this linear representation is arguably overly simplistic, when used appropriately the logframe can prove particularly useful in increasing stakeholder understanding of the project, decreasing ambiguity and increasing accountability and transparency. Box 2.1 highlights some of the benefits of a logframe that can guide actors in its elaboration and can be used as criteria in its assessment before its finalization.

Suggested components of a logframe include the following:

- ***Goal:*** This is the ultimate objective to which the implementation of the IFC component is expected to contribute. Within the IFC framework, the goal is to "contribute to the improvement of MNH." It is common to all IFC work plans.

- ***Purpose:*** This is the immediate impact on the intervention area or target group. Within the IFC framework, the purpose refers to the overarching aims, i.e. "to contribute to the empowerment of individuals, families and communities to improve MNH and increase access to and utilization of quality MNH services."

- ***Outcomes:*** Outcomes are the specific changes or benefits the implementation of the IFC component is expected to achieve. These will typically be formulated based on the four priority areas of intervention and the five areas of health system strengthening of the IFC framework (see section 1.1 and Module 1, sections 1.2 and 1.3).

- ***Outputs:*** Outputs are the main interventions that are intended to contribute to reaching the outcomes. For example, if one of the planned outcomes is that women have the capacity to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies, a related planned output may be "Community health workers (CHWs) assist women and their families to develop a plan for birth and potential complications." Note that the specific activities conducted under each of these outputs are not included here in the logframe, but rather in the activities plan (see section 2.5).

Box 2.1: Goals of a logframe

The purpose of the logframe is to:

- bring together in one place a clear, concise and accessible explanation of all of the key components of the interventions.
- clarify how the interventions are expected to work and what they are expected to achieve, ensuring that inputs, activities, outputs and objectives fit together;
- identify some of the factors that will be required for the success of the interventions by summarizing the assumptions and the risks that can be foreseen; and
- clarify how progress and change will be assessed, providing the basis for monitoring and evaluation.

Source: DFID, 2003a.

- ***Indicators:*** Indicators are measures used to demonstrate change in a situation, or the progress in, or results of, an initiative or interventions. A list of illustrative IFC indicators is provided in Annex 3.

- ***Means of verification:*** These are the sources of information and means of data collection related to indicators (discussed in detail in section 2.4).

- ***Assumptions and risks:*** Assumptions are the necessary and positive conditions that are required in order for objectives to be reached. They are related to the overall context and environment of the implementation site. For instance, continued cultural, social and political stability are generally assumed. Risks are the possible negative events and occurrences that could potentially compromise the achievement of results. These may be related to political unrest, changes in the political orientation of the governmental administrations towards sexual and reproductive health, or natural disasters, among others.

Identifying assumptions and risks allows stakeholders to acknowledge the factors lying outside their influence and discuss contingency plans in case assumptions do not hold or risks are realized. Clearly not all risks and assumptions will be able to be identified in advance as many changes in the system are unpredictable. However, this component of a logframe should be seriously considered during planning as success will be largely dependent on these factors and on IFC coordinators' and partners' abilities to appropriately respond and adjust to them.

The terms that we have selected to refer to each component of the logframe may be referred to differently in other tools used for the same purpose. It is important that IFC coordinators keep this in mind when using local tools and in verifying that all necessary components are in place. Once the logframe is complete, the team can test the logic of the interventions. Box 2.2 provides questions that may be useful in this exercise. The team will want to honestly recognize when the link in the logic does not work and revise the logframe accordingly.

Table 2.1 provides a sample logframe for the IFC component. This provides an example of each of the logframe elements and ideally will be integrated into the logframe of the district health action plan.

Once again, we strongly suggest that the logframe be used flexibly and that IFC coordinators take the time to review it on an ongoing basis to adjust it when necessary and assure that it remains relevant. Use of the logframe will be optimized when it is used as a tool for learning by all partners.

Box 2.2: Questions to test the logframe logic

1) If the outputs are carried out, can we reasonably expect the outcomes to be produced?
2) If the outcomes are produced, can we expect this to contribute to the purpose of the IFC framework?
3) If positive change in the purpose is achieved, will this contribute to the overall goal of the IFC component?

Table 2.1: Example of a district IFC logframe

	NARRATIVE SUMMARY	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS/RISKS
Goal	Contribute to improved MNH	# of maternal deaths \# of newborn deaths	Health information system Health information system	Continued political commitment in favour of MNH and the IFC component
Purpose	Empower women, families and communities to improve MNH and increase utilization of MNH services	# of health facilities performing activities to mobilize community actors in MNH % of births attended by a skilled attendant	Health services survey Health information system	Continued political commitment to the IFC component at district level Need for skilled birth attendants can be met within the health services
PRIORITY AREAS OF INTERVENTION				
Outcome 1	Women have the capacities to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies	% of women who are aware of three danger signs during pregnancy % of women who sought care at a health facility for obstetrical, postpartum and/or postnatal complications	Baseline and end-line survey Baseline and end-line survey	Weather conditions remain stable allowing for target group to be reached
Planned Output 1.1	CHWs assist women to develop a plan for birth and potential obstetric and neonatal complications	% of pregnant women having discussed a plan for birth and complications with their partners and/or other household members	Baseline and end-line survey	CHWs are willing and able to add efforts in birth preparedness and complication readiness to their current tasks
Outcome 2	Families and communities are aware of the rights related to MNH	Men's awareness of women's right to access quality MNH services % of partners who accompany the woman to the health facility for birth	Focus group discussions with men Baseline and end-line survey	Target group is amenable to changes in gender relations
Planned Output 2.1	Awareness campaign conducted to sensitize men to rights and needs related to MNH	# of meetings held with men on MNH rights and needs	Routine monitoring data	Men are disposed to participate in meetings on MNH
Outcome 3	Linkages for social support between women, families and communities and with the health care delivery system are strengthened	% of women accompanied at the health facility by a TBA for birth or for an obstetrical/ neonatal complication	Baseline and end-line surveys	Health facility policies and health care provider attitudes are favourable to allowing TBAs to accompany women receiving MNH services

	NARRATIVE SUMMARY	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS/RISKS
Planned Output 3.1	Workshops are held with TBAs to orient them to refer and accompany women to health facilities for birth or an obstetrical/neonatal complication	# of TBAs oriented on referring and accompanying women to health services Degree of satisfaction of TBAs with their new role in MNH	Annual reports Focus group discussions with TBAs	TBAs are willing to adopt new role in MNH
Outcome 4	Health providers' interactions with women, families and communities are improved	% of women who mention an improvement in how they are received by health care providers	Baseline and end-line surveys	Health care providers have time and structural support to counsel women on MNH issues
Planned Output 4.1	Health care providers are trained to counsel women on MNH issues and improve their interpersonal skills	% of health care providers trained to improve their interpersonal and intercultural skills	Health services surveys	Health facility managers agree to have providers trained to improve their interpersonal and intercultural skills
PRIORITY AREAS OF HEALTH SYSTEMS STRENGTHENING				
Outcome 5	The IFC component integrated in the district MNH programme	% of public budget dedicated to IFC component within the MNH programme	District health reports	Orientation of health policies remain favourable to the incorporation of health promotion within health programmes
Output 5.1	IFC committee advocates for IFC component to be integrated into the district MNH programme	# of meetings with health officials to discuss integrating the IFC component in the MNH programme	Meeting minutes	Health officials value the contribution of the IFC framework within MNH
Outcome 6	Coordination of IFC actions within the health sector as well as between the health sector and other sectors strengthened	Active functioning of district level intersectoral/ interinstitutional IFC committee with an annual action plan	Annual report Open-ended questionnaires with IFC committee members	Sectors outside of the health sector have human resources available to participate in the IFC component
Output 6.1	District level IFC committee formed	# of IFC committee members identified Terms of reference for IFC committee finalized # of quarterly IFC meeting held	Annual report IFC District Committee terms of reference available Meeting minutes	Implementation of the IFC component is prioritized at the local level

	NARRATIVE SUMMARY	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS/RISKS
Outcome 7	Community participation is strengthened in the management of MNH problems	% of community members who can name three activities in favour of MNH within their community # of health facilities that collaborate with community health committees to guarantee community participation in health services planning and management	Baseline and end-line surveys Annual reports/field visits	Health official and provider attitudes favourable toward communities and the importance of their participation
Output 7.1	Health facilities are supported to institutionalize participatory processes for MNH programme planning	# of meetings conducted with community health committees Tools developed to conduct participatory processes	Meeting minutes Tools for participatory planning available	Health official and provider attitudes favourable toward communities and the importance of their participation
Outcome 8	Capacity of the health workforce is built to implement the IFC component	Presence of a training programme on the IFC component at the district level	Annual reports/field visits	Health workers have time available to participate in IFC training/workshops
Output 8.1	A team of trainers is formed to train the health workforce on the IFC component	# of active training team members # of workshops conducted by the training team	Annual reports/field visits Annual reports	Qualified individuals to be trainers are available at the local level
Outcome 9	Monitoring and evaluation of the IFC component strengthened	Monitoring and evaluation tools for the IFC component developed and agreed upon by partners Mechanisms/processes established for assuring community participation in the monitoring and evaluation process	Availability of monitoring and evaluation documents and tools Monitoring and evaluation tools	A shared consensus and vision of IFC monitoring and evaluation is reached
Output 9.1	IFC component monitoring and evaluation tools are finalized	Finalized logframe Finalized activities plan	Logframe available Activities plan available	A shared consensus and vision of IFC monitoring and evaluation is reached

2.3 INDICATOR SELECTION

Once the objectives have been formulated in the logframe, the team will want to organize a system for measuring change related to the implementation of the IFC component. A central feature of this measurement will be carefully selected indicators. Indicators are empirically measurable conditions used to assess how activities are being carried out and if there are any changes in the defined outcomes/outputs. A continuum of performance indicators can be used to track the progress of the interventions at different levels, as described in Table 2.2.

Table 2.2: Indicator description

TYPE OF INDICATOR	PURPOSE
Impact	Measures long-term results generated by outputs related to the goal of the IFC framework to improve maternal and newborn health. Impact indicators measure results from transformative changes to the system, including the contribution of integrating the IFC component.
Outcome	Measures the intermediate results generated by the outputs, often corresponding to changes in behaviour, such as self-care and care-seeking behaviour, to which interventions have likely contributed. One example within the IFC framework is "Percentage of births attended by a skilled birth attendant."
Output	Measures the results of activities at the intervention level that directly result from the inputs and processes. These are often related to changes in knowledge or opinions. For example, if one intervention is to educate women on danger signs, an appropriate indicator may be, "Percentage of women who are aware of three danger signs during pregnancy."
Process	Measures the progress of activities and the way they are carried out. Again using the example of educating women on danger signs, an appropriate indicator may be, "Number of women educated about danger signs during pregnancy."
Input	Measures the means required to implement the interventions. These may include for example, human and financial resources, physical facilities, operational guidelines, training workshops, educational materials distributed.

Carefully selecting indicators will optimize the chance that they will accurately reflect the results of the interventions. One way to aid the selection process is by using the **"SMART"** criteria, suggesting that indicators be: **specific** (focused and clear), **measurable** (quantifiable and reflecting change), **attainable** (reasonable in scope within the set time-frame), **relevant** (pertinent to the review of performance) and time-bound (progress can be charted within the

set time-frame). Box 2.3 provides questions that can be asked to assist in ensuring that indicators are appropriate using the SMART criteria.

To facilitate the selection of indicators, Annex 3 provides an illustrative list of outcome and output indicators representative of the IFC framework. This list is intended to facilitate the formulation of indicators related to IFC interventions; however, it is not exhaustive and other indicators may be considered as appropriate and relevant to the interventions in each specific context. This will be especially true in regions where certain specific health concerns (e.g. violence against women, adolescent pregnancy, HIV/AIDS) merit a particular emphasis within the IFC efforts.

A mix of both quantitative and qualitative indicators may be selected in order to more fully capture the changes resulting from the interventions and to compensate for the limitations of each type. Quantitative indicators are used to numerically measure the effect of programme interventions. They are typically expressed as numbers, percentages, rates and ratios. Qualitative indicators are descriptive and are therefore not measured numerically. They may be expressed as extent, level, quality or compliance. They may be used to explore attitudes, behaviours or actions through observational methods, focus group discussions or other participatory methods. Box 2.4 provides some examples of these two different types of indicators.

