



## **Project Monitoring**

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This resource will help health partnerships to plan their monitoring and evaluation activities with reference to the context they are working in and with a strong awareness of their stakeholder audiences.

It will help health partnerships find ways to improve data collection and interpretation, and to make the most of the resources they have available to them, both in the collection of evidence, and the dissemination of results.

This workshop was delivered by THET's Evaluation and Learning team in London on 21 November 2012.

# Workshop Objectives

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Defining your audience

Gathering data: ambition, feasibility,  
participation

Communicating results

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# Setting the scene

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## Gauging success in a complex environment

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The majority of health partnerships are focused on increasing the numbers of adequately skilled health workers through training and education.

Consider a health partnership working in rural Burma. Maternal and neonatal mortality and morbidity rates at the district hospital are high. There is a severe shortage of staff able to manage situations requiring critical care such as emergency obstetrics.

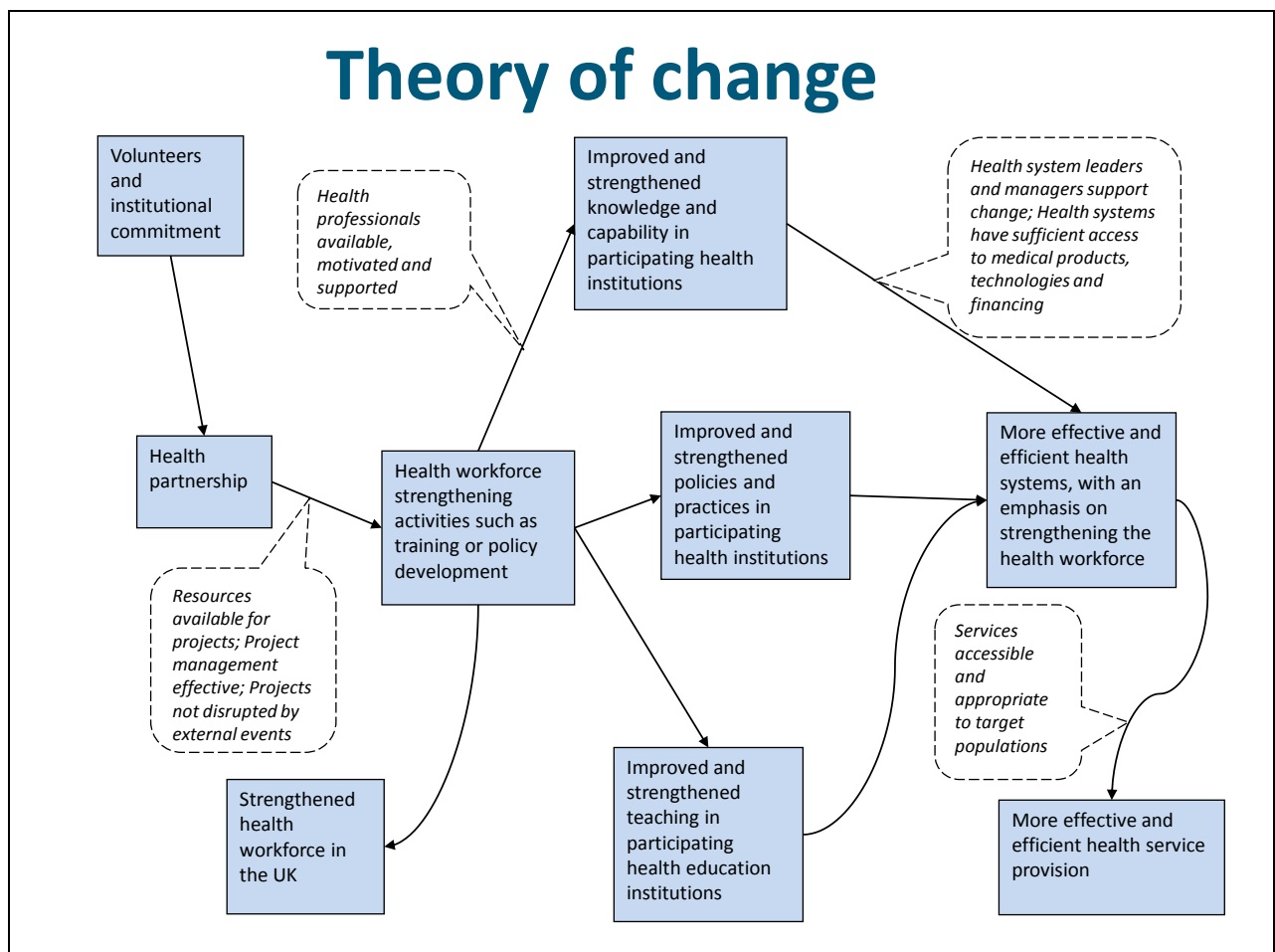
In response to this situation, the health partnership plans to train nurses and doctors in obstetric emergencies and neonatal resuscitation. Integral to the project is the introduction of task-shifting whereby obstetric emergencies will be treated by trained nurse anaesthetists and midwife surgeons. This task-shifting currently does not take place in Burma.

