PHE partnerships guide

Monitoring, evaluation and learning

Version 1

blue ventures
beyond conservation

PHE Madagascar
Population Health Environment Network

About this guide

This guide consists of 15 chapters covering the core values, skills and knowledge needed to develop and implement effective cross-sector Population-Health-Environment (PHE) partnerships. You have downloaded **chapter 8 - Monitoring, evaluation and learning**. If you wish to download other chapters or the entire guide please visit the Madagascar PHE Network's website here.

This guide is primarily designed for use by the staff of environmental organisations wishing to develop cross-sector PHE partnerships with health service providers in line with priority community needs and their organisational missions. Many chapters will also be relevant to the staff of health organisations wishing to develop cross-sector PHE partnerships with environmental organisations working in under-served zones. And of course livelihoods-focused organisations working at the interface of sustainable development and natural resource management are also ideally placed to develop and implement collaborative PHE initiatives with relevant partners.

This guide draws on the PHE implementation experiences of Blue Ventures and other members of the Madagascar PHE Network in order to provide practical advice structured in a conversational format with case study examples. As such it should be highly relevant to organisations working in Madagascar and much material will be applicable to organisations working in other countries as well.

This guide is accompanied by various complementary resources including an integrated PHE community outreach tool (illustrated PHE story cards) available via the Madagascar PHE Network's website here. Please note that a comprehensive online library of documents relating to PHE programming has been collated by the Population Reference Bureau and can be found here.

This guide should be considered a living document and as such it will be updated regularly. Please don't hesitate to contact Blue Ventures (pheinfo@blueventures.org) if you have any suggestions for improvement or requests for elaboration. We look forward to incorporating your feedback into future versions of this guide.

Credits and acknowledgements

This guide was written and produced by Laura Robson, Blue Ventures' Health-Environment Partnerships Manager.

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This guide should be referenced as follows: *Robson, L. (2017) PHE partnerships guide. London, UK / Antananarivo, Madagascar: Blue Ventures Conservation.*

8. Monitoring, evaluation and learning

By the end of this chapter you should:	This chapter may be of particular relevance to:
▪ Know what a programme theory is and why it's important ▪ Know how to develop a programme theory for your PHE partnership ▪ Understand the difference between monitoring and evaluation ▪ Know some top tips for fostering organisational learning ▪ Know how to develop a monitoring plan for your PHE partnership and select a few indicators based on your programme theory ▪ Know how to monitor contraception use, calculate a standardised measure for contraception use (couple years of protection) and estimate number of unintended pregnancies averted ▪ Understand why it's important **not** to set targets for contraception use or fertility changes ▪ Have some examples of family planning, health, environmental and cross-cutting indicators that you could use ▪ Know the basics of how to conduct a social survey and be aware of some important considerations to take into account first ▪ Know the basics of how to collect qualitative data including most significant change stories ▪ Know the basics of how to plan an evaluation	▪ Managers and M&E staff of environmental organisations ▪ Managers and M&E staff of health organisations

What is a programme theory?

A programme theory is a theory of how a programme is believed to work. It can be represented by a diagram illustrating how various programme activities are believed to lead to the achievement of one or more programme goal(s). It may also be known as a theory of change, a conceptual model, a conceptual framework or a results chain!

A programme theory is made up of a series of linked "if… then…" hypotheses. It fills in what can be described as the "missing middle" between what a programme does and the outcomes it produces.

A PHE programme theory often encompasses the achievement of improved ecosystem and human health resulting from anticipated changes in the knowledge, attitudes and practices of programme participants following the input of new information (through training or discussion), resources and services.

Why develop a programme theory?

Some PHE partnerships may arise quite spontaneously and informally when environmental and health organisations working in the same geographical area spot opportunities for collaboration. Soon though the need for monitoring, evaluation and learning (MEL) is likely to become clear: most organisations (and their funders) will want to measure the outcomes of their PHE partnership and understand the processes through which these outcomes are being generated.