Box 2.3: SMART indicators

Specific: Is the indicator likely to measure exactly the condition or event it is expected to measure?

Measurable: Is data collection feasible? Is the data source readily available?

Attainable: Are the results in which the indicator seeks to chart progress realistic?

Relevant: Is the indicator relevant to the intended output/outcome?

Time-bound: Can the indicator be collected within the programme time period?

Box 2.4: Example quantitative and qualitative indicators

Quantitative indicators:

- % of pregnant women having at least four antenatal care visits
- % of pregnant women having discussed a birth and emergency preparedness plan with their partners and/or other household members
- % of partners who accompany the woman to the health facility for birth

Qualitative indicators:

- Partners' awareness of danger signs during pregnancy
- Women's awareness of their right to access maternal health services

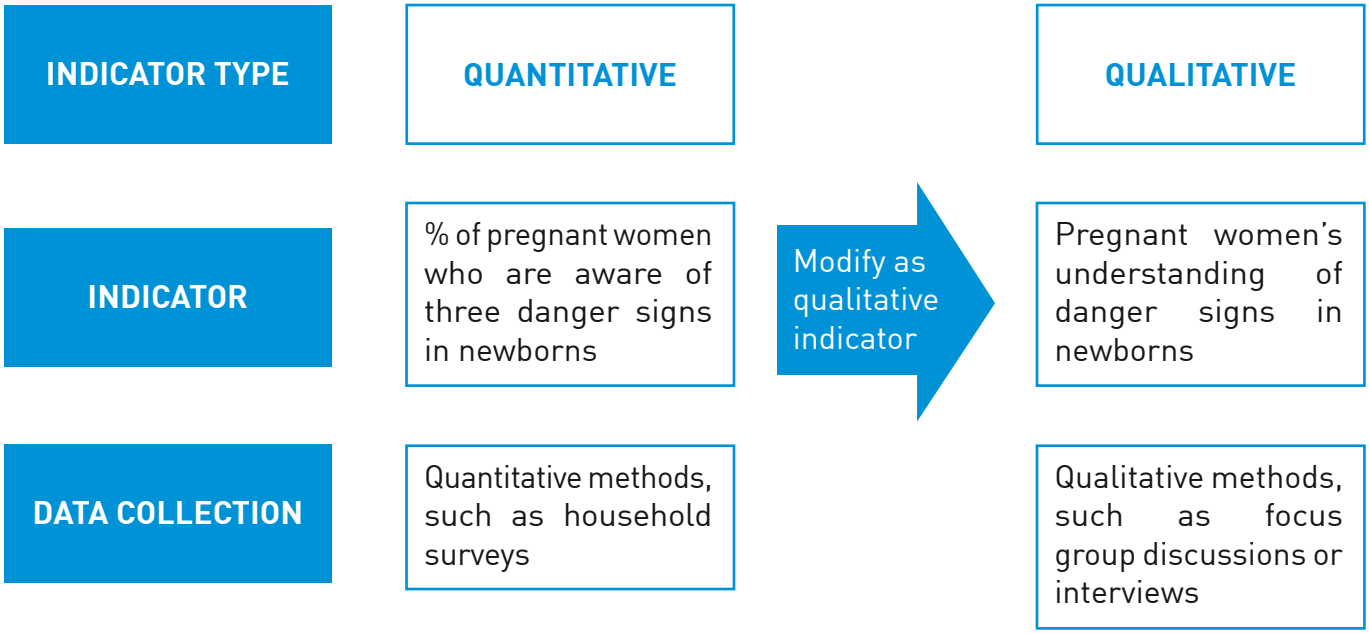
The proposed list of indicators found in Annex 3 includes both quantitative and qualitative indicators, but it is worth noting that it is often possible to modify an indicator to represent the other category of indicator. Fig. 2.1 provides an example of indicator modification. This modification will take place primarily based on the plan for measuring the indicator. Quantitative methods will generate data to measure quantitative indicators while qualitative methods will generate data to measure qualitative indicators. Quantitative and qualitative approaches are not mutually exclusive, but rather complementary. Using both will allow for the greatest insight into what is occurring in response to the IFC efforts, as well as why and how, illuminating both results and processes.

When formulating indicators, we strongly advise including indicators to measure empowerment, as it is one of the primary aims of the IFC framework and also central to a rights-based

approach. This can generally be achieved through proxy indicators that may demonstrate whether the capacities of women, families and communities are developed to make choices and to transform these choices into desired outcomes (see Module 1, section 1.1). Indicators related to awareness can often be used in this way, as knowledge is fundamental to being able to make appropriate decisions. Indicators used to measure changes in the environment allowing women to make health-promoting decisions can also be used, as without a supportive environment it is much more difficult for women to transform their choices into desired actions. IFC coordinators and stakeholders will need to determine how best to capture these changes and this may be a particularly salient moment for consulting with community members to understand what empowerment means to them.

While participation of stakeholders is important throughout the development of these tools, this is particularly true for the selection of indicators. It is important that community members are able to voice their opinions as to how progress in certain areas could be captured and ensure that they are satisfied with the indicators chosen to measure progress. Also, as their empowerment is one of the main objectives of the IFC component, they will ideally be given a voice to express how they envision empowerment. When selecting indicators, it is advisable to ensure that they are limited in number. Limiting the number of indicators to a manageable level increases the chance that they will be measured appropriately within the planned timeframe, avoids the collection of unnecessary data that is less likely to be used and is conducive to more focused results. It is therefore important to aim to select the few indicators that are most likely to accurately reflect the results of IFC interventions. One or two indicators per output/outcome are generally sufficient.

Figure 2.1: Adapting quantitative indicators



2.4 MEANS OF VERIFICATION

During the process of identifying indicators, it is essential to determine how the data related to the indicator will be collected. This is done through selecting a means of verification and specifying it in the logframe. It is crucial to ensure that each indicator has a reliable means of verification that will allow for data to be collected at the planned intervals. It is important that the data source used for a specific indicator remains consistent throughout the planning timeframe as changing the source will likely lead to inconsistencies and interpretational errors. In order to save time, effort and resources, data are collected through existing sources when possible, particularly in IFC expansion sites. However, it will be necessary to collect primary data in certain cases, especially in the initial implementation site when conducting an impact evaluation or implementation research. Table 2.3 provides a description of existing data sources that may be used as means of verification.

Table 2.3: Existing means of verification

DATA SOURCE	DESCRIPTION
Routine health information system	Data collected by facility-based staff and recorded on standard reporting forms that are sent to higher levels in the system where they are aggregated. Data are most often service statistics such as the number of cases seen by category, the number of deaths at the facility, the number of pregnancies and births, estimates of coverage using local population data, and the number of outreach visits conducted.
Health services surveys, medical records, and administrative files	Records maintained by health facilities that may track the number of antenatal care (ANC) and postnatal care (PNC) visits, births, diagnoses, etc. They can be used to measure indicators of coverage.
Registry systems of the civil state	Registries at the municipal/district level that record routine data such as births, deaths, migrations. They may have sub-registries in some cases (e.g. remote areas, abortion, early infant deaths).
Demographic and Health Surveys (DHS)	Comprehensive large sample surveys that include information on maternal and child health, reproductive health, and mortality. A national sampling frame is usually used, although data are sometimes disaggregated to the level of smaller administrative units such as districts.
Multiple Indicator Cluster Surveys (MICS)	Comprehensive large sample surveys that include information on maternal and child health, reproductive health and mortality.
Population censuses	Data collected from the entire population at a certain point in time. Depending on the country, the census may include indicators on health topics, including maternal and child health.

While a great deal of data can be collected through these or other existing information systems, particularly in relation to the utilization of MNH services, many of the activities conducted within the IFC priority areas of intervention will require the collection of complementary data. This will generally be the case for interventions seeking to impact on knowledge, attitudes and practices related to MNH. Table 2.4 provides a description of suggested methods for collecting this type of data within the context of IFC monitoring and evaluation.

Table 2.4: Complementary means of verification

METHOD OF DATA COLLECTION		DESCRIPTION	TARGET PARTICIPANTS
Quantitative	Household surveys	These surveys allow for the collection of specific information among an appropriate sample of the target population. For example, surveys may be used to collect information concerning knowledge, attitudes and practices related to MNH and specifically to the selected themes within the four IFC priority areas.	Community members, e.g. women having recently given birth; husbands/partners of women having recently given birth.
Qualitative	Focus group discussions	These groups are conducted with approximately 6-12 participants and led by a facilitator. Group members discuss certain topics freely and spontaneously. These discussions provide the opportunity to explore a range of opinions and practices related to the IFC component, including rights and gender. They may also provide a platform to explore local perceptions of the IFC interventions and the implementation process, its strengths and weaknesses, thus promoting participation.	Intervention target populations, e.g. women having recently given birth; husbands/partners; influential family members (e.g. mother, mothers-in-law, grandmothers); health workers, including TBAs; and community leaders.
	In-depth interviews	These may be conducted with varying levels of structure, although semi-structured guidelines are advised in this context. The interviewer follows a set of prepared topics, allowing the interviewee to speak freely and openly concerning the defined topics. They are used to explore informants' perceptions and beliefs, as well as the context and structures affecting their behaviour and practices, including aspects related to rights and gender. These may prove especially useful when inquiring about sensitive issues (e.g. abortion, adolescent pregnancy, violence against women). Like the focus group discussion, this method should be used in a manner that promotes participation.	Key informants, including women of reproductive age and their husbands/ partners; community members/leaders; health workers, including facility based health care providers and community health workers, including TBAs; and local authorities.

Qualitative	Client-exit interviews	These interviews are conducted to understand experiences of and opinions about the health care services received. Within the context of the IFC framework, these interviews would most likely be used to explore the woman's interactions with the health care provider, as well as her awareness and enjoyment of her rights related to maternal health.	Women having received antenatal care, postnatal care or given birth in a health facility.
	Open-ended questionnaires	Designed to allow participants to provide additional information regarding their opinions and perceptions related to survey questions. They may be used with IFC partners to explore their experiences and satisfaction participating in the IFC component or with the actors and health workers involved and to better understand the degree that rights and gender perspectives are mainstreamed into the implementation processes.	IFC partners; health workers.
	Group discussions	Not strictly limited in number of participants, these discussions provide a platform for IFC actors to meet to discuss their experiences participating in the IFC component, their general opinions and satisfaction, as well as other strategic issues such as the degree of incorporating rights and gender perspectives within the management of IFC implementation.	IFC partners.

In the spirit of participatory monitoring and evaluation, qualitative methods may be used not only as sources of data collection, but also as opportunities to promote the participation of various stakeholders in monitoring and evaluation, to better understand their needs and experiences and initiate change based on their opinions.

Whenever possible, it is advisable to use data that can be disaggregated or design data collection tools so that the indicators can be disaggregated.

Disaggregated data contributes to the detection of inequities and/or discrimination that is critical to a rights-based approach and may also be used to identify what groups are benefiting most from implementation of the IFC component and who may not be benefitting but should be. Data may be disaggregated according to socio-economic status, ethnicity, gender or other relevant factors.

2.5 THE DISTRICT IFC ACTIVITIES PLAN

Once the logframe is complete, it is necessary to consider how the IFC interventions will take shape in terms of timing, resources and responsible actors in order to facilitate implementation. This can be done by developing an activities plan. A sample activities plan is provided in Annex 2. To elaborate the activities plan, the team details the practical aspects of the implementation of interventions as suggested in the steps below:

1) ***List the planned outcomes and outputs:*** These are found in the logframe.

2) ***Under each output, list the corresponding activities:*** For example, if one of the planned outputs is to train health care providers to improve their interpersonal skills, sub-activities may include developing/ adapting training materials, conducting a training of trainers, and finally conducting the actual training workshops for health care providers.

3) ***Clarify sequences and relationships between activities in terms of timing:*** Some activities are dependent on other activities being completed first. It is necessary to specify these dependencies and list the activities in the appropriate order. For example, if birth preparedness and complication readiness are among the selected interventions, the necessary tools, including a training manual for those who will assist women in developing a plan and potentially a card, or other planning tool provided to women, will generally be developed before one-to-one education with women begins.

4) ***Specify the timing:*** This involves estimating the duration of each task and establishing the likely start-up and completion dates.

5) ***Identify responsible actors and their role:*** This is intended to reduce ambiguity and increase accountability among partners.