By doing these activities, they hope that ultimately, they will make an impact on the high mortality and morbidity rates at the district hospital.

However, their project is being implemented in an environment where:

- Task-shifting is not yet politically accepted or culturally embedded so they anticipate institutional scepticism and potentially resistance to their activities;
- Women may be saved in child birth but then may die from another cause such as an infection from the ward or lack of adequate postoperative treatment;
- Pay for staff at the hospital is poor and inconsistent and working conditions are very challenging for staff. These factors are demotivating and turnover is a high risk.

If this is the context, then how can the health partnership begin to understand the difference they are making?



This is explained by a ‘theory of change’ for the contribution health partnerships make to health systems strengthening.

The change process begins in the top left with volunteers and institutional commitment. The arrows indicate the step to the next stage in the change process.

The theory is:

1. Volunteers and institutional commitment leads to the formation of a...
2. Health partnership;
3. The health partnership carries out activities to strengthen the workforce at the developing country partner (DCP) institution.
4. Over time, these activities will lead to: strengthened knowledge and capability; strengthened policies and practices; and strengthened teaching at the DCP institution. In addition, these activities will enhance the UK volunteers’ personal and professional skills;
5. With these elements strengthened, we reach a stage where the health system is more effective and efficient, which then leads to...
6. More effective and efficient health service provision at the end of this change process – the last box, bottom right.

The complexity of the change process increases as the health partnership moves from one stage to the next and it is important to note that even the first stage of getting volunteers and institutional commitment can be very difficult to achieve.

There are lots of stages in the theory of change and many factors are built into the progression from one stage to the next. These are shown in the speech bubbles. E.g.

to move from training and policy development to improved and strengthened knowledge and capability of health workers at the DCP institution, health workers need to be available, motivated and supported.

You will notice that we do not have a stage for health outcomes. This stage would come after 'more effective and efficient health service provision' (point 6), with many external factors potentially interrupting the flow from one stage to the next. Health outcomes come far along the change process and so it is very difficult to attribute changes (or failures to change) at the health outcome level to your health partnership' intervention.

So if this is the complexity of the context that health partnerships are operating in, why should they still undertake rigorous monitoring?

## Why monitor progress?

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Are you meeting  
your targets

Process review and  
improvement

Motivate

Challenge

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### Purpose of project monitoring

- To check if you are meeting your targets;
- Accountability to funders;
- Identify and highlight strong or weak areas in the project implementation and give grounds for changing your methods – N.B. health partnerships are not scientific research projects therefore, if you're methods appear not to be achieving the desired results, good evaluation means that you can identify the reasons for this and amend your approach accordingly;
- Motivational evidence for the target group, which in the majority of cases this will be a group of health workers; if results are shared properly, people can see their practice improving.
- Evidence to challenge current practice and promote change.

## Why monitor progress

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Health  
Partnership  
story

But who wants  
to know ?



Ultimately you want to tell a compelling, informative story about your health partnership.

But who are you communicating this story to?

To know what story to tell and how best to tell it, you need to know who your audience is.

Audiences for the results and findings from your health partnership are known as your stakeholders. These are the people, organisations, and institutions who are interested in your activities and results.