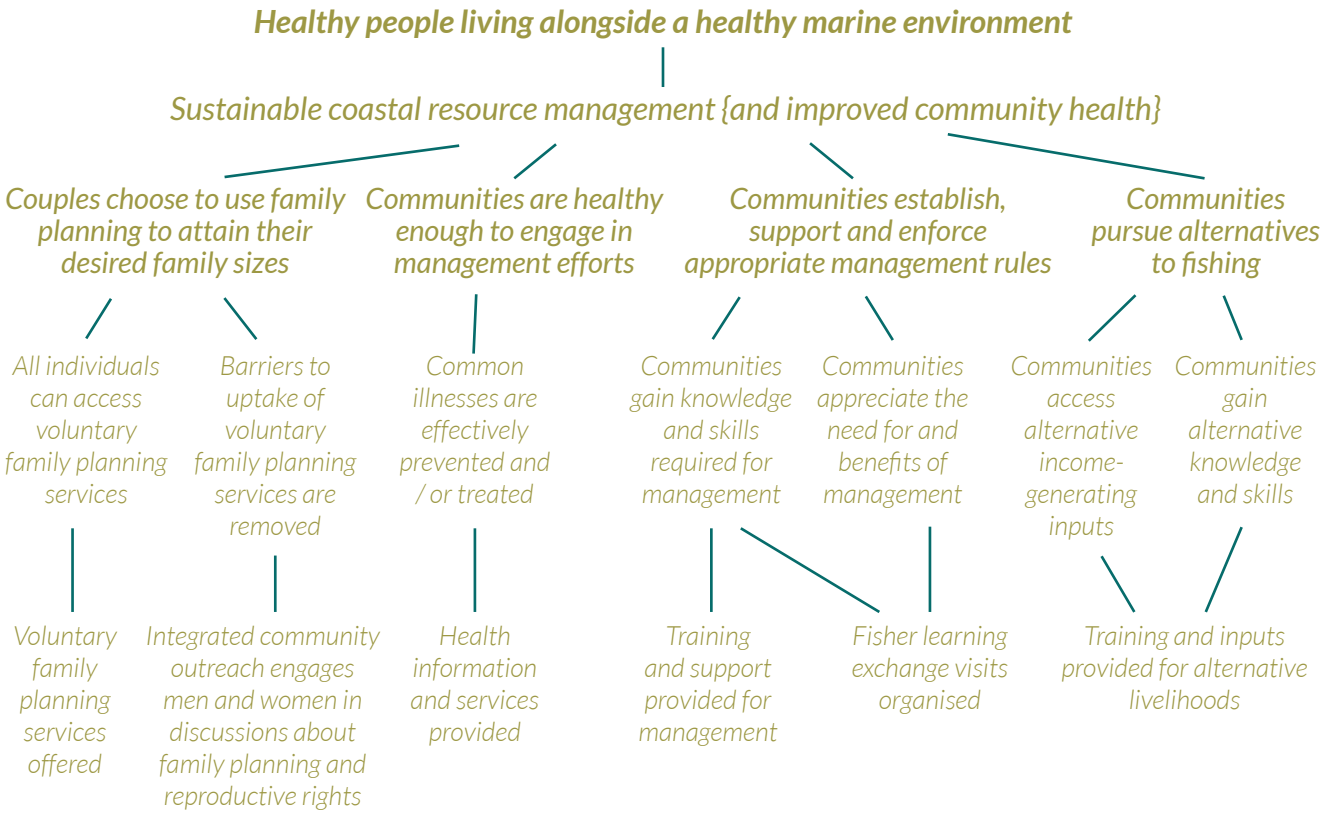
In order to decide which outcomes to measure (and how), you first need to outline the changes that you believe your PHE partnership is generating. For this, a programme theory is required. In addition to providing the foundation for the development of your monitoring plan (allowing you to identify a few key outcomes to monitor), a programme theory can also be very helpful for building a clear and shared

understanding among all staff of how their activities feed into the achievement of the overall PHE partnership goal(s).

How to develop a programme theory?

- Start by agreeing on the overall **goal** of your PHE partnership with your partner - e.g. healthy people living alongside a healthy ecosystem - identified through community consultations (see chapter 4) and outlined in your PHE partnership agreement (see chapter 5).
- Work back from this goal to identify all of the **conditions** that must be in place in order for it to be achieved - e.g. changes in existing knowledge, attitudes and practices.
- Work back from these conditions to identify all of the **programme activities** that must be in place in order for them to be achieved - e.g. input of new information (through training or discussion), resources and services.
- Check that your assumptions are valid and make any adjustments as necessary - e.g. "*if* full access to family planning services is ensured *then* family planning needs are met" may not be valid because there may be other causes of unmet family planning needs (such as lack of support from partners) in addition to inadequate access to services.

Map all of these out in a diagram, remembering that the basic format of any theory of change can be expressed as: *if* [this condition is met] *then* [this change occurs], *if* [this condition is met] *then* [this change occurs], *if* [this condition is met] *then* [this change occurs], etc. The number of linked "if... then..." hypotheses may vary depending on the nature of your PHE partnership and the degree of specificity that you use to outline your programme theory.



A highly simplified (and therefore limited) example of a PHE programme theory

Would you like more support with this process? Blue Ventures can facilitate bespoke monitoring planning workshops and provide tailored advice with regards to the development of your PHE programme theory. To find out more please contact pheinfo@blueventures.org.

Another way of producing a programme theory is to create a problem tree mapping out the root causes of the challenge that you're trying to address, then turn these negative statements into positive statements to produce a solution tree which is essentially a programme theory.

What is the difference between monitoring and evaluation?

Monitoring is the routine collection and analysis of data throughout the life of a programme, with a focus on tracking outputs (or activities) and outcomes (or changes) in order to determine if the programme is set to achieve its goals. Such data should be reviewed at different stages during the programme timeframe to ensure that learning is ongoing and implementation strategies are adapted as necessary. Monitoring data are often also used for evaluation.

Evaluation probes deeper to assess the results and effectiveness of a programme, possibly including some reflection on performance against expectations or goals, how the programme worked (the processes through which it generated changes), what went well and what could have been done differently. Evaluation should take place at appropriate intervals for the outcomes being evaluated, although often generally takes place at the "end" of a programme or funding cycle, or sometimes at a midway point.