6) ***Outline the necessary resources and the source:*** This may include human, material and financial resources. The currently available resources should be specified as well as a preliminary strategy for mobilizing additional resources. Moreover, the resource mobilization for the IFC component will ideally be linked to the broader effort for mobilizing resources for the district MNH programme.

To facilitate the implementation and the monitoring of interventions, the team may also elaborate an annual action plan apart from the three- to five-year action plan. It contains the activities planned for the course of the year in question, detailing activity implementation by month. This may be done with the logframe as well. Generally, the first year of the annual action plan will be more detailed than subsequent years, as certain activities are repeated and routines established.

2.6 FINALIZING AND PRESENTING THE DISTRICT IFC ACTION PLAN

After having elaborated the IFC action plan, we suggest that the team review the plan with participating actors and the community before its finalization. This promotes transparency in planning as well as the participation of stakeholders, including the community, throughout the process, ensuring that IFC planning is indeed a joint planning process. One systematic way to approach this process may be to invite representatives from among the community and institutional actors who participated in the PCA to a joint meeting. Separated into subgroups, they may look through the logframe and activities plan, contributing amendments according to their competencies and personal experiences. This meeting will ideally result in an action plan that is satisfactory to the participants and that may be finalized.

With the action plan finalized, the district IFC committee presents it to MNH actors and other sectors. As mentioned in section 5.3 of Module 3, it is ideal to disseminate the finalized plan simultaneously with the PCA results in order to demonstrate the committee's capacity to act quickly on the basis of results.

Next, the action plan and the PCA results may be presented to the IFC and MNH committees at the province and national levels. These meetings can also provide an opportunity to coordinate the IFC component planning, monitoring and evaluation at these levels and begin discussing a strategy for scaling-up the IFC framework (see section 2.16 of Module 1). The process of presenting the action plan can also provide a platform for integrating IFC activities into the broader MNH programme.

2.7 THE NATIONAL AND PROVINCE IFC ACTION PLANS

In addition to the district IFC action plans developed to guide implementation of the IFC component at this level, the national and province levels are also advised to elaborate a plan for implementation of the IFC component at their respective levels. As in elaborating the district action plan, whenever possible the IFC work will be directly integrated into the broader national or provincial MNH work plan. In the absence of this possibility, due to timing or other impediments, it is preferable to use the tools utilized for the in-country MNH strategy for the IFC component. However, once again, if this is not feasible, IFC committees can adapt and use the logframe (Annex 1) and the activities plan (Annex 2) provided in this module, remembering to use them flexibly and recognizing and compensating for their limitations. As at the district level, it is important that planning processes at the national and provincial levels be transparent and that the resulting tools facilitate accountability.

The IFC action plans at national and province levels will generally focus on:

1) ***Plans for rolling out the IFC component:*** This includes selection of provinces/districts for implementation and actions related to scaling-up.

2) ***The five priority areas of health systems strengthening:*** For example, the national and province action plans may include action on public policies (e.g. institutionalization of the IFC component); coordination of the IFC component (e.g. creating and/or strengthening the IFC committees, establishing communication between actors involved in IFC implementation both horizontally and vertically); promotion of community participatory processes in the country; building the capacity of in-country actors on the IFC framework; and monitoring and evaluation of the IFC component.

3) ***Centralized interventions:*** While many of the planned activities based on the PCA or other participatory mechanisms will be specific to a district and implementation focused at this level, some activities may be amenable to centralization at the national or provincial levels. Activities that may be centralized include modifications of national programmes, mass media campaigns and the production of didactic materials related to health. For example, if multiple districts are identifying a need for birth preparedness and complication readiness, or if actors at national or province levels see the need for such interventions more broadly than in one district, they may develop a centralized strategy for rolling out the intervention. This would facilitate the creation of the tools necessary to effectively promote birth preparedness and complication readiness and avoid the duplication of efforts. Centralized interventions will preferably be integrated into the national MNH action plan so as to ensure the complementary nature of the IFC component in the broader MNH strategy. They will also need to be carefully adapted before being applied to the local level.

At these levels, as at the district level, IFC actors will want to ensure that these activities are appropriately implemented, monitored and evaluated. At the national and provincial level it is critical to select indicators to measure progress toward achieving planned outcomes and outputs. Particularly when selecting outcome indicators related to the objective of the IFC component at the national and province levels, the respective committees will generally want to select from those that the IFC component contributes to (e.g. use of services) and that are already used within the existing MNH strategy. This means that they will ideally already be part of the monitoring mechanisms and processes employed by the MNH programme. Any new indicators related to the IFC framework that the IFC committees at these levels would like to see measured would ideally be completely integrated into the existing MNH monitoring and evaluation system. At all levels, IFC committees will want to carefully avoid creating parallel systems of monitoring and evaluation. When certain indicators important to the IFC component are not already included, committee members may consider advocating for their inclusion in the current monitoring and evaluation system, in censuses or other regularly conducted data collection systems. In WHO regions where monitoring and evaluation tools for MNH have been developed[5], IFC committee members can use these as a starting point for determining how to incorporate IFC indicators into the national MNH monitoring and evaluation system and use the strategy in advocacy.

[5] For an example see PAHO, 2011.

3. MONITORING AND EVALUATING THE IFC COMPONENT

3.1 OVERVIEW OF MONITORING AND EVALUATING THE IFC COMPONENT

Monitoring and evaluation are critical elements of the IFC implementation process. As such, actions and budgeting for monitoring and evaluation will ideally be included in the IFC action plan. Typically, the foundation for monitoring and evaluation will have been laid during the planning processes at district, provincial and national levels. Monitoring and evaluation will serve to assess whether and how activities are being implemented and how they are contributing to change. They also contribute to assuring accountability to stakeholders.

Monitoring will generally be conducted in the same manner regardless of the type of implementation site, whether an initial implementation site or expansion site.

Evaluation, on the other hand, may be more rigorous in the initial implementation sites allowing for an impact evaluation, and potentially implementation research while simplified processes will typically be employed in expansion sites.

The monitoring and evaluation of the component will need to be adapted to the context of the country, province and district. However, a coordinated approach between different levels of the health sector will facilitate the collection, analysis and comparison of data between districts. With this goal, the national level can play an important support role in selecting appropriate monitoring and evaluation tools and instruments to be used by the districts.

Box 3.1: Provincial and national roles in monitoring and evaluation

While the majority of the monitoring and evaluation of the IFC component will occur at district level, there are certain areas that the national and provincial IFC committees will be responsible for. These include:

- monitoring the national and province actions related to the IFC component within the MNH strategy;
- evaluating the contribution of the IFC component to the achievement of national and provincial MNH goals and strategy;
- agreeing on an IFC monitoring and evaluation framework and overseeing its implementation;
- promoting partnerships and coordination between ongoing IFC efforts in different districts. This gives partners a common vision of the outputs and outcomes to which the various in-country IFC interventions are contributing;
- carrying out, participating in, and ensuring the overall quality of IFC evaluations and ensuring that the processes and products meet international standards;
- ensuring the centralization of monitoring and evaluation results generated from all district level IFC efforts in the country;
- ensuring effective use and dissemination of monitoring and evaluation information in future planning and decision-making for improvements.

3.2 MONITORING OF THE IFC COMPONENT

Monitoring consists of the continuous tracking of activities throughout the implementation period. It reveals whether activities are being implemented according to the plan and shows progress toward the planned outputs. It allows IFC partners to assess whether interventions are on course, provides information to support continuous decision-making and supports accountability throughout the implementation period.

IFC committee members at the various levels will need to work together to determine the tools that they will use for monitoring. The national IFC committee generally assumes a role in assuring consistency in the monitoring tools used in different districts in which the IFC framework is being implemented. Typically these tools will include the **action plan, field visits** and **annual reports**. It is not realistic to expect that any one monitoring tool will be able to fulfil all monitoring needs; therefore, a mix of tools will generally be beneficial. In addition, monitoring tools may be used differently in different contexts. It is important that IFC committee members and partners agree on which tools will be used and how the tools will be used, and that they have a shared vision of monitoring of the IFC component. While all IFC committee members have a shared responsibility in monitoring, the primary responsibility lies with the IFC coordinator.

It is especially important that monitoring be conducted in the spirit of learning. Partners will be able to make the best use of monitoring activities and data when they feel that they are being employed for their benefit rather than judgement. IFC coordinators can play a key role in creating a learning-focused monitoring environment through their attitudes and leadership.

In order to collect data for monitoring, the IFC committee can use the **action plan** for the given period. The activities plan is an especially useful tool in this exercise, as it lays out the specifics of what was expected to have occurred during a certain time frame: the planned activities, the partners responsible for conducting the activities, the resources that were to be used for the activities, and ultimately the outputs to which the activities were expected to contribute. IFC coordinators can examine each activity planned for the time period and first determine whether the activity was conducted. If the activity was conducted, they can collect data on the input and process indicators related to the activity, as specified in the logframe. For example, if during the time period one of the planned activities was to train health care personnel in counselling women and families on MNH issues, the IFC coordinator can first determine whether the training was conducted, and if so, if it was conducted according to plan. They can then track how many health personnel were trained. If a pre- and post-test was conducted during the training they could also collect these results. This process is facilitated when the actors responsible for a given activity submit the data related to the activity directly to the IFC coordinator. They can then compare what was planned to what actually took place (e.g. did each responsible actor fulfil their role? Were the planned number of health personnel trained, or more, or less?). Preferably, IFC partners will collect monitoring data related to the input, process and output indicators on a quarterly basis.

If the activity was not conducted or certain indicators are not as expected (such as, from our previous example, fewer health care providers were trained than anticipated), the IFC committee can explore reasons for this and learn from these unexpected results. Often the reasons will be related to complexities in implementation that were not anticipated. The success of implementation will largely depend on the partners' and stakeholders' abilities to

respond to these complexities appropriately. Monitoring provides the opportunity to identify these complexities and then make decisions and take action to address them effectively.

Some information may be collected by health authorities, such as those related to the utilization of health services. Ideally, the IFC committee will work with health authorities to integrate indicators specific to the IFC framework into the monitoring grids used in routine supervision within the health services. Other data will be accessible through local and national health information systems. The IFC coordinator will generally be responsible for compiling the data submitted by IFC partners and those collected from the health system. It is advisable for the coordinator to compile and prepare this data prior to each IFC committee meeting.

Field visits may also be used as a monitoring tool. Field visits serve to validate the results reported by partners and involve assessing progress, results and problems. At the district level, the IFC coordinator will generally be responsible for conducting field visits within the district. These visits may be conducted jointly with other IFC partners or health authorities monitoring MNH activities in order to optimize ownership. Field visits to the district level may also be conducted by IFC coordinators at national and province levels. Results from these visits may be shared and analysed during IFC committee meetings.

Finally, it is strongly encouraged to develop **annual reports** as part of the monitoring process. Normally, this report will be used for assessing performance, learning and decision-making. It also serves to ensure transparency and accountability within IFC implementation. The format of this report will be determined and agreed upon by the IFC committee. However, it is advisable to base the format on a generally accepted reporting format already utilized in the country. This report serves as a self-assessment of the IFC committee and implementation of the IFC component. Ideally it will present the most up-to-date results of the IFC component, identify major constraints and propose future directions. Optimally, a draft of the report will be developed and circulated to IFC committee members prior to holding the annual monitoring meeting so that the report can be discussed at this time.

Box 3.2: Monitoring of the IFC component

Monitoring of the IFC component is part of the IFC implementation framework and not an addition to it. It is not to be regarded simply as a management or reporting requirement, but rather as an opportunity to:

- engage IFC partners and stakeholders, with an emphasis on the community, so that they feel ownership of the results being achieved and are motivated to sustain them;
- demonstrate progress toward the achievement of IFC objectives, how the IFC interventions are benefiting women and families, and leverage support of the community and other stakeholders to address any challenges faced; and
- nurture an inclusive and purposeful monitoring culture to make implementation and management effective and interesting, as well as to ease the gathering of objective data and evidence to support achievements and make decisions.

Adapted from: UNDP, 2009.