# STAKEHOLDERS

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- Who?
- What do they want to know and why?
- What can they do for you?

**Be discerning**

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## Stakeholders (audience)

1. Which audiences are interested in your project/partnership?
2. What questions will they ask and why?
3. What benefit is it to the health partnership that these stakeholders have answers to their questions?

When thinking about which stakeholders you will communicate with and why, be discerning, think through the questions above, particularly number 3, to help create a manageable list of stakeholders. This will give your monitoring activities focus and make them realistic given the limited resource that most health partnerships have to carry out M&E activities.

Being clear on what you are monitoring and why is important for:

- Gaining buy-in to the processes and information gathering tools you will use;
- Keeping the workload to a minimum; project teams are stretched in delivery so monitoring needs to be integral to the workload for implementation, not an add-on;
- Generating useable, influential data, not information for information's sake.



## Stakeholders exercise

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Who is interested in your health partnership?

What do they want to know?

Why should you tell them?

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In this exercise, consider which groups of people, institutions, or organisations might be interested in your health partnership.

### Examples of possible stakeholders for health partnerships:

- NHS Trust board of management. They may agree to annual/study leave for volunteers; they must be amenable to all cadres of health worker taking part; how might the health partnership's activities raise the Trust's profile in the UK and overseas?
- Peers in other hospitals or other health partnerships. They may want to know how successful your methods are and why; opportunities for learning and collaboration; appreciation of others' challenges and frustrations in implementation; sharing contextual information about working in a particular country, specialism area etc.;
- Professional peers e.g. associations or societies. They may want to know about implementation methods; opportunities for further training in other countries; potentially as funders; peer review of your methods;
- Internal audience. Your own project team has much to learn from the project and its results can be highly motivational and instructive.

## How to Monitor : a case study

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Butabika Hospital, Uganda – East London NHS Foundation Trust

- Improve management of violent and aggressive patients to create a safer environment for staff and patients at Butabika Hospital.
  - Multiple cadres trained
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This is a case study of the Butabika Hospital Uganda – East London NHS Foundation Trust partnership and their approach to monitoring their project results.

The project trains staff at the psychiatric hospital (Butabika), in how they can manage violence on the wards in a way that reduces harm to both staff and patients.

The training targets many different cadres of health worker at Butabika: nurses, health officers, psychiatric clinical officers, psychiatrists, psychologists, and hospital guards. So they have multiple groups to monitor.

- Was the training translated into practice?

The partners want to know: was the training translated into positive outcomes on the wards with patients and staff involved in fewer violent incidents?

### Stakeholders

- They want to be able to tell their **UK and Ugandan partners** whether or not their methods have worked in order to validate the approach and find ways to develop it and maybe expand it into other settings;
- Their **peers** in other mental health projects want to know if this training has worked and why;
- Their **donors** (THET and in-house fundraising activities) want to know what difference this project has made to the health workers' practice and their patients.

# How they did it

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Target of 150 staff (multiple cadres) received training in prevention & management of violence and aggression



Number / types of staff attending training



Course registers – roles and numbers



First blue box - ? - This is what they want to know: have they met their target of training 150 staff?

The measure (ruler symbol) is a simple measure of participation in training – they will count the numbers and types of staff in attendance. So the tool they are using (spanner symbol) is a simple record – a course register.

This measure and data gathering tool do not answer questions about competency of staff following the training so this stage is early on in the theory of change process (i.e. towards the left hand side of the diagram).

## How they did it

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Staff feel confident using techniques learnt in training



Increased self-reported confidence before vs. after training



Survey

Number of times techniques are used.