Looking out for unintended consequences!

It's a good idea to use your PHE programme theory to inform and guide your monitoring efforts so that you can monitor those results that you hope to achieve (and avoid the burden of collecting additional unnecessary data), however, it's also very important to look out for unintended consequences or unexpected outcomes of your PHE initiative. Collection of most significant change stories (as detailed below) and/or open discussions in focus groups with community members can be an effective way of identifying any results that may have been overlooked by your PHE programme theory, and then you can decide whether it would be appropriate to incorporate these into your more formal monitoring efforts.

What about learning?

It's generally assumed that monitoring and evaluation (M&E) is how the majority of learning in an organisation takes place, but often M&E ends up focusing on results and accountability to funders. If M&E is separated from active learning, then it risks becoming a judgmental exercise.

PHE partnerships are highly complex and context-specific initiatives, and the processes through which they generate changes are not yet fully understood and may vary across different contexts. This is why it's very important to think about monitoring, evaluation *and learning* (MEL) and to create space for active learning by all programme staff, so that the PHE partnership can be managed adaptively in line with their growing understanding of what works and how in your particular context.

Top tips for fostering organisational learning

- Nurture an organisational culture that is supportive of learning - i.e. one that encourages, enables, values, rewards and uses the learning of its members both individually and collectively
- Map out the internal creation and flows of knowledge within your organisation currently - highlight rich sources and under-tapped processes of learning in order to identify possible mechanisms for ensuring that your organisation can benefit more from its own experiences
- Build learning into job descriptions - make it as an integral and legitimate part of each staff member's work responsibilities
- Strengthen interpersonal relationships and build trust so that staff don't fear negative repercussions of discussing challenges openly
- Encourage staff to approach their work with a spirit of curiosity, ask questions and listen to each other, and constructively challenge each other's assumptions - and model this behaviour yourself (e.g. request feedback from colleagues about your approaches or assumptions)

- Prioritise time for individual and collective reflection - e.g. keeping learning journals, post-mission team debriefs, reflection periods or retreats, etc.
- Welcome difficulties or apparent "failures" as opportunities for collective learning
- Surface issues and deal with them without blame
- Provide informal physical spaces where staff can meet and exchange ideas
- Include a lessons learned section in all internal documents e.g. mission reports
- Share and celebrate effective approaches
- Make sure that learning is shared among all partners e.g. through regular review meetings
- Set up action learning sets - groups of peers who meet regularly to work through challenges by reflecting on their actions and using this learning to brainstorm and plan more appropriate ways forward

Who is monitoring and evaluation for?

M&E is generally designed to meet the different needs of (and ensure accountability to) various stakeholders including community members, implementing organisations, their funders and policy makers. For example, implementing organisations might want to know how their programme is working so that they can improve its design and implementation (adaptive management), while funders might want to know if their grant is achieving its goals so that they can decide whether to keep supporting the programme. It's important to bear this in mind when developing a monitoring plan, so that the needs of all stakeholders are adequately met.

How to develop a monitoring plan?

Once you've outlined your programme theory, you can develop a monitoring plan for your PHE partnership. Start by identifying a few outputs and outcomes from your programme theory that you'd like to monitor (for yourself and/or your stakeholders including community members), and think about what kind of indicators you could use for these and what kind of data you need to collect (and if this is feasible with the resources you have). Also think about how you will use and disseminate these data: who needs what information when?