Quarterly and annual IFC committee meetings at the district level and annual IFC committee meetings at the national level help to ensure that monitoring is a joint process involving the collaboration of various stakeholders (see Annex 4 for draft guides for quarterly and annual IFC committee meetings). During these meetings, the IFC committee analyses the monitoring data gathered using the action plan and from field visits and may review the annual report and any other report submitted

to the committee (e.g. training and workshops reports, other activity reports). Based on these monitoring tools they determine whether the actions are on target for achieving the outputs and outcomes, what complexities may exist in the context both internal and external to the implementation process that effect implementation and plan adjustments to the interventions, optimizing their implementation. In addition to analysing monitoring data, they can also use these monitoring meetings as an opportunity to assess the functioning of IFC implementation and coordination more generally.

Box 3.3: Key questions that monitoring seeks to answer

- Are the pre-identified outputs being produced efficiently and as planned?
- What are the issues, risks and challenges that we face or foresee that we can adjust for in order to facilitate the achievement of results?
- What decisions need to be made in subsequent stages concerning changes to the work already planned?
- Will the planned and delivered outputs continue to be relevant to achieve the envisioned outcomes?
- Are the outcomes we envisioned still relevant and effective for achieving the purpose of the IFC framework?
- What are we learning?

Source: UNDP, 2009.

In sum, monitoring of the IFC component will generally identify the following:

- progress towards results – this involves periodically analysing the extent to which intended results have been achieved or are being achieved;
- factors contributing to or impeding achievement of the outcomes – this requires a broader perspective taking into consideration the complexity and factors lying outside the IFC actors and action plan, such as economic, social, political and other developments;
- partner contributions to IFC interventions;
- partnership within the IFC committees – this requires the review of current partnerships within the IFC committees and their functioning as well as the consideration of new actors and sectors as needed. This helps to ensure that all partners have a common perspective of the needs and problems within the IFC component and that the action plan is known and accepted by all partners. Annex 5 contains two tools for assessing the district IFC committee: a self-assessment questionnaire and an IFC committee assessment discussion guide. Administering the self-assessment questionnaire can be a useful exercise for determining committee members' knowledge and understanding of the IFC component and to reveal their experience collaborating on the committee. This questionnaire is designed for participants to complete anonymously so that they feel comfortable answering honestly. When administering the questionnaire, ensure that all partners are able to participate. If some IFC committee members are unable to read and/or write, for example, you may want to bring in an external person to assist them in completing the questionnaire. The IFC committee assessment discussion guide can be used to lead the IFC committee through an exchange on collaboration and committee functioning. Monitoring meetings can also provide an opportunity to look at issues related to gender (such as whether the IFC committee adequately represents a gender balance and integrates gender perspectives) and the level and functionality of community participation (this is critical at all levels); and
- lessons learnt (see section 4).

Using information gained through monitoring, district coordinators and partners can analyse and

take action on activities to ensure that the intended results of the IFC component are achieved.

It is important that each member of the IFC committee is involved in monitoring. In practical terms, monitoring as a joint process with IFC actors involves the following:

- regular data collection related to activities by all partners and submission of data to the IFC coordinator;
- assessing during IFC committee meetings the progress towards results already stated in the logframe and sharing information gathered by partners (see Annex 6);
- planning and conducting joint field monitoring missions to gauge achievements and constraints;
- identifying lessons learnt, sharing them, and promoting their use by all IFC actors;
- identifying capacity development needs among IFC partners for fulfilling their roles in implementation;
- reporting regularly to stakeholders and IFC committees;
- bringing lessons learnt to the attention of policy-makers; and
- contributing to common reports.

It is important to maintain participation throughout the process of monitoring, and IFC partners will need to keep this in mind when developing their monitoring strategy. Assuring that community leaders or representatives of women's groups or other community-based organizations are included in the district IFC committee and participate in quarterly and annual review meetings is one way to ensure participation in monitoring. Community participation may also be promoted by integrating participatory methods in routine data collection. For instance, health workers could be trained to conduct focus group discussions with women and men on an annual basis and report the results to the IFC coordinator to ensure that community members' opinions and experiences are included in monitoring on a regular basis. In addition, the IFC committee is strongly encouraged to share monitoring results with the community in order to allow the community to participate in interpreting the data. This process also promotes transparency and accountability. These activities are critical to promoting the rights of the community members.

3.3 EVALUATION OF THE IFC COMPONENT

Evaluation overview

Evaluation, while closely related to monitoring, is a more extensive and detailed assessment generally conducted by independent actors. Evaluation seeks to assess the extent to which implementation of the IFC component is contributing to planned outcomes in the four priority areas of intervention and the priority areas of health systems strengthening, the component's contribution to improving MNH, and an assessment of the general functioning of implementation processes. It provides information on what is and is not working in implementation and provides objective information allowing IFC coordinators to make informed decisions about next steps and expansion to other sites.

Evaluation in the initial implementation site

In the initial implementation site(s), the IFC committee is strongly advised to consider conducting an impact evaluation or implementation research. This is done to provide evidence linking interventions with

results, to provide insight on what is working, in what context and for whom and to equip policy-makers and managers with information to improve operation and guide scale-up. The IFC committee will need to determine the main objectives and primary evaluation or research questions that will largely guide how to best conduct the evaluation or research. In many cases either a cluster-randomized controlled trial or a quasi-experimental design can be used to generate actionable information, preferably comparing the intervention district to a matched control district where IFC activities are not being implemented. Indicators are measured before and after implementation to capture changes in the intervention district. It is important to try to shed light not only on what has changed, but how, for whom and what factors of the context have either enhanced or deterred implementation and results. Accomplishing this will require a mixed-methods approach using both quantitative and qualitative methods in order to leverage the unique contributions of each type of method.

Selecting and supporting an evaluation team

The impact evaluation or implementation research in the initial implementation site will generally be conducted independently and require a specific set of technical skills and expertise. Therefore, the IFC committee will generally choose to engage an external evaluation institution to conduct it. IFC coordinators and committee members will need to carefully select the evaluators as this will largely determine the quality of the evaluation. Box 3.4 provides some areas for consideration in this selection process.

The IFC committee is advised to select evaluators who are open to participatory approaches to evaluation. This will require the evaluators to work closely with IFC committee members and other stakeholders, including community members. The evaluators will need to be aware and accepting of the implications of this participatory approach in terms of methods and time.

The IFC committee will be involved in supporting the evaluation team and in managing the process. Key roles of the IFC coordinator and IFC committee members include the following:

- draft the terms of reference (ToR) for the evaluation team – sample ToR are provided in Annex 6 to aid the IFC committee;
- brief the evaluators on the purpose and scope of the evaluation and explain expectations of the IFC committee and other stakeholders in terms of the required quality standards of the conduct of the evaluation and the deliverables;
- make all necessary information available to the evaluators;
- if asked by the evaluators, provide a preliminary list and contact information of stakeholders whom they should meet;
- organize a meeting to introduce the evaluation team to IFC partners and stakeholders and key informants to facilitate the initial contact. The evaluation team can also take this opportunity to receive inputs from the stakeholders in the formulation of the evaluation questions, seek clarifications in the ToR and exchange ideas about the ways in which to conduct of the evaluation;
- arrange interviews, meetings and field visits when requested; and
- provide comments on and ensure the quality of the work plan and the protocol prepared by the evaluation team.

Box 3.4: Some consideration when selecting the evaluation team

- Proven expertise and experience in conducting evaluations;
- Technical knowledge and experience in MNH and preferably in community-based MNH programmes;
- Knowledge of the national, province and district situations and contexts;
- Experience in social science research;
- Expertise in both quantitative and qualitative research methods;
- Open attitude toward participatory approaches in evaluation;
- Familiarity with the IFC framework is advantageous.

In many ways, the success of the evaluation will depend on the level of cooperation and support that the evaluation team receives from the IFC coordinator and committee.

In keeping with the principles of participation, the IFC committee will want to verify that opportunities for community members to participate in the evaluation are present in the protocol. This may include ensuring that community representatives have a say in what they would like to see evaluated, that participatory methods are part of data collection, allowing community members to voice their opinions and including community representatives in data analysis.

Equity should be a primary concern of the evaluation, and it should explore the question of who is benefitting from the implementation. It is important to identify whether certain groups are being excluded from the benefits and take action to remedy the situation. In addition, it is important to take gender issues into account within the evaluation, including in the context the evaluation and within the evaluation methods. For example, ideally the evaluation team will include both women and men to ensure that gender perspectives are taken into consideration throughout the entire evaluation process. In addition, evaluation methods should be designed to allow to accommodate to the opinions and experiences of both women and men in relation to the IFC component. The IFC committee will have a central role in verifying that gender considerations are integrated in the evaluation.

Evaluation in the expansion sites

Evaluation that occurs in the expansion sites will generally be simpler than in the initial site, it will focus more on monitoring than evaluation, and will require fewer resources, both human and financial. The IFC committee will need to work together during planning to determine the local evaluation needs and a strategy, in line with available resources. Quantitative indicators measuring output and outcome indicators can often be gathered in coordination with health monitoring conducted in the district or province. It may be possible to work with health officials to integrate indicators particular to IFC interventions. Complementary data collection using participative methods such as group discussions, in-depth interviews, client-exit interviews and reflection meetings with partners can be used to complete evaluations in expansion sites and to maintain participation in the evaluation process. It may be possible to train health workers to dialogue with communities and to conduct some data collection activities.

4. DOCUMENTATION OF LESSONS LEARNT

Throughout the course of IFC implementation, many lessons will be learnt. They will be learnt both through strengths and successes, as well as through weaknesses and failures. These lessons, when documented and disseminated, will be useful for others to build on what worked well or avoid similar mistakes. It is advisable to establish a process of documenting lessons learnt from the outset of IFC implementation, particularly in the initial implementation sites. These lessons will be particularly instructive as the IFC framework is scaled up. Documentation of lessons learnt will likely be less rigorous in expansion sites, unless IFC partners are testing or introducing something new or the site is considerably different from sites where lessons learnt have been thoroughly documented.

Learning lessons can only happen when there is time to reflect on practice, identify lessons and disseminate them to others, allowing them to absorb and apply the lessons. IFC committees can schedule time during quarterly and annual meetings for this type of reflection on lessons and record them in monitoring information. This process requires open-mindedness among IFC partners in reviewing experiences so that difficulties and complexities are acknowledged rather than ignored.

A discussion of lessons learnt can form a part of each quarterly district IFC committee meeting, allowing partners to discuss the lessons from the previous quarter before they are forgotten. One systematic way to go about this is to review each of the priority areas of intervention and priority areas of health systems strengthening, including those which are not included in the logframe, and discuss the following:

- What was learnt about what went well?
- What was learnt about what did not go well?
- What was learnt about what needs to change?
- How can this be incorporated into implementation?

Based on this discussion, the key points can be highlighted and documented. A sample template for documentation of lessons learnt can be found in Annex 7. It is suggested to include the following:

- implementation district and IFC coordinator contact information;
- priority area of intervention/health systems strengthening concerned;
- activities conducted during the period;
- what went well;
- what challenges were faced;
- the results; and
- a generalizable summary of the lesson learnt.

The IFC committee can also discuss and document lessons learnt that may fall outside of the scope of the priority areas of intervention and the priority areas of health systems strengthening when the need arises.

It will be beneficial to share lessons learnt at the district level with IFC committees at the province and national levels during annual IFC committee meetings. Before sharing these lessons, it is recommended that the district coordinator reviews the documentation of all lessons learnt from the specified time period, ensuring their relevance and consolidating documented lessons when appropriate. Lessons learnt by definition are to be generalizable and therefore not specific to the context. They are also independent of the actual results of interventions (see Box 4.1 for some examples of lessons learnt).

In addition to their documentation at district level, lessons learnt will also be discussed and documented at the province and national levels following a similar process. These lessons at all three levels can be incorporated into annual reports and disseminated to stakeholders along with results from monitoring and evaluation (see section 5).

National actors may need to support district and province level teams in documenting lessons learnt when these teams are not experienced in this process. The national team will also generally be responsible for assuring that the lessons are made available to actors involved in IFC implementation throughout the country, so that they can be used to optimize effectiveness and avoid pitfalls that have already been experienced.

Box 4.1 Lessons learnt from IFC implementation in Kazakhstan

- At the district level the concept of involving communities as well as other sectors to improve maternal, newborn and child health is perceived as very innovative but requires a shift in thinking at several levels and a significant amount of time to adopt.
- Districts often require a high level of support from the national and province level at the outset of IFC implementation.
- At the national and province levels, advocacy for the IFC component is critical to its success.
- Financing the IFC component is an issue of concern. Securing the support of decision-makers at all levels is a long process and is facilitated by continuous advocacy and involvement during the PCA process. National level decision-makers' commitment is key to ensuring that budgets are allocated to the IFC component.