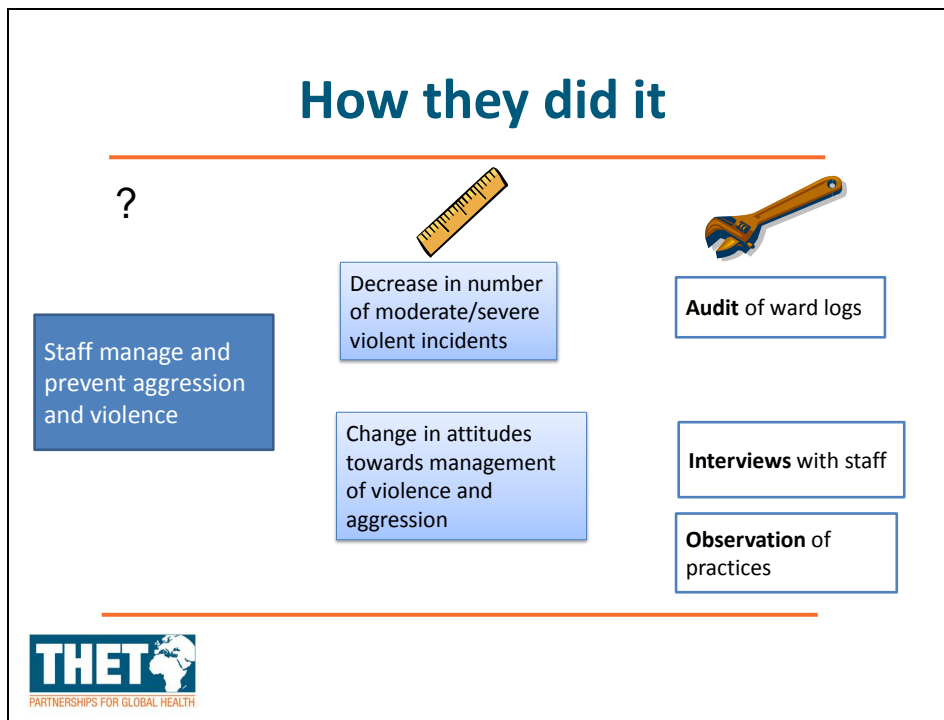
Staff log book



Here the question is looking at confidence in using the new techniques learnt in training. This means that the measures are getting more complex so this is moving further along the theory of change process and the measures (ruler symbol) are beginning to show a development of competency.

### Tools

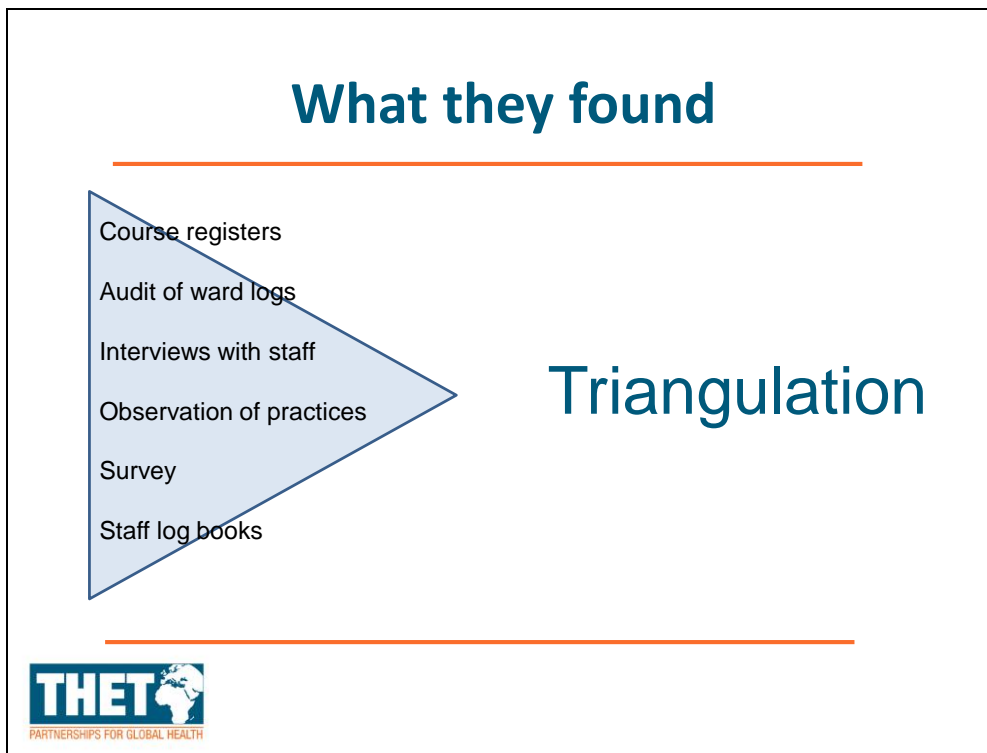
- Likert **scale survey** used before, soon after, and a longer period after training to assess the change in self-reported confidence;
- Staff **log book** where individual staff members record when they used a technique and how it went.