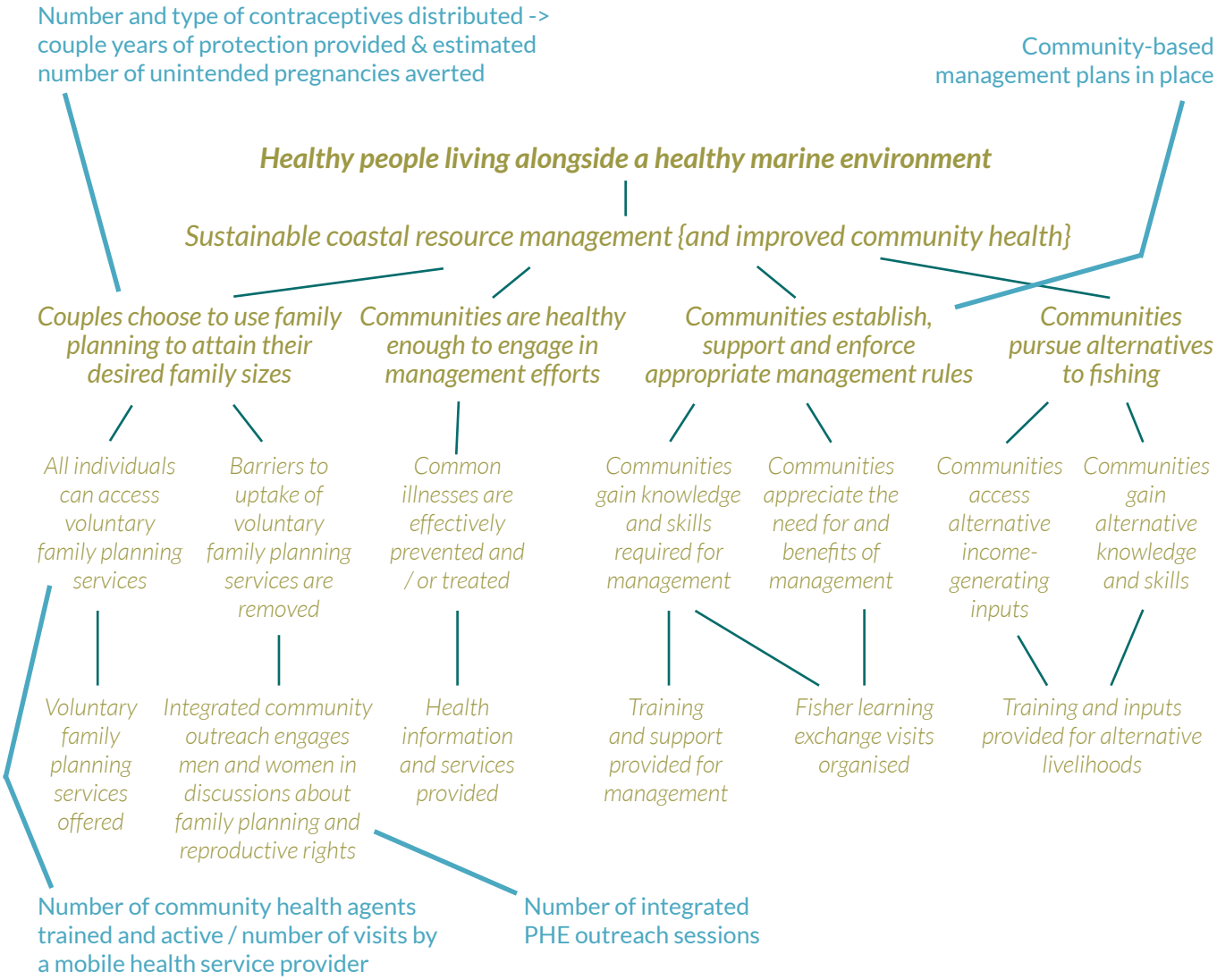
If your organisation already has a monitoring plan for its existing environmental or health activities, then you may simply need to consider whether it would be appropriate to add any indicators relating to the new health or environmental components that you're integrating through your PHE partnership (and any associated hypothesised "added-value" gender equality, food security or livelihood outcomes).

You could use the following template to develop a monitoring plan:

Anticipated output / outcome	Indicator	Data source (e.g. service delivery records, activity records, etc)	Who to collect? (which partner?)	When to collect? (e.g. annually, quarterly, monthly, etc)	How to analyse?	Resources needed to collect and analyse?	Of interest to which stakeholders?

Selecting indicators based on your programme theory

The following sections of this chapter present some indicators that you may like to consider using to monitor key anticipated outputs and outcomes of your PHE partnership. Because PHE initiatives are so multifaceted, there are lots of possible indicators to choose from and it can get quite overwhelming if you think that you have to monitor everything! This is why it can be helpful to focus closely on your own PHE programme theory and consider who needs to know what. Generally you won't monitor everything in your PHE programme theory, but rather **select a few key anticipated outputs and outcomes that are of greatest interest to you and your stakeholders** and that are feasible to measure (for example, just using service delivery records and activity records).



Possible indicators for a highly simplified (and therefore limited) example of a PHE programme theory

Would you like more support with this process? Blue Ventures can facilitate bespoke monitoring planning workshops and provide tailored advice with regards to the selection of your indicators. To find out more please contact pheinfo@blueventures.org.

A fairly standard set of indicators can be used to measure family planning and health outcomes, but environmental outcomes vary depending on the site (e.g. marine vs. terrestrial) and tend to take longer to occur. It can be challenging to identify appropriate environmental outcomes that can be measured in short time periods (1-2 years), so often environmental indicators focus on outputs.

Top tips for developing a monitoring plan

- Collaborate with your partner(s) to select a suitable set of indicators based on your programme theory, funder requirements and resource availability - **note that it may be most feasible to use service delivery records and activity records as data sources rather than conducting social surveys**
- Clarify expectations and develop consensus on data collection timelines and data quality standards with your partner(s)
- Integrated social surveys can allow analysis of possible associations between health and environmental knowledge, attitudes and practices while sharing of costs among partners - but don't underestimate the time, resources and expertise needed to conduct these properly!
- Think of monitoring as an iterative process so your plan may need to be revised periodically as your PHE programme theory evolves

Monitoring contraception use

Anticipated output / outcome	Indicator	Data source	Who to collect?	When to collect?	How to analyse?	Resources needed to collect and analyse	Of interest to which stakeholders?
Increased contraception use	Number of couple years of protection (CYPs) provided	Service delivery records: number and type of contraceptives distributed	Health partner (from community health agents / mobile outreach teams)	Monthly	Calculate CYPs using USAID-approved conversion factors	Reporting forms, etc	Community health agents, natural resource management committees, implementing organisations, funders, national PHE network, policy makers

One important thing to track within your PHE partnership is the **number and type of contraceptives distributed** as this will allow you to calculate two key indicators: number of couple years of protection provided - which is a key family planning output - and estimated number of unintended pregnancies averted (see below) - which is a key family planning outcome.