5. DISSEMINATION AND USE OF IFC MONITORING AND EVALUATION RESULTS

5.1 RESULTS DISSEMINATION

Ideally, disseminating the results from monitoring and evaluation will occur as soon as possible after the monitoring results are compiled or after evaluation is complete so that the findings remain relevant and in order to assure accountability and transparency. It is important to include results dissemination as a budget line when planning monitoring and evaluation to ensure that the resources will be available to do so effectively.

There are many different audiences to consider when designing a dissemination strategy. Table 5.1 presents some of the audiences that may be considered. In all cases, it is important to ensure that the results are disseminated in an easily understandable manner to the intended audiences so they can learn from it. This may be facilitated by using visual tools (see section 1.3).

Table 5.1: Results dissemination audiences

TARGET AUDIENCE		PURPOSE	METHODS
Stakeholders	Province/ district IFC committees	• Allow partners to ask questions and receive clarifications from evaluators • Discuss implications for implementation redirection, funding and expansion • Prepare actionable next steps	• Meetings with evaluators who present results and recommendations • Workshops in which partners prepare actionable next steps
	National MNH committee	• Preparation to coordinate the dissemination of results to other provinces and districts • Preparation for compilation of the results of all in-country evaluations of IFC interventions • Institutionalization of the IFC framework at country level • Guide scale-up	• Meetings with evaluators at the national level • Meetings with district/ province coordinators and partners • Workshops to prepare actionable next steps • Information and communication technologies (ICTs), such as a blog developed for the IFC component, information networks for knowledge management, social networks, learning communities

TARGET AUDIENCE		PURPOSE	METHODS
Stakeholders	Other provinces and districts in which the IFC framework is being implemented	• Provide a broader vision of the results of the IFC interventions throughout the country • Optimize implementation, building on success and avoiding pitfalls	• National level meetings/ workshops with participation of various district/province IFC partners • ICTs, such as blogs, information networks for knowledge management, social networks, learning communities
	Community	• Increase accountability to the community • Increase community awareness of the results of the IFC component in order to increase motivation to participate • Contribute to the empowerment process and ensure that inventions are not "done to" the community, but rather "done with" the community • Provide communities the opportunity to comment on the results and contribute to a strategy of using the results for improving interventions	• Community meetings with the district coordinator, community representatives and evaluators to allow community members to ask questions and present suggestions based on the results; visual methods to present data, etc. • Dissemination through health centres/providers • Print material (carefully considering literacy status and local languages of the target audience) • ICTs, such as a blog developed for the IFC component, information networks for knowledge management, social networks, learning communities (carefully considering literacy status, local languages and access to technologies of target audience)

TARGET AUDIENCE		PURPOSE	METHODS
Outside audiences	Local: community groups, religious organizations, health workers, government officials, local NGOs, etc.	• Increase local awareness of the IFC component • Inform about what is taking place in the district and the results of the initiative • Increase the support of the IFC component at district level • Enlist new actors from various sectors	• Oral presentations • Meetings with organization representatives • Written reports, fact sheets, etc. • ICTs, such as blogs, information networks for knowledge management, social networks, learning communities, visual methods to present data
	Province/ national: policy-makers, country offices of international organizations, national NGOs and funding agencies	• Increase country-level awareness of the IFC component • Inform about what is taking place in the country and the results of the initiatives • Increase the support of the IFC component • Increase collaboration	• Oral presentations • Meetings with organization representatives • Written reports, press releases, fact sheets, etc. • ICTs, such as blogs, information networks for knowledge management, social networks, learning communities
	International: actors and organizations involved in maternal and child health, community-based interventions	• Contribute to a broader understanding of what works in improving MNH • Advance the field by building a body of lessons learnt and best practices that can strengthen MNH programmes around the world	• News articles, journal publications • Presentations delivered at international congresses • ICTs, such as blogs, information networks for knowledge management, social networks, learning communities

The national IFC committee, in its role in coordinating the monitoring and evaluation system, generally takes the lead in ensuring that the results obtained from monitoring and evaluation are compiled, understood and incorporated into future interventions to contribute to the success of the expansion of the IFC component to other districts and provinces.

When disseminating results, it is suggested to highlight both **strengths and weaknesses**, as there are valuable lessons to be learnt by various audiences based on both successes and shortcomings. Disseminating experiences in dealing with, or failing to deal with, complexity can be particularly instructive to those involved in MNH programming. In addition, reporting both strengths and weaknesses can reinforce accountability and increase credibility.

While mentioned in the table, we would again like to highlight the importance of prioritizing dissemination of results to the community. Sharing information gained from monitoring and evaluation with community members is fundamental to participatory processes and to ensuring transparency and accountability, which are core elements of a rights-based approach. The participation of the community in the IFC component can only be meaningful and relevant if they have access to timely information. This information must be accessible to community members, taking into account their gender, ethnic, religious and cultural background as well as their literacy status. The IFC committee will want to address these considerations to be sure that results are accessible to community members and that they have the opportunity to provide input on results in a meaningful way (see section 1.3).

5.2 USING MONITORING AND EVALUATION RESULTS

While dissemination and knowledge generation is a critical first step in the utilization of monitoring and evaluation results, use of information will ideally extend far beyond this. When IFC monitoring and evaluation is exploited effectively, it will support improvements, vertical and horizontal scale-up of IFC framework, advocacy and accountability.

Intervention improvements

Monitoring and evaluation results will help IFC partners improve interventions and make decisions about the best use of resources. Specifically, results may be used to:

- highlight strengths and accomplishments: this will allow IFC coordinators to build on and reinforce assets;
- improve management and planning of the IFC component: as the IFC framework promotes a high level of interagency and intersectoral collaboration, evaluation is critical in assessing the functioning of this collaboration and making needed changes to improve what can sometimes prove to be a complicated process;
- identify implementation weaknesses: once IFC implementation weaknesses are identified, appropriate corrective action can be taken to overcome these shortcomings;
- horizontal scale-up: monitoring and evaluation results will be particularly instructive in scaling up the IFC framework to new areas. This will help policy-makers identify the best strategy for expanding, and help other IFC coordinators and committees understand what has previously been effective and avoid mistakes that have already been made;
- identify needs: existing needs may not become evident until identified through monitoring and evaluation. Once identified they can be incorporated into future plans.

An implementation strategy for improvements based on monitoring and evaluation results will ideally be developed jointly with IFC committee members, after which the IFC coordinator will generally be responsible for following up to ensure that the strategy is implemented. As IFC partners take time to reflect on implementation and make necessary adjustments, they are also more likely to feel supported by the monitoring and evaluation process.

Vertical scaling-up: institutionalization

Monitoring and evaluation results can help stakeholders and communities understand what the programme is doing, how well it is meeting its objectives and whether there are ways that progress can be improved. Sharing results can help strengthen the social, financial and political

commitment to the IFC component within the MNH strategy and establish or strengthen the network of actors and sectors working within the IFC component in the country. This can lead to an increased level of institutionalization of the IFC framework at all levels.

Advocacy

Disseminating monitoring and evaluation results can raise awareness of the IFC framework among the general public and help build positive perceptions about community participative strategies in improving MNH. Results can also be used to lobby for policy changes that relate to MNH by pointing out unmet needs or barriers to success of the IFC component.

Accountability

Monitoring and evaluation results can be used to strengthen accountability to stakeholders and donors by providing an unbiased account of intervention implementation and use of resources. Learning from past lessons and taking corrective action is also a critical component of accountability.

Use of monitoring and evaluation results will ideally be institutionalized within IFC processes. This can occur through the sharing of knowledge and information at regular IFC committee meetings, reporting and management of evaluation results. It is also possible to use information and communication technologies to increase accountability and build a sense of transparency by making information available on the internet and electronically as soon as possible after it becomes available. Ensuring that results are used effectively to strengthen the IFC framework at all levels and that they feed back into planning will optimize and complete the IFC implementation cycle.

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ANNEXES

1. Sample IFC Logframe
2. Sample IFC Activities Plan
3. List of illustrative IFC indicators
4. Draft Guides For Quarterly and Annual IFC Committee Meetings
5. District IFC Committee Assessment Tools
6. Sample Terms of Reference For Evaluation Institution
7. Documentation Form for Lessons Learnt

ANNEX 1: SAMPLE IFC LOGFRAME

	NARRATIVE SUMMARY	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS/RISKS
Goal	*Contribute to the improvement of MNH*	*[Impact]*		
Purpose	*Empower women, families and communities to improve MNH and increase utilization of MNH services*	*[Outcome]*		
PRIORITY AREAS OF INTERVENTION				
Outcome 1	*Capacities developed*	*[Output/Outcome]*		
Planned Output 1.1…		*[Input/Process/Output]*		
Outcome 2	*Awareness increased*	*[Output/Outcome]*		
Planned Output 2.1…		*[Input/Process/Output]*		
Outcome 3	*Linkages strengthened*	*[Output/Outcome]*		
Planned Output 3.1…		*[Input/Process/Output]*		
Outcome 4	*Quality of care improved*	*[Output/Outcome]*		
Planned Output 4.1…		*[Input/Process/Output]*		

PRIORITY AREAS OF HEALTH SYSTEMS STRENGTHENING				
Outcome 5	*Public policies favourable to MNH*	*[Output/Outcome]*		
Planned Output 5.1…		*[Input/Process/Output]*		
Outcome 6	*Coordination of IFC actions within the health sector as well as between the health sector and other sectors strengthened*	*[Output/Outcome]*		
Planned Output 6.1…		*[Input/Process/Output]*		
Outcome 7	*Community participation is strengthened in the management of MNH problems*	*[Output/Outcome]*		
Planned Output 7.1…		*[Input/Process/Output]*		
Outcome 8	*Capacity of the health workforce is built to implement the IFC component*	*[Output/Outcome]*		
Planned Output 8.1…		*[Input/Process/Output]*		
Outcome 9	*Monitoring and evaluation of the IFC component strengthened*	*[Output/Outcome]*		
Planned Output 9.1…		*[Input/Process/Output]*		

ANNEX 2: SAMPLE IFC ACTIVITIES PLAN

	ACTIVITY	TIMEFRAME (YEAR)					ACTORS AND ROLES		RESOURCES		
		1	2	3	4	5	RESPONSIBLE ACTOR(S)	ROLE	NECESSARY RESOURCES	AVAILABLE RESOURCES	HOW TO MOBILIZE ADDITIONAL RESOURCES
PRIORITY AREAS OF INTERVENTION											
OUTCOME 1: CAPACITIES OF WOMEN DEVELOPED											
Output 1.1...											
OUTCOME 2: AWARENESS INCREASED											
Output 2.1...											
OUTCOME 3: LINKAGES STRENGTHENED											
Output 3.1...											

OUTCOME 4: QUALITY IMPROVED											
Output 4.1...											
PRIORITY AREAS OF HEALTH SYSTEMS STRENGTHENING											
OUTCOME 5: PUBLIC POLICIES											
Output 5.1...											
OUTCOME 6: COORDINATION											
Output 6.1...											
OUTCOME 7: COMMUNITY PARTICIPATION											
Output 7.1...											
OUTCOME 8: CAPACITY BUILDING OF HEALTH WORKFORCE											
Output 8.1...											
OUTCOME 9: MONITORING AND EVALUATION											
Output 9.1...											

ANNEX 3: LIST OF ILLUSTRATIVE IFC INDICATORS

This annex presents a list of illustrative indicators pertinent to the IFC framework. This list of indicators is the result of a detailed examination of numerous documents pertinent to the IFC framework and to the monitoring and evaluation of MNH programmes. Almost all the indicators mentioned in this document are already used at the national and international levels to measure the impact of MNH programmes and the results of interventions in the area of MNH. As such, using the list as a guide is expected to facilitate data collection and allow the use of existing information systems (such as health information systems, Demographic and Health Surveys) while avoiding the implementation of parallel systems and non-sustainable data collection. When possible, indicators used to measure interventions related to the IFC component will be incorporated directly into the monitoring and evaluation system of the MNH programme at national, province and district levels (see sections 2.3 and 2.4 of this module for more information on selecting indicators and means of verification).