Here the measures are of staff's competency to manage and prevent aggression and violence. These are more complex and further along again in the theory of change.

### Tools

- **Audit** of ward logs to compare violent incidents before vs. after training;
- **Interviews** with staff to get a subjective assessment of impact of training;
- **Observation** of practices by the project team on visits to Butabika hospital.



### Courses registers

- Met their target number for staff trained: psychiatric clinical officers, cooks, social workers, drivers, domestic assistants, doctors, nurses, guards, occupational therapists.

### Audit of ward logs

- Over a 2-year period instances of both moderate and severe violence fell.

### Interviews with staff

- Subjective assessment of the impact of training was gained so that they could make improvements to the design and delivery of the training courses.

### Observation of practices

- The project team observed that security guards no longer routinely carried weapons which indicated a reduction in the risk of serious injury and importantly, a shift in culture around common practice.

### Survey using likert scale

- On a four point scale, staff reported an increase in confidence in dealing with threatening behaviour and a substantial increase in confidence in dealing with verbal aggression and physical violence.

### Staff log books

- The results from the log books were crossed referenced with the audit of ward logs and the confidence survey results to support/counter the data from these other two sources.

### Triangulation

- Triangulation is using multiple sources of data to understand your results more clearly and accurately and to improve validity and reliability. Butabika used both quantitative and different types of qualitative data gathering tools to help them see how and where the training has made a difference to staff's practice.

# Lessons Learnt by HPs

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## Participation

- Devise your plans in partnership
- Give sufficient training in the tools
- Empower your team – know purpose of M&E

## Feasibility – Ambition

- Ambition - volume of data equal to resource to analyse, interpret and use it
  - Anecdotal evidence valid – not scientific research
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## Devise your M&E plans in partnership

- What is currently being done at the DCP institution to track progress, assess, and improve?
- What would be the implications of introducing a new tool e.g. a) on people's workload; b) creating parallel records/systems? Hospitals may have reporting requirements to their boards or to district/national bodies. Find out what these are and try to align your data gathering objectives with these;
- What if no monitoring is taking place? In this instance, it will be more difficult to introduce the concept of progress tracking and review so more time needs to be dedicated to education about its purpose, the stakeholders, and gaining buy-in.

## Standardisation of tools

- The Butabika – East London partnership found inconsistency in results where data collectors had a different understanding of the terms 'moderate' and 'severe' in relation to recording violent incidents. This example illustrates the importance of education around terminology where staff are responsible for record-keeping and reporting e.g. is there common understanding of what is meant by 'moderate' and 'severe'?

## Empowerment

- It is important that all those expected to contribute to M&E know the purpose of it if they are going to commit to doing it and to seeing the benefits to them i.e. in tracking success as their skills and capacity improve. Without this communication for purpose, it could lead to problems with patchy data and lack of buy-in to the M&E plan.

## Feasibility: how ambitious are your M&E plans?

- Take into account: a) the number of people to monitor on an on-going basis; b) who is responsible; c) are there transport, printing, database costs; d) do any personnel need training/equipment in order to do monitoring activities?
- Are you collecting the right data for your stakeholders? Are you collecting any data that does not have an obvious audience (avoid wasted effort).



- Make the most of anecdotal evidence as informal signs of change, which will help to build the picture of impact and change e.g. observations, conversations.

### A note on inferential methods

Can we use inferential methods e.g. random controlled trials (RCTs) to help us understand the effectiveness of health partnerships?

#### Challenges:

- Methodological – defining populations and controls in complex social systems;
- RCT treats a health partnership as a black box – you put in activities, resources etc. and what are the outcomes? It does not tell us *how* an intervention is working or *why* it is not;
- Practical – management and logistical issues; resources and skills required.