1 couple year of protection (CYP) is 1 year of protection from unintended pregnancy for 1 couple.

It's very easy to calculate CYPs from the number and type of contraceptives distributed using the following formulae:

15 pill packs = 1 CYP (divide the number of pill packs distributed by 15 to get CYPs)

4 injections = 1 CYP (divide the number of injections given by 4 to get CYPs)

1 implant = 2.5 CYPs (multiply the number of implants inserted by 2.5 to get CYPs)

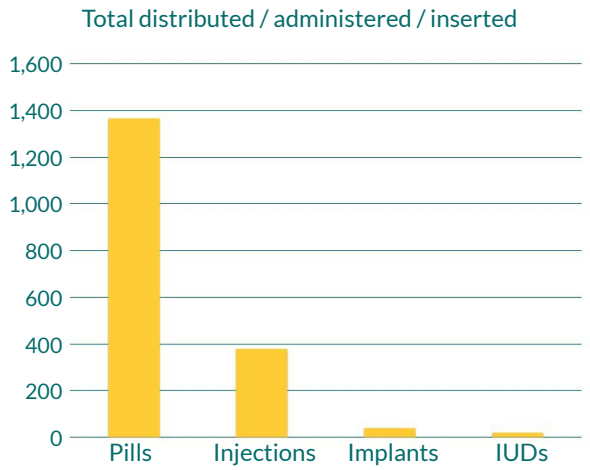
1 intra-uterine device (IUD) = 4.6 CYPs (multiply the number of IUDs inserted by 4.6 to get CYPs)

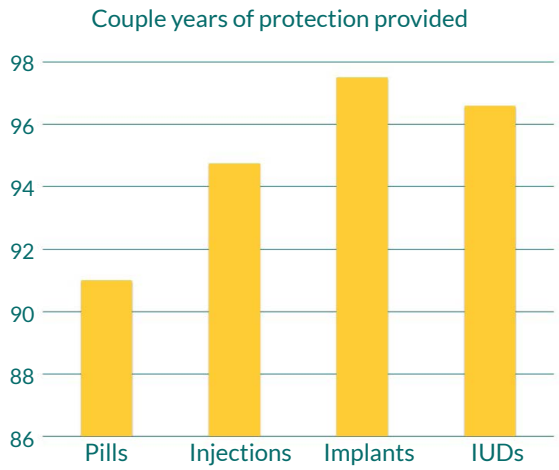
These USAID-approved CYP conversion factors take into account that some methods like pills may be used incorrectly and/or discarded, while implants and IUDs may be removed before their lifespan is realised.

Why calculate CYPs?

Different contraception methods provide different durations of protection: a pill pack provides 1 month (4 weeks) of protection, an injection provides 3 months (12 weeks) of protection, an implant can provide up to 3 years of protection (or be removed earlier if the woman so chooses), and an intra-uterine device can provide up to 10 years of protection (or be removed earlier if the woman so chooses). If you distribute 10 pills packs or fit 10 intra-uterine devices, you've actually delivered very different amounts of protection: you can't meaningfully compare distributing 10 pill packs to fitting 10 intra-uterine devices because they provide such different durations of protection. This is why calculating CYPs is so important. CYP conversion factors account for the different durations of protection provided by different contraception methods, and thereby allow you to compare like with like.

	Pills	Injections	Implants	IUDs
Total distributed / administered / inserted	1,365	379	39	21
Couple years of protection provided	91	95	98	97





Expressing the services you've delivered in terms of CYPs is a much more meaningful way of communicating the amount of contraceptive protection you've provided. After applying the relevant CYP conversion factors, you can compare the amount of contraceptive protection that you've provided across different methods. You can also communicate the total amount of contraceptive protection that you've provided - it's best to do this with reference to the total population served. For example: "More than 1,000 couple years of protection were provided in 2016 among a population of 10,000 people." (This is more impressive than if the population served was 100,000 people, for example.) Good census data are therefore vital for putting CYPs into context!


Photo credit: Garth Cripps

Monitoring unintended pregnancies averted

Anticipated output / outcome	Indicator	Data source	Who to collect?	When to collect?	How to analyse?	Resources needed to collect and analyse	Of interest to which stakeholders?
Increased spacing and/ or limiting of births	Estimated number of unintended pregnancies averted	Service delivery records: number and type of contraceptives distributed	Health partner (from community health agents / mobile outreach teams)	Monthly	Calculate using Marie Stopes International's Impact 2 Tool	Reporting forms, etc	Community health agents, natural resource management committees, implementing organisations, funders, national PHE network, policy makers

Another useful calculation that you can do with the number and type of contraceptives distributed is to estimate the number of unintended pregnancies averted by these contraceptives using Marie Stopes International's Impact 2 Tool, which is freely available to download at https://mariestopes.org/impact-2. You input the number and type of contraceptives distributed, and it calculates a variety of estimated impacts including the estimated number of unintended pregnancies averted. It's best to communicate this with reference to the total population served. For example: "More than 500 unintended pregnancies are estimated to have been averted in 2016 among a population of 20,000 people." (This is more impressive than if the population served was 200,000 people, for example.) Good census data are therefore vital for putting the estimated number of unintended pregnancies averted into context!