This list identifies impact, outcome and output indicators exclusively. Input and process indicators are not included as these will be numerous and specific to planned actions. Note also that while we have divided outcome and output indicators, in reality this distinction is not always clear-cut. Whether an indicator is considered an outcome or output will often depend on the level of progression of interventions and the defined objectives.

In order to keep the list of indicators to a manageable number we have identified the indicators among the most representative of the IFC component, without addressing themes that, although impacting MNH, are either common to several programmes or specific to certain countries. These include violence against women, sexually transmitted infections, HIV/AIDS, malaria, malnutrition, female genital mutilation, adolescent pregnancy, sexual and reproductive health and abortion. As a result this list is not designed be exhaustive and IFC coordinators will often be working with indicators outside the scope of this list when formulating indicators specific to the interventions in a particular county or district.

The majority of the indicators presented in this list can be applied to the district level, while some can be used at all three levels (district, province and national) and a few can only be used at the national level, notably those related to mortality rates. In general, the majority of indicators at the national and province levels will fall within the IFC priority areas of health systems strengthening while the majority of indicators at the district level will fall within the four IFC priority areas of intervention.

We would like to emphasize once again that these indicators are illustrative. When using this list as a reference, IFC coordinators will need to carefully adapt indicators to ensure that they are specific to their particular interventions, and also that the chosen indicators are able to measure processes, outputs and outcomes directly related to implementation of the IFC component in their area.

LIST OF ILLUSTRATIVE IFC INDICATORS		
GOAL	**SOCIAL IMPACT INDICATORS**	**HEALTH IMPACT INDICATORS**
Contribute to the improvement of maternal and newborn health	Improved status of women (Indicator to be determined at country level) Improved social cohesion (Indicator to be determined at country level) Reduced inequity and discrimination (Indicator to be determined at country level)	Maternal mortality ratio Neonatal mortality rate # of maternal deaths # of neonatal deaths Perinatal mortality rate Stillbirth rate Adolescent birth rate Postpartum depression prevalence
PURPOSE	**SOCIAL OUTCOME INDICATORS**	**HEALTH OUTCOME INDICATORS**
Contribute to the **empowerment** of individuals, families and communities to improve maternal and newborn health and **increase access to and utilization of quality health services**	% of women involved in the decision regarding maternal and newborn health care-seeking % of women who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care* % of women subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months* % of women/men reporting improved family dialogue around maternal and newborn health Increased accountability and community participation in health services	% of pregnant women having at least eight antenatal care visits per income quintile % of pregnant women initiating antenatal care within the first 12 weeks of pregnancy per income quintile % of births attended by a skilled attendant/in a health facility per income quintile % of women/newborns receiving postnatal care from a skilled attendant, within the first 24 hours, on day 3 (38-72 hours), between days 7-14, at six weeks Coverage of essential maternal and newborn health services (index based on composite of antenatal care, skilled attendance at birth and postnatal care utilization)*

* Sustainable Development Goal indicator

LIST OF ILLUSTRATIVE IFC INDICATORS			
PRIORITY AREAS OF INTERVENTION		**OUTPUT INDICATORS**	**OUTCOME INDICATORS**
Developing **CAPACITIES** to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies	*Self-care/ care in the household*	% of pregnant women who are aware of self-care practices during pregnancy (e.g., reducing workload, nutrition, malaria/HIV/syphilis treatment and prevention, etc.) % of pregnant women who are aware that infants should be exclusively breastfed for the first 6 months % of women who are aware of self-care practices postpartum (e.g., reducing workload, nutrition, etc.)	% of infants who were breastfed within the first hour of birth % of women breastfeeding exclusively for 6 months postpartum % of women taking iron folate tablets % of women reducing workload during pregancy
	Care-seeking behaviour	% of pregnant women who can state at least two benefits of antenatal/postnatal care visits % of pregnant women who are aware of labour signs	% of pregnant women having at least eight antenatal care visits % of pregnant women initiating antenatal care within the first 12 weeks of pregnancy % of births attended by a skilled attendant/in a health facility % of women/newborns receiving postnatal care from a skilled attendant (within the first 24 hours, on day 3 (38-72 hours), on day 7-14, at six weeks) % of women seeking care for obstetric complications
	Birth preparedness and complication readiness	% of pregnant women who have a card (or similar tool) to prepare for birth and obstetrical and neonatal complications % of pregnant women having discussed a plan for birth and complications with a healthcare provider % of pregnant women who are aware of three danger signs during pregnancy/after birth % of pregnant women who are aware of three danger signs for newborns % of pregnant women who are aware of accessible health services in case of obstetrical and neonatal complications % of pregnant women having discussed a plan for birth and complications with their partners and/or other household members	% of pregnant women who save money for birth % of pregnant women having identified a companion of choice to accompany them during birth % of pregnant women having identified a birthplace % of pregnant women having identified a mode of transportation to reach the birthplace

LIST OF ILLUSTRATIVE IFC INDICATORS			
PRIORITY AREAS OF INTERVENTION		**OUTPUT INDICATORS**	**OUTCOME INDICATORS**
Increasing **AWARENESS** of the rights, needs and potential problems related to maternal and newborn health	*Male involvement and family support*	% of women/partners/mothers/mothers-in-law who mention the support of household members for women during pregnancy and/or after birth % of women who mention household member support for exclusive breastfeeding % of partners/mothers/mothers-in-law who are aware of the plan for birth and complications of their partner/daughter/daughter-in-law % of partners/mothers/mothers-in-law who are aware of three danger signs during pregnancy/after birth % of partners/mothers/mothers-in-law who are aware of three danger signs in newborns % of partners/mothers/mothers-in-law who are aware of the importance of exclusive breastfeeding for the first 6 months after birth	% of partners/mothers/mothers-in-law who accompany the woman to antenatal and/or postnatal care visits % of partners who accompany the woman to the health facility for birth % of partners/mothers/mothers-in-law who participate in antenatal care visits/birth preparation/postnatal care visits % of women reporting depression symptoms during pregnancy
	Promotion of human, sexual and reproductive rights	% of women who are aware of rights related to maternal health (e.g. right to access quality maternal and newborn health services, right to respectful maternity care, rights related to decision-making, rights related to family planning, etc.) % of men who are aware of rights related to maternal health (e.g. right to access quality maternal and newborn health services, right to respectful maternity care, rights related to decision-making, rights related to family planning, etc.) % of health care providers who are aware of rights related to maternal health (e.g. right to access quality maternal and newborn health services, right to respectful maternity care, rights related to decision-making, rights related to family planning, etc.)	
	Community participation in maternal death surveillance and response	# of health facilities that have a maternal and perinatal death surveillance system Presence of community representative on the maternal and perinatal death review committee	Mechanism/process established to share information with community on the results of the maternal and perinatal death review Activities carried out by health services and/or the community based on maternal and perinatal death surveillance Mechanism/process to share information between health services and the community on the results of data and/or research on maternal and newborn health (e.g., information from the health information system, community epidemiological surveillance, verbal autopsies)

LIST OF ILLUSTRATIVE IFC INDICATORS			
PRIORITY AREAS OF INTERVENTION		**OUTPUT INDICATORS**	**OUTCOME INDICATORS**
Strengthening **LINKAGES** for social support between women, families and communities and with the health care delivery system	*Partnership with traditional birth attendants*	% of women/men/community members who are aware of the new role of traditional birth attendants % of traditional birth attendants satisfied with their relationship with health care providers % of traditional birth attendants satisfied with their new role in maternal and newborn health Mechanism of dialogue established between health services and traditional birth attendants to define the new role of traditional birth attendants in maternal and newborn health New role of traditional birth attendants integrated in the local health strategy (district, regional, or health services level) # of health facilities that recognize the new role of traditional birth attendants # of health facilities that organize regular meetings with traditional birth attendants	% of women accompanied at health facility by a traditional birth attendant for birth or for an obstetrical/neonatal complication
	Maternity waiting homes	% of women/men/community members who are aware of the existence of a maternity waiting home % of women/men/community members who have a positive opinion regarding the existence of a maternity waiting home Education activities conducted at maternity waiting home	% of women who have used a maternity waiting home % of women satisfied with their stay in a maternity waiting home
	Community organized transport schemes	% of women/partners/mothers/mothers-in-law who mention activities at the community level to overcome transportation barriers to accessing health facilities	
	Community mobilization through participatory learning and action cycle with women's groups	# of active groups % or groups with participation of 30% of pregnant women	% of women/partners/mothers/mothers-in-law who mention community activities to overcome financial barriers to accessing health services % of women who mention difficulties in accessing health facilities for obstetrical and neonatal complications and/or birth

LIST OF ILLUSTRATIVE IFC INDICATORS			
PRIORITY AREAS OF INTERVENTION		**OUTPUT INDICATORS**	**OUTCOME INDICATORS**
Improving **QUALITY** of care, health services and interactions with women, families and communities	*Community participation in quality-improvement processes*	Consultation mechanism/process with women and with the community established concerning their satisfaction with the quality of maternal and newborn care	% of women who mention three positive changes in the quality of care received during antenatal care visits/birth/postnatal care visits % of women giving birth in the health facility who expressed satisfaction with the health services Community participation institutionalized in defining and monitoring of quality care
	Companion of choice at childbirth	% of women who know that they have the option of being accompanied by a companion of choice during birth % of partners/mothers/mothers-in-law who know that women have the option of being accompanied by a companion of choice during birth % of health care providers favourable toward women being accompanied by a companion of choice during birth	% of women accompanied by a companion of choice during birth Presence of a companion of choice authorized in health facilities % of all births attended where the woman had a companion of choice
	Providing culturally appropriate skilled maternity care	Health facility level consultation process established to identify women's preferences/satisfaction related to maternal and newborn health care services % of women giving birth in the health facility who did so in a labour position of their choice # of health facilities that have mechanisms in place to take into consideration the cultural preferences of the community related to maternal and newborn health	# of health facilities that have responded to intercultural perspectives in the birth process % women giving birth in the health facility who were satisfied that their choices and preferences were respected % women giving birth in the health facility who would recommend childbirth in that facility % of women giving birth in the health facility who reported that their needs and preferences were taken into account during labour, childbirth and postnatal care

LIST OF ILLUSTRATIVE IFC INDICATORS			
PRIORITY AREAS OF INTERVENTION		**OUTPUT INDICATORS**	**OUTCOME INDICATORS**
Improving **QUALITY** of care, health services and interactions with women, families and communities	*Interpersonal competence of health care providers*	% of women satisfied with the responses/explanations they receive to their questions from health care providers during antenatal care visits/birth/postnatal care visits % of healthcare staff in the health facility who demonstrated the following skills: active listening, asking questions, responding to questions, verifying women's and their families understanding, and supporting women in problem-solving % of women giving birth in the health facility who report they were given the opportunity to discuss their concerns and preferences % of women undergoing examination or procedures in the health facility who reported that their permission was sought before the examination or procedures % of women receiving care in the health facility who were aware that they have the right to choose, accept or decline treatment	% of women giving birth in the health facility who report that they were satisfied with the health education and information they received from the care providers % of women examined and treated in the health facility who expressed satisfaction with the level of privacy during examination and treatment % of women giving birth in the health facility who were satisfied with the level of privacy during the stay in the labour and childbirth area % of women giving birth in the health facility who reported having been treated with respect and dignity
PRIORITY AREAS OF HEALTH SYSTEMS STRENGTHENING		**OUTPUT INDICATORS**	**OUTCOME INDICATORS**
Contributing to **PUBLIC POLICIES** favourable to maternal and newborn health			The IFC component integrated in the maternal and newborn health programme/strategy Community participation integrated in the maternal and newborn health programme/strategy IFC component maintained in revised maternal and newborn health programme/strategy % of public budget and/or budget of international agencies dedicated to IFC component within the maternal and newborn health programme/strategy Laws and regulations in place that guarantee women (aged 15-49) access to sexual and reproductive health care, information and education*