There are questions about the appropriateness of doing an RCT in capacity building contexts when it is valuable to modify projects as they run. There are also ethical issues to implementing RCTs in social systems.

It may be possible to use inferential methods to explore elements of health partnerships and health system strengthening activities, such as the effectiveness of different types of training, but even that is difficult for example, there is a lack of this use in the UK health education system.

Therefore, we focus on **descriptive approaches** to understanding the effects of health partnerships because they are best suited to the health partnership context.

# Indicators



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Indicator	Source of information (tool)
Number / types of staff attending training	Course registers – roles and numbers
Increased self-reported confidence before vs. after training	Survey
Number of times techniques are used	Staff log book
Decrease in number of moderate/severe violent incidents	Audit of ward logs
Change in attitudes towards management of violence and aggression	Interviews with staff Observation of practice

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To re-cap, these are the indicators and sources of information used by our case study example, the Butabika – East London health partnership.

## INDICATORS: the logframe

<u>Goal</u>	Indicators	Source of information
<u>Outcomes</u>	Indicators	
<u>Outputs</u>	Indicators	
<u>Activities</u>		



If you are using a logical framework (logframe) for your project plan, you will need to present your indicators in this structure.

You will need to divide your theory of change into activities, outputs, outcomes and a goal, which can be an artificial breakdown for some projects. For more guidance on putting together a theory of change and then working with a logframe in project planning, see this THET resource: <http://www.thet.org/hps/resources/good-practice-guidance/project-planning-theory-of-change>

## Setting Indicators

How you will measure success for your objectives.

To achieve this need to be:

Specific	Access
Measurable	Level of use
Achievable	Extent/coverage
Relevant	Quality
Time bound	Presence



Considerations: in many health partnership contexts, data quality is poor/hard to access so choose contextually relevant indicators and sources of information.

We are often advised to make indicators SMART:

**Specific** – not open to interpretation

**Measurable** – should be able to gather the information for them. Should be possible to measure the change

**Achievable** – realistic given the scale of the intervention and the resources involved

**Relevant** – to what you are trying to demonstrate; directly relevant to the outcomes

**Time bound** – within the period of the project; suggest when the target will be achieved.

Indicators may or may not include targets. If you cannot set a meaningful target – for instance, because you are trying a new approach in the context and you don't know exactly what to expect – it is best not to set one at all. Instead, you will simply monitor the indicator you have set. In that case, you will still need to be Specific, Measurable and Relevant, but you do not need to worry about Achievable or Time bound. Once you have a sense of how the indicator is changing, you may choose to set a target later.

The purpose of indicators is to *measure* changes

- Access e.g. to a service;
- Level of use e.g. number of people attending a clinic to seek treatment or diagnosis; use of consumables;
- Extent/coverage e.g. of activity; geographical reach into rural areas;
- Quality e.g. of a service;
- Presence e.g. of well-maintained equipment.

## SOURCES OF INFORMATION



Where you will source the evidence for your indicators; your data gathering tools.

Objective	Indicators	Sources of Information
Staff manage and prevent aggression and violence	Decrease in number of moderate/severe violent incidents	Audit of ward logs
	Change in attitudes towards management of violence and aggression	Interviews with staff Observation of practices



Sources of information are how or where you look for evidence for your indicators.

## Indicators: examples

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Common quantitative indicators/sources of information. Uses and challenges.

Common qualitative indicators/sources of information. Uses and challenges.

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### Common quantitative indicators: uses and challenges

- Training provided – Number of participants in training – Simple, easy to measure, says nothing about relevance or quality of training or selection of trainees;
- Mortality – Number of deaths associated with specified population/condition/timeframe – of great interest, patchy data and hard to collect, many confounding factors in interpretation;
- Medical equipment installed and in use – Number of procedures carried out using specified equipment – data hard to collect and interpret.

### Common qualitative indicators: uses and challenges

- Health worker performance – Observed adherence to best practice – of great interest, data may be expensive to collect, learning opportunity for observers and observed but observation may influence performance;
- Improved quality of care – Recorded care of patients with specified condition – of great interest, data hard to collect, confounding factors in interpretation
- Improved health education curriculum – (independent) expert opinion of revised curriculum – of great interest.