Detailed instructions for using MSI's Impact 2 Tool:

- Open the Excel file (it may take a moment to load), and click "enable macros"
- Click "next", and agree to terms & conditions (click "yes")
- Click on "organisation(s)" to select this mode
- Select your country from the drop-down list, select "service provision to impacts (past/future)", enter the years for which you have data, and click "next"
- Enter the number of contraceptives distributed in the years and methods for which you have data, and click "next"
- Leave the client profile data blank if you don't have this information, and click "next"
- Select "create report" (in the lower right corner of the dialogue box), and click "create report" again when prompted
- Wait for it to generate the report (this may take several minutes)
- You will now see a variety of estimated impacts including the estimated number of unintended pregnancies averted in the years for which you have data, with guidance about how to write about different impacts and what they mean / how they are estimated

Should we / can we set targets for contraception use or changes in fertility?

No!

PHE initiatives aim to uphold the reproductive rights of all individuals to choose freely the number and spacing of their births without coercion or discrimination. PHE initiatives can aim to reduce unmet family planning needs (women wanting to space or limit their births but not using contraception) by ensuring full access to voluntary family planning services and removing any barriers to uptake (for example, lack

of information about different options). However, no one involved in providing family planning services should set targets for contraception use or changes in fertility because these depend entirely upon the choices made freely by individuals in line with their reproductive rights. This is outlined in US law (Tiahrt Clause) and USAID policy.

While it's important to monitor (and report on) the number of CYPs provided and estimated number of unintended pregnancies averted, it's not appropriate to set targets for these numbers. If you wish to set explicit targets relating to your family planning work, you could aim to increase access to services and/or to reduce unmet family planning needs (as detailed immediately below).

Family planning / demographic indicators

A few examples (in addition to CYPs and estimated number of unintended pregnancies averted - as detailed above):

Anticipated output / outcome	Indicator(s)	Data source
Increased access to family planning information and services	Number of programme staff trained to provide information Number of community health agents trained and active Number of visits by a mobile outreach team Number of active service delivery points	Training and service delivery records
Increased knowledge of family planning options	Proportion of people who know at least X number of contraception methods	Individual surveys - see Annex II
Reduced unmet family planning needs	**Unmet family planning needs:** proportion of sexually active women of reproductive age (15-49 years) who report wanting to space or limit their births but are not currently using contraception plus those who are currently pregnant but wanted to wait or not get pregnant	Individual surveys - see Annex II *(multiple questions required)*
Increased contraception use	**Contraceptive prevalence rate:** proportion of women of reproductive age (15-49 years) who are currently using modern contraception (often only reported for those sexually active or in union)	Service delivery data + census data / individual surveys - see Annex II
Increased spacing and/or limiting of births	**General fertility rate:** number of live births per 1,000 women of reproductive age (15-49 years) in the last 12 months	Census data / household surveys - see Annex II

Health indicators

A few examples (in line with some of the health-promoting behaviours detailed in chapter 13):

Anticipated output / outcome	Indicator	Data source
Increased condom use	Proportion of people who report using a condom the last time they had sexual intercourse	Individual surveys - see Annex II
Increased use of mosquito nets	Proportion of households who report use of mosquito net(s) last night *(with visual check)*	Household surveys / observation - see Annex II
Increased use of water purifying solution	Proportion of households who report use of water purifying solution	Household surveys - see Annex II
Increased practice of handwashing with soap or ash	Proportion of households who report handwashing with soap or ash *(with visual check)*	Household surveys / observation - see Annex II
Increased practice of exclusive breastfeeding for six months	Proportion of mothers with a child <1 year who report having breastfed / planning to breastfeed for six months with no other liquids or solids given during this time	Individual surveys - see Annex II
Increased formal care-seeking for treatment of common childhood illnesses	Proportion of mothers with a child <5 years who report seeking formal care for treatment of diarrhoea, malaria and respiratory infections	Individual surveys - see Annex II

Environmental indicators

A few examples:

Anticipated output / outcome	Indicator	Data source
Increased community-based natural resource management (NRM)	Proportion of communities with an NRM plan / committee in place	NRM plan / committee documents
Increased participation of women and youth in NRM decision-making	Proportion of women and youth attending and speaking at NRM meetings	NRM meeting registers and records
Increased enforcement of local NRM rules	Proportion of infraction sanctions applied	NRM committee records
Increased local fisheries management efforts	Number of fishery closures held	Activity records
Increased local forest management efforts	Number of fast-growing trees planted (fuelwood alternatives)	Activity records