* Sustainable Development Goal indicator

PRIORITY AREAS OF HEALTH SYSTEMS STRENGTHENING	OUTPUT INDICATORS	OUTCOME INDICATORS
Contributing to the **COORDINATION** of actions within the health sector as well as between the health sector and other sectors	% of committee members who are aware of committee functioning (e.g., annual action plan, timing of meetings)	Active functioning of a national intersectoral/ interinstitutional IFC committee (e.g., regular meetings, annual action plan) Active functioning of a sub-national (regional/ provincial) intersectoral/interinstitutional IFC committee (e.g., regular meetings, annual action plan) Active functioning of a district-level intersectoral/ interinstitutional IFC committee (e.g., regular meetings, annual action plan) Functioning mechanisms of communication and coordination between the different committees (e.g., vertically between national, sub-national and district level committees, horizontally between the different regional/district level committees)
Promoting **COMMUNITY PARTICIPATION** in the management of maternal and newborn health problems	% of community members who can name three activities in favour of maternal and newborn health within their community	# and % of health facilities with a consultation mechanism for community members (e.g., opinions related to maternal and newborn services) # of health facilities performing activities to mobilize community actors in maternal and newborn health # of health facilities working or collaborating actively with community actors in maternal and newborn health (e.g., in-service management, service provision, resource allocation) # of districts that use participatory community assessments or a similar strategy to guarantee community participation in health services planning and management
Contributing to **CAPACITY BUILDING** of the health workforce in the IFC framework	Participation of national actors in training related to the IFC component	Presence of a group of trainers at the national level Presence of training programmes on the IFC component at the national/sub-national/district level
Implementing an interinstitutional system of **MONITORING AND EVALUATION** for the IFC component	Monitoring and evaluation tools for the IFC component developed and agreed upon by partners	Integration of the IFC monitoring and evaluation system in the existing system Evaluation results shared with stakeholders including community members Baseline/endline evaluation results used by IFC committees at different levels in the planning process Mechanisms/processes established for assuring community participation in the monitoring and evaluation process

ANNEX 4: DRAFT GUIDES FOR QUARTERLY AND ANNUAL IFC COMMITTEE MEETINGS

The following guides can be adapted and used to conduct quarterly and annual IFC meetings at the district, province and national level. They provide a general outline of areas for discussion during meetings at each level. Before using them, however, it is important to review them and assure that they will respond to local needs.

Draft guide for quarterly monitoring meetings

The district IFC committee is advised to meet regularly to monitor the IFC component. We suggest a quarterly meeting; however, the IFC committee may decide to meet more or less often based on their needs. The following guide can assist IFC coordinators and committee members in approaching this monitoring meeting in an organized way.

(1) Review of IFC activities plan: The team reviews the activities plan containing the details concerning what activities were planned for the time period, how they were to be implemented and responsible actors. They can compare this plan with actual performance and analyse discrepancies between the two.

The following questions can fuel this discussion:

- To what degree have planned activities been implemented?
- Are there differences between what was planned and what took place? If yes:
  - How can these be explained?
  - Are there problems with the implementation of interventions (their conception, management, etc.)?
  - Are there problems in the environment, outside of the control of the IFC committee?
  - Are there any unintended consequences, positive or negative, related to activity implementation?

(2) Review of input, process and output indicators: The committee assesses the process and output indicators of the interventions as found in the logframe. It is important to note that data related to some indicators may be collected on an ongoing basis, while others will only be collected at specified times, such as during the baseline and end-line evaluations. The committee compares actual data against targets and examines variations observed between periods.

The following questions can fuel this discussion:

- How do actual data related to indicators compare against targets?
- Are targets being reached?
  - If yes: What internal and external factors are contributing to this?
  - If no: Why not? Can it be explained by unanticipated factors in coordination and implementation efforts? Can it be explained by problems outside of the control of the IFC coordinators and committee? Were targets unrealistic?

(3) Review of the IFC priority areas of health systems strengthening: The team then verifies that they have thoroughly considered all the components of context conducive to the implementation of the IFC framework and the improvement of MNH. This can be done by systematically considering the five priority areas of health systems strengthening, regardless of whether these have been included in the action plan:

- **Public policies:** Is the IFC framework integrated into the broader MNH strategy at the district level? Does the committee need to take action to see that it is better integrated? Are local policies favourable to MNH?

- **Coordination:** Are MNH actions within the health sector and between the health sector and other sectors well-coordinated? Are the IFC activities coordinated in these efforts? Is action required to achieve better coordination?

- **Community participation:** Is the community actively participating in the IFC component? Is community participation present in the management of MNH overall? Is action required to promote community participation?

- **Capacity building of the health workforce:** Is the training of health workers and other actors in topics related to MNH and the IFC framework taking place? Does this need to be strengthened?

- **Monitoring and evaluation:** What is the status of monitoring and evaluation of IFC interventions at the district, province and national levels? Is monitoring and evaluation of the IFC component integrated in the MNH monitoring and evaluation system? Does this need to be improved?

Based on this discussion, the committee can decide whether action in these areas should be taken in order to improve implementation.

(4) Identification of lessons learnt: The committee discusses what lessons have been learnt during the previous quarter (see section 5) and determines whether there are lessons that should be documented for future consideration and sharing. If lessons are identified for documentation, the team agrees on what should be documented and the IFC coordinator takes responsibility to document this or delegates this responsibility to another committee member.

(5) Planning of corrective action: Finally, the committee elaborates a revised plan based on their analysis. With the analysis as a backdrop, the team reviews the action plan for the upcoming period and proposes adjustments. In addition, if the monitoring results indicate that there are significant problems or obstacles that make the achievement of the final goals of the interventions improbable, the committee may plan an evaluation to specifically analyse a certain aspect of implementation in order to address it appropriately.

Draft guide for annual district IFC meetings

At the district level, the annual IFC meeting, which generally includes IFC committee members and other key stakeholders, provides a platform to:

(1) Present the implementation of the IFC component and an overview of the progress throughout the previous year to partners. The district committee addresses each of the domains of the IFC component by discussing:

- achievements;
- the measures in which the targets have been reached;
- the challenges encountered in the implementation and environment of implementation; and
- solutions planned to address these challenges for the coming year/period.

(2) Inform the district of the progress of the implementation of the IFC framework in the country. The national IFC committee presents the state of the implementation of the IFC framework at the country level to their district level partners. They inform them specifically of the manner in which the activities implemented locally contribute to changes in the national plan and on the

situation of the district compared to other districts.

(3) Understand the opinion of the partners on the implementation of interventions. Each step of the meeting is ideally followed by a time for exchange and discussion, but a specific period of the meeting agenda will be dedicated to free expression of partners' opinions on the implementation of the IFC component.

(4) Use a spidergram or another visual tool (see section 1.3 of this module) to discuss and plot the status of the IFC implementation processes.

(5) Draw lessons learnt from the experiences of the implementation of the IFC framework for the completed year in the district and formulate suggestions and recommendations for the coming period. Documented lessons from the quarterly meetings are reviewed to assess relevance and to determine those which should be retained and shared at the annual meetings at the province and national levels. The committee can also formulate additional lessons learnt from the year that did not surface during the quarterly meetings if appropriate.

(6) Based on these analyses, the action plan for the coming period is reviewed and adapted. This information will be shared with other districts during the annual meeting at the national level.

Draft guide for province/national IFC meetings

The annual meeting at the national/provincial level provides the platform to:

(1) Share with all actors the experiences in the implementation of the IFC component in the country. The committee of each district presents its own experience of implementing the IFC component. The following questions can help to prepare the discussion:

- Are partners fulfilling their roles and responsibilities in the implementation of the IFC component? What are some areas for improvement? Are there areas where they could benefit from capacity building?
- What changes has implementation of the IFC component contributed to?
- What unanticipated complexities have been encountered?
- What solutions are envisioned?
- What lessons can we draw from the experiences?
- What are some suggestions/recommendations?

(2) Understand the opinions of partners on the implementation of the component. As during the meetings at the district level, each step of this meeting is followed by a time for exchange and discussion but it is also useful to dedicate a specific time period in the agenda for the free expression of partners' opinions.

(3) Draft the profile of the IFC framework at the national/province level. Draft a summary of implementation of the IFC component at the national/province level. The planned IFC interventions at the district level as defined in the various logframes can be compiled to demonstrate how action undertake at the national/province level intends to contribute to implementation at the local level. The committee can then jointly analyse the results of action at their level and determine whether these efforts are indeed facilitating local implementation.

(4) Share lessons learnt from each district and draw lessons learnt jointly, share experiences of implementation in the country from the completed year and formulate suggestions and recommendations at a national scale to be integrated in the action plan for the coming year.

ANNEX 5: DISTRICT IFC COMMITTEE ASSESSMENT TOOLS

IFC SELF-ASSESSMENT QUESTIONNAIRE

This self-assessment questionnaire is designed to be completed by partners participating on the IFC committee.

Please answer honestly as your responses are anonymous and will help us to improve the work of the IFC committee.

UNDERSTANDING OF THE IFC FRAMEWORK	
1. I know the primary aims of the IFC framework.	**Y / N**
They are:	
2. I can name the four priority areas of intervention of the IFC framework.	**Y / N**
They are:	
3. I can name the IFC priority areas of health systems strengthening.	**Y / N**
They are:	

IFC COORDINATION	
4. I can name the District IFC Coordinator.	**Y / N**
The coordinator is:	
5. I know who is coordinating implementation of the IFC component at the national and province levels.	**Y / N**
Please list:	
6. I can name non-health sector representatives on this committee.	**Y / N**
Please list sectors represented:	
7. I know when and how often meetings are held.	**Y / N**
How often are meetings held?	
PARTICIPATION IN IFC IMPLEMENTATION	
8. I participated in developing the IFC component action plan.	**Y / N**
9. I have seen the terms of reference for the IFC committee.	**Y / N**
One key function of the IFC committee is:	
10. I have met the MNH and IFC coordinators from the province and national teams.	**Y / N**
11. I know what my roles and responsibilities are in IFC implementation.	**Y / N**
12. I feel that my participation is valued on the IFC committee.	**Y / N**
13. Community participation is prioritized within the IFC committee.	**Y / N**
If yes, how?	

SATISFACTION	
14. How satisfied are you with your participation on the IFC committee? (1 = not satisfied, 5 = very satisfied)	**1 2 3 4 5**
15. How effective do you think communication and coordination is within the IFC committee? (1 = not effective, 5 = very effective)	**1 2 3 4 5**
16. Do you want to continue your participation on the IFC committee?	**Y / N**
Suggestions for improvement:	

Thank you for your participation!

IFC committee assessment discussion guide

The guide below can be used to lead the IFC committee through a discussion regarding the committee functioning. This discussion will ideally be used to generate recommendations and a plan for improving coordination of implementation of the IFC component.

1. What do you see as some of the strengths of the IFC committee?
2. What do you see as some of the weaknesses of the IFC committee?
3. How do you feel about the communication and coordination within the IFC committee?
4. What could improve the communication and coordination within the IFC committee?
5. How well do you feel the IFC committee communicates and coordinates with IFC committees in different districts and at different levels (i.e. province/national levels)?
6. What could improve the communication and coordination between different committees, either between districts or between levels?
7. Do all partners know when and where meetings are held?
8. How regularly are committee meetings held?
9. Are you satisfied with the regularity of meetings? Why or why not?
10. Have you seen the terms of reference for the IFC committee?
11. Do you feel that the work of the IFC committee is in line with the terms of reference? Why or why not?
12. How many sectors are represented on the IFC committee?
13. Do other sectors outside of the health sector have equal voice and clear responsibilities?
14. What sectors not currently participating on the IFC committee could be invited to participate?
15. How is community participation assured within the IFC committee?
16. Does community participation need to be strengthened? How could it be strengthened if it needs to be?
17. Did all partners participate in developing the action plan? How is the IFC action plan used within IFC implementation?
18. What support or capacity building could the IFC committee benefit from to strengthen committee functioning?