Remember the lessons from health partnerships about participation and ambition.

## Indicators & Tools exercise

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Define your indicators

What evidence gathering tools (sources of information) do they rely on.

Discuss participation, feasibility, anticipated yield of results.

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## Presenting Results

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What will effective communication of your results, tailored for the audience, mean for your project/partnership?

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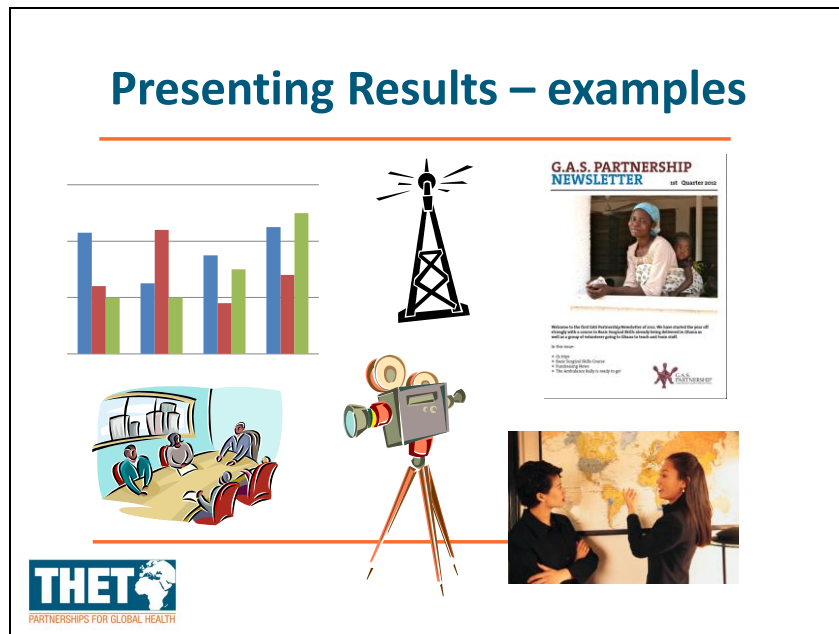


### Why tailor your communication for your different stakeholders?

- Gain greater buy-in to the project and partnership from those already involved in implementation or as recipients of training activities;
- Motivation of hospital staff on both sides of the partnership;
- Help with fundraising by colleagues at the UK institution;
- Gain interest from your senior management e.g. NHS Trust, especially in demonstrating benefits to the UK volunteers;
- Future funding;
- Facilitate and increase self-reflection such as questioning whether you are following evidence-based good practice in capacity-building.



## Presenting Results – examples



### Bar Graph

Bristol University – Mpilo hospital, Zimbabwe project draws up a simple bar graph on flipchart paper and displays it in the matron’s office as a way of visually tracking improvement in the mortality rates on the maternity ward. This is aimed to motivate staff when results are positive and can be used to open up discussion when the results are negative.

### Radio antenna

NHS Tayside – Queen Elizabeth Central Hospital, Malawi has gone on local Malawian radio to talk about the project and use this as a platform to enhance their awareness-raising activities of burns injuries to communities.

### Newsletter

[G.A.S partnership](#) produces a newsletter which brings the partnership and its projects to life for a wide audience.

### Presentations to board/steering committee

Central and Northwest London NHS Foundation Trust– Mirembe Hospital and Nursing School, Tanzania partnership gives a presentation to the NHS Board, highlighting project activities and results. They have found this to be successful in increasing interest and buy-in from the Board.

### Film

Gloucestershire Hospitals NHS Foundation Trust – Kambia District Health Management Team ([The Kambia Appeal](#)) made a film about Kambia to help them with recruiting volunteers.

And lastly, it may be obvious but conversations are equally important in communicating your successes and results, so make the most of them.

## Presenting Results: exercise

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Take your stakeholders.

How will you present your findings to these groups, and why?





**THANK YOU**

[www.thet.org](http://www.thet.org)



For more resources, visit the Resource Library on the THET HPS website

<http://www.thet.org/hps>