Cross-cutting indicators

A few examples:

Anticipated output / outcome	Indicator(s)	Data source
Increased community discussions of the links between health and environmental issues	Number of integrated PHE outreach sessions Number of occasions of health and environmental organisations addressing non-traditional groups	Activity records
Increased livelihood diversity	Average number of household income-generating / food production activities	Household surveys - see Annex II
Increased participation of women in livelihood activities	Average proportion of household income-generating / food production activities undertaken by women	Household surveys - see Annex II
Increased household dietary diversity	Average household dietary diversity score	Household surveys - see Annex II *(composite measure based on multiple questions)*
Reduced household food insecurity	Average household food insecurity access scale score	Household surveys - see Annex II *(composite measure based on multiple questions)*

Is there a single indicator that can be used to capture the "added-value" of integrated PHE initiatives for people, their health and the environment?

Unfortunately no!

PHE implementers and their funders have been searching for such an indicator for many years but with no success. The difficulty is that the supposed "added-value" of a holistic PHE approach resides in the ***interactions*** between different PHE outcomes (or indicators).

Different components of integrated PHE initiatives are believed to work together synergistically to unlock a series of positive chain reactions and feedback loops. For example, increased access to and use of contraception may be hypothesised to support increased household food security, increased household livelihood diversity and increased engagement of women in natural resource management decision-making. However, the possible connections and pathways between these different outcomes are poorly theorised and only weakly supported by anecdotal evidence.

A number of PHE implementers including Blue Ventures are therefore currently trying to develop and apply more joined-up approaches to PHE data collection, with the aim of exploring possible interactions between observed PHE outcomes (please contact pheinfo@blueventures.org to find out more). In the meantime, many organisations are using qualitative data (such as most significant change stories) alongside key quantitative data (such as the estimated number of unintended pregnancies averted) to communicate the results of their integrated PHE initiatives to their funders.

When is it appropriate to conduct a social survey?

Conducting a social survey may appear to be relatively straightforward but don't underestimate the time, resources and expertise needed to design and implement one properly!

Some data that you may wish to collect through a social survey can be collected in other ways, such as through service delivery records and activity records, in which case it's certainly worth pursuing these options first. If the data that you wish to collect is absolutely vital for understanding the outcomes or functioning of your programme, required by your stakeholders and can only be collected through a social survey, then you'll need to take various important considerations (detailed immediately below) into account when designing and implementing such a social survey.

Important considerations for conducting a social survey

If you want the results from your survey to represent the whole population in the area where you work, it's important to sample randomly across that population or else understand fully the sampling frame that you're using, the limitations of it, and why and how to apply weights to your survey data. Census data can help you to choose the size of your survey sample and select a sample that is representative of your total population (e.g. that has the appropriate proportions of men and women in it). Census data can also help you to adjust or weight your results after the survey if you find that - despite your best efforts - you did not end up with a representative sample (e.g. it's quite common in household surveys to find the final sample biased towards female and elderly respondents as these demographic groups may be more commonly at home and available to answer questions).

Another important element of survey design that's often overlooked is the questions. Common challenges that should be taken into account when designing questions include: social desirability bias (a tendency to give a certain answer because it's what is "expected" or socially desirable); agreement bias (a tendency to agree with opinion statements); questions that are filtered according to previous responses (in-depth surveyor training and/or the use of electronic data collection methods can help to ensure the correct flow of the survey); questions that are embarrassing, intrusive or rude in the local context (these can be identified and adapted through reviews with community-based programme staff and piloting / testing with community members); and questions that require respondents to incriminate themselves or jeopardise their livelihoods (these should be avoided or else can be mitigated somewhat by assurances of confidentiality). Ethical approval should be sought for all questions, and the overall survey design.

Surveyors should be trained in confidentiality, informed consent and also in the specific sampling frame and survey questions that you've chosen; such training and follow up supervision is vital because even if the sampling frame and survey questions are well designed, if poorly implemented then the data collected are unlikely to be meaningful.

Another very important point to consider is survey fatigue and length. Surveys should be kept as short as possible and should not be seen as a replacement for poor record-keeping on a day-to-day basis. Surveys demand respondents' time and goodwill to answer the questions so this imposition should be kept to a minimum. The purpose of the survey should be explained to the whole community and results should be shared back to them in a timely and accessible manner.

In sum, a social survey should not be undertaken lightly, and certainly not without careful design of the sampling frame and questions, testing of questions in the relevant context, and careful attention to ethics. In addition, one shouldn't expect too much from a survey: some indicators, such as those relating to food security, change very slowly and have many complex inputs.

How to conduct a social survey?