ANNEX 6: SAMPLE TERMS OF REFERENCE FOR EVALUATION INSTITUTION

TERMS OF REFERENCE (ToR)[6]

EVALUATION OF WORKING WITH INDIVIDUALS, FAMILIES AND COMMUNITIES (IFC) TO IMPROVE MATERNAL AND NEWBORN HEALTH

1. BACKGROUND AND CONTEXT

[The background section makes clear what is being evaluated and describes the implementation site including the MNH situation. This description should be focused, highlighting the issues most pertinent to the evaluation. The key background and context descriptors that should be included are listed below:

- *brief description of the IFC framework;*
- *description of the IFC interventions that are being evaluated;*
- *purpose and objectives of the IFC component, including when and how it was initiated, who it is intended to benefit, what outcomes or outputs it is intended to achieve, the duration of the interventions and their implementation status within that time frame;*
- *the geographic context and boundaries, such as the region, country, landscape and MNH challenges where relevant;*
- *key partners involved in implementing the IFC component, including IFC committee members, other key stakeholders and their interest concerns and the relevance for the evaluation;*
- *how the IFC framework fits into the government's strategies and priorities; international, regional or country development goals; strategies and frameworks, etc.; and*
- *description of how this evaluation fits within the context of the IFC implementation process. More detailed background and context information (e.g. initial funding proposal, strategic plans, logic framework or theory of change, monitoring plans and indicators) should be included in annexes.]*

Although the most recent assessment of global maternal deaths revealed a drop in mortality from an estimated 500,000 to 287,000 deaths per year between 1990 and 2010, the burden of mortality has remained unchanged, with 99% of maternal deaths occurring in developing countries.[7] Nearly the same distribution is exhibited for the 2.9 million annual newborn deaths worldwide, with 98% in low- and middle-income countries.[8]

The World Health Organization (WHO) has developed a framework for working with individuals, families and communities (IFC) to improve MNH. The IFC framework is designed to form a health promotion component of a broader MNH strategy in countries. Within this framework, a combination of community, health services and policy level interventions are implemented in order to develop the capacities of women, men, families and communities to identify and address MNH needs, mobilize local resources to address these needs, and increase access to quality skilled care to ultimately improve MNH.[9]

[6] Adapted from: UNDP, 2009.
[7] WHO, UNICEF, UNFPA, World Bank, 2012.
[8] UNICEF, WHO, World Bank, UN, 2013.
[9] WHO, 2010.

The following four priority areas form the basis of interventions identified within the IFC framework:

1) Developing capacities to stay healthy, make healthy decisions and respond to obstetric and neonatal complications: including care of pregnant women and newborns, care-seeking behaviour related to MNH services and birth preparedness and complication readiness;

2) Increasing awareness of the rights, needs and potential problems related to MNH: including awareness of human and reproductive rights, the role of men and other influentials, and use of community epidemiological surveillance and maternal-perinatal death reviews;

3) Strengthening linkages for social support between women, families and communities and with the health delivery system: including community financing and transport schemes, maternity waiting homes and the role of traditional birth attendants within the health system;

4) Improving quality of care, health services and interactions with women and communities; including community involvement in the quality of care, a companion of choice during childbirth and interpersonal and intercultural competence of health care providers.

Through a participatory planning process, several interventions within the framework that respond to local needs and resources are selected and then implemented. These community prioritized interventions are integrated into ongoing activities to address MNH services and they may ultimately affect policy. As a result, women and communities are empowered to improve the care of women before, during and after childbirth as well as newborns, while simultaneously increasing the use of skilled care during this period, thus improving MNH.

In addition to the four priority areas of intervention, five priority of health systems strengthening are identified within the IFC framework that serve to contribute to an environment conducive to implementation of action within the areas of intervention and also contribute directly to the primary aims of the IFC framework. They are as follows:

1) *Contributing to PUBLIC POLICIES favourable to MNH;*

2) *Contributing to the COORDINATION of actions within the health sector as well as between the health sector and other sectors;*

3) *Promoting COMMUNITY PARTICIPATION in the management of MNH problems;*

4) *Contributing to CAPACITY BUILDING of the health workforce in the IFC framework;*

5) *Implementing an interinstitutional system of MONITORING AND EVALUATION for the IFC component.*

Robust evaluations are required to assess the contributions of the implementation of the IFC component in reaching planned outcomes and outputs, and in improving MNH. It is expected that these evaluations will be used nationally to guide MNH programming and scaling-up of the framework as well as contribute to the body of evidence regarding the IFC framework and Health Promotion in MNH.

[To add detailed information on the implementation site and interventions specific to the context.]

2. EVALUATION PURPOSE

[This section should explain clearly why the evaluation is being conducted, who will use or act on the evaluation results and how they will use or act on the results. A clear statement of purpose provides the foundation for a well-designed evaluation.]

The purpose of the evaluation is to measure and asses the changes in knowledge, attitudes and practices, particularly MNH services utilization, associated with the implementation of the IFC component. The results will be used to make strategic decisions by stakeholders in relation to the IFC implementation and will contribute to the body of knowledge regarding the IFC framework and safe motherhood programming.

3. EVALUATION OBJECTIVES

[This section states the general and specific objectives of the evaluation. These will be formulated based on the goal and planned outcomes designated in the logframe.]

General objective:

- To assess the contribution of the IFC component to the improvement of MNH and to the empowerment of women, families and communities

Specific objectives:

- To measure changes in MNH knowledge and household level care practices of women and their male husbands/partners pre- and post-intervention
- To evaluate changes in care-seeking practices during pregnancy, birth and the postpartum/postnatal period pre- and post-intervention
- To assess functioning and change within the IFC priority areas of health systems strengthening

4. EVALUATION QUESTIONS

[Evaluation questions define the information that the evaluation will generate. This section proposes the questions that, when answered, will give intended users of the evaluation the information they seek in order to make decisions, take action or add to knowledge. Evaluation questions must be agreed upon among users and other stakeholders and accepted or refined in consultation with the evaluation team.]

- Were stated outcomes and/or outputs achieved?
- What factors have contributed to achieving or not achieving intended outcomes?
- Has the intersectoral and interagency collaboration strategy within the IFC framework been appropriate and effective?
- What factors have contributed to effectiveness or ineffectiveness?

5. METHODOLOGY

[The final decisions about the evaluation design and methods should be made jointly by the IFC committee, the evaluators, and key stakeholders. Together they will determine what is appropriate and feasible to meet the evaluation purpose and objectives and answer the evaluation questions, in light of limitations of budget, time and existing data. It is important to keep the principles of participation in mind when designing the methodology.]

The final decisions regarding methodology will be made jointly by the evaluators and the IFC committee. A mixed-methods approach employing both quantitative and qualitative methods is requested in order to provide a more complete picture of the results and challenges in IFC implementation. The IFC committee requests that the evaluators prioritize the participation of multiple stakeholders, including the community, throughout the evaluation.

6. EVALUATION DELIVERABLES

[The evaluators will be responsible for producing the documents listed in this section and submitting them to the IFC committee.]

The evaluators will be responsible for submitting the following to the IFC committee for the baseline, intermediate and end-line evaluations:

- **an evaluation protocol:** specifying the expected results of the study, the methodology, a proposed work plan and a Gantt chart. A draft of the protocol will be submitted to the IFC committee before being finalized. The protocol is an important document that will assure the quality of the evaluation;
- **a draft report:** a draft report of the study should be submitted to the IFC committee two weeks after the completion of field work. The different stakeholders will have one week to provide comments on the draft report;
- **an oral presentation:** in the presence of the IFC committee;
- **an executive summary:** the analytical executive summary should be a maximum of five pages and should be able to stand on its own. It should be organized according to the following format: Introduction, Methods, Principal results, and Conclusions;
- **a final report:** the final report includes the executive summary (5 pages) and the details of the study (maximum 50 pages). *[A format for the final report may be provided in the annex.]*

7. EVALUATION TEAM REQUIRED COMPETENCIES

[This section details the specific skills, competencies and characteristics needed in the evaluator or evaluation team specific to the evaluation. The section also should specify the type of evidence that will be expected to support claims of knowledge, skills and experience. The ToR should explicitly require that the evaluator be free from conflicts of interest.]

The evaluator should:

- be competent in conducting scientifically rigorous evaluations/implementation research;
- be competent in conducting community-level evaluations/implementation research;

- have experience in social science research methods;
- have experience and knowledge in MNH;
- have experience in participatory monitoring and evaluation; and
- have no conflicts of interest related to the evaluation.

Members of the evaluation team should provide the following:

- current curriculum vitae;
- references;
- work samples, if requested.

8. EVALUATION ETHICS

[The ToR should clearly outline how ethical approval will be obtained and how participants will be protected, including the process of obtaining informed consent.]

As the evaluation will include human subjects, measures will need to be taken to ensure that ethical requirements are met in order to protect participants. Central to protecting participants will be obtaining informed consent. Researchers will inform potential participants of the scope of the study, the type of questions that may be asked, how the results will be used, how the participants' words may be used in reports, the method of keeping participants anonymous that will be employed, and that they may withdraw consent and discontinue participation at any time. After having been thoroughly informed, potential participants will then be given time to reflect and ask questions to the researcher before signing a written consent form. The consent form will be translated into the local language and illiterate participants will be thoroughly briefed on the contents of the informed consent form and may sign using their fingerprint. Two consent forms will be signed by each participant and a member of the research team. The research team will keep one of the forms while the other form will be retained by the participants for their personal records. Consenting participants will be informed that they may withdraw consent and discontinue participation at any time. Ethical approval will be obtained from the necessary institutions (national, intra-institutional, WHO, etc.) prior to data collection.

9. ROLES AND RESPONSIBILITIES

[This section defines the roles and responsibilities of all parties involved in the evaluation process. This will include the evaluators, the IFC committee and any other institutions or parties participating in the evaluation. Clarifying this in the ToR is intended to eliminate ambiguities and facilitate an efficient and effective evaluation process.]

Evaluator responsibilities:

- review and comment on the ToR;
- elaborate the evaluation protocol detailing the study design, methodology, tools to be developed, data analysis, etc.;
- prepare guidelines and questionnaires;

- recruit and train staff;
- develop evaluation instruments for data collection (to be reviewed by the IFC committee before finalization);
- manage the evaluation operations;
- administer evaluation instruments;
- review documentation;
- submit deliverables to the IFC committee; and
- adhere to the timeline of the consultancy.

IFC committee responsibilities:

- draft the ToR for the evaluation team;
- brief the evaluators on the purpose and scope of the evaluation and explain expectations of the IFC committee and other stakeholders in terms of the required quality standards of the conduct of the evaluation and the deliverables;
- provide all necessary information to the evaluators;
- arrange interviews, meetings and field visits when requested; and
- provide comments on and assure the quality of the work plan and the inception report prepared by the evaluation team.

10. TIMELINE FOR THE BASELINE/END-LINE EVALUATIONS

[This section describes the timeline for the baseline and end-line evaluations, listing when various activities related to the evaluation will be conducted, including the data collection, data analysis and submission of deliverables.]

ACTIVITIES	MONTH 1				MONTH 2				MONTH 3				MONTH 4				MONTH 5			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Preparation of protocol																				
Submission of protocol																				
Recruitment and training of staff																				
Quantitative data collection																				
Qualitative data collection																				
Data transcription and coding																				
Data analysis																				
Report preparation																				
Submission of 1st draft of report																				
Final report submission																				

11. COSTS

[This section should indicate the total dollar amount and other resources available for the evaluation. It is not meant to be a detailed budget but should provide the evaluators with an understanding of financial limitations so they can propose an appropriate and feasible evaluation methodology. If the available amount is not sufficient to ensure a high-quality evaluation, discussions can take place between the evaluators and the IFC committee early on in the process.]

12. ANNEXES

[Other relevant information should be included as annexes. These could include:

- *a list and contact information of IFC partners and key stakeholders;*
- *documents to be consulted before finalizing the evaluation protocol (e.g. IFC framework documents, intervention reports, MNH national strategy documents, the logframe and activities plan, memorandums of understanding (MOUs) among partners, previous evaluations and assessments);*
- *evaluation matrix: this is a tool that details the questions that the evaluation will answer, indicators, data sources, data collection, analysis tools or methods appropriate for each data source, and the standard or measure by which each question will be evaluated;*
- *format for the evaluation report.]*

ANNEX 7: DOCUMENTATION FORM FOR LESSONS LEARNT

The form below can be used to document lessons learnt throughout the course of IFC implementation.

Lessons to document and information to include will generally be agreed upon during IFC committee meetings.

DOCUMENTATION OF LESSON LEARNT	
GENERAL INFORMATION **Title:** [Working with Individuals, Families and Communities (IFC) to improve maternal and newborn health (MNH)]	
Time period of lesson:	**Date of recording:**
Country: **Province:** **District:**	**IFC Coordinator:** **Address:** **Phone:** **Email:**
Which priority area of intervention/health systems strengthening is concerned?	
What activities were conducted during the period?	
What went well?	

What challenges were faced?

What solutions were put into place to address these challenges?

What were the results?

Please provide a generalizable summary of the lesson learnt.

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