- Design your questions in line with the indicators detailed in your monitoring plan which should have been informed by your PHE programme theory and goals arising from community consultations
- Decide whether it will be an individual and/or household survey depending on the questions you want to ask (as some are for individuals and some are for households) and the level of detail that you need (as sometimes it may be important to differentiate between men and women while other times it may be acceptable to have an average indicator for entire households)
- Construct your sampling frame (using the best available census data / population estimates - you may actually need to start by collecting your own)
- Design a random sampling strategy (so that every *nth* individual and/or household has an equal probability of being included in your sample)
- Seek ethical approval
- Recruit and train surveyors in confidentiality, informed consent, probing skills, the specific survey that you've designed, etc.
- Conduct a small pilot - remembering that you must allow sufficient time to redesign and retest the survey or certain questions after the pilot as necessary
- Review answers - revise the wording of the questions as necessary to ensure maximum clarity and cultural acceptability
- Roll out the survey across the target area - keep monitoring responses and how the questions are being received throughout this phase
- Enter the data into a database with quality checks (usually including double entry) - although this might not be necessary if you choose to use electronic data collection methods such as tablets or smart phones
- Analyse the data (frequencies, percentages, associations between variables, etc)

Please see Annex II for some sample questions.

How to collect qualitative data?

Collecting stories from community members can be an effective way of understanding and documenting the outcomes of your PHE initiative, especially unexpected outcomes. These stories are likely to yield rich and detailed information, complementing and helping to explain quantitative data. Stories can be collected through one-off interviews or longitudinal case studies, whereby you speak with the same person or household multiple times over several months / years in order to track changes over time. Informed consent must be obtained from all respondents. If you'd like to share their stories in your external communications then you should explain what


Photo credit: Garth Cripps

this would entail and check whether they agree to this, and if so whether they'd be comfortable with their own name being used or whether they'd prefer to remain anonymous.

A systematic way of collecting and analysing stories is called the "most significant change" technique. It involves the collection of significant change stories from community members and community-based staff, which can be analysed individually to provide insights into the impacts that a programme is having in the lives of community members. An additional step is the identification of the most significant of these stories by groups of staff and stakeholders. These people sit down together, read the stories aloud, sort them into themes and have in-depth discussions about the value of the reported changes. The stories are gradually reduced in number through a systematic and transparent process; every time stories are selected, the criteria used to select them are recorded and fed back to all interested stakeholders. After this process has been used for some time, a document is produced with all of the most significant change stories and the reasons why they were selected. Where possible, these most significant change stories are triangulated with quantitative data.

Significant change stories are collected from community members and community-based staff using the following question (or a variation thereof that is appropriate locally / to the programme being evaluated):

Looking back over the last month / year, in your opinion, what was the most significant change that took place for you / your family / participants in this initiative?

In addition to this, it's very important that respondents are encouraged to report why they consider a particular change to be significant to them.

The "most significant change" technique was originally developed to address some of the challenges associated with monitoring and evaluating a complex participatory rural development programme in Bangladesh, so it's well-suited for PHE partnerships and particularly helpful for shedding light on unexpected and "added-value" outcomes of cross-sector programming as it doesn't use pre-defined indicators.

There are many other ways of capturing some of the richness and impacts of PHE initiatives using qualitative data; please contact pheinfo@blueventures.org if you'd like to know more.

How to plan and carry out an evaluation?

- Start by deciding the aims of your evaluation with your partner(s), bearing in mind your learning objectives and the needs of different stakeholders.
  - For example, you may wish to assess the (expected and unexpected) outcomes of your initiative, how these were achieved, what worked well and what could have been done differently.
  - Other questions to consider: was your programme theory valid (sound logic and assumptions met), did the initiative respond to community needs, were the activities implemented well and targeted appropriately (or could they have been more efficient), did your staff have adequate training and support?

- Next, decide who will conduct the evaluation (your staff or an external evaluator).
  - In deciding this, it's important to consider that conducting a robust evaluation of your PHE initiative may require significant expertise not found within your organisation. PHE initiatives are highly complex and therefore most amenable to mixed methods evaluation (using both quantitative and qualitative data). Different methodological approaches can be used to evaluate such data. For example, realist evaluation is one approach that is being pursued by several PHE implementers at present (please contact pheinfo@blueventures.org if you'd like to know more, and further details will be included in version 2 of this guide).
  - Budgetary considerations / priorities will of course also shape the overall scope of your evaluation, and the feasibility of engaging an external evaluator. It may be that each partner already has a plan (and some funding) for monitoring and evaluating their own sector-specific work that you can build upon. If this is the case, you may want to focus any additional evaluation work looking at the synergies and interactions between these different components of your PHE partnership.
- Review all learning documented by programme staff to date (e.g. mission reports, team debriefs, learning journals, etc.) as well as all existing monitoring data (e.g. service delivery and activity records, survey results, most significant change stories, etc).
  - If you're wanting to understand how your PHE initiative functioned, you may like to map these data onto your PHE programme theory to assess whether it was valid and/or identify any gaps requiring further data collection.
  - You may also like to investigate any hypothesised causal mechanisms (processes through which you believe the observed outcomes may have been generated) using most significant change stories and/or focus group discussions with community members; these can help to pinpoint key activities or strategies for future PHE initiatives to prioritise.
  - Mixing quantitative and qualitative data in this way can strengthen evidence of programme outcomes and functioning, as quantitative data may be required by funders to assess the achievement of outcomes while qualitative data can help to illuminate how these outcomes were generated and what they meant to community members.

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