

CHAPTER 5

ASSESSMENT, MONITORING, AND EVALUATION

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5.1 INTRODUCTION

In order to ensure sexual and reproductive health (SRH) programming is responsive to the needs of a population affected by humanitarian crisis, we use assessment, monitoring, and evaluation at different stages during a humanitarian response in order to:

- Understand and quantify the needs of populations of concern and contributing factors
- Ensure effective and efficient use of resources
- Identify programmatic barriers and enablers
- Determine the success or failure of a program
- Provide accountability and transparency to donors, beneficiaries, and other stakeholders

The type of humanitarian crisis and the form of displacement has implications for the way we design and execute assessments, monitoring, and evaluation. Methodological approaches and methods may vary depending on the context, such as in sudden onset natural disasters, protracted armed conflict, or epidemics or the location of

BOX 5.1: CHALLENGING CONTEXTS & SPECIAL POPULATIONS

URBAN SETTINGS

Over 60% of the world's refugees and 80% of internally displaced persons (IDPs) live in urban environments. Whereas refugee camps offer a controlled setting with easily defined boundaries and a population whose health status is relatively easy to track, refugees can live anonymously in cities. Though this can offer them better opportunities for livelihoods and self-sufficiency, it presents challenges in trying to collect data about their health status and needs.

Assessments in urban areas require mapping relevant stakeholders and service providers, conducting a situational analysis of the political, legal, and socio-economic context of the host city, and consideration of the differences between refugee subpopulations and their access to services and experiences within the host city.

When undertaking an assessment in an urban setting, it is encouraged to consider disaggregating the assessment components (i.e.,

mapping, situational analysis) by subpopulations within the refugee community. Among these subpopulations are women, children, lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual (LGBTQIA) individuals, persons with disabilities, people who engage in sex work, male survivors of sexual or gender-based violence (GBV), and the elderly.

MIGRANT POPULATIONS

Migrants are different from refugees. They are not forced from their homes, but rather choose to move for work, education, family reunion, or other reasons. Nevertheless, due to their mobility and often lack of legal status in the host country, this population presents special challenges in data collection.

Identifying migrants:

- Work with employers that hire large numbers of migrants
- Develop relationships with

community-based organizations or leaders in the communities from which migrants originate

Monitoring migrants' health status:

- Use mobile applications

Many migrants do not have legal status in the country they travel to, or are afraid of their own government. As such, it is important to explain to migrants how you will use the data you are collecting. In addition, ensure that you address concerns about confidentiality with the organizations you work through to identify migrants.

Remote or inaccessible locations

Some populations in humanitarian settings are unreachable due to natural barriers (mountains, flooding, earthquake upheaval, etc.) or insecurity. These situations require creative data collection techniques to assess the affected population's needs and monitor their SRH health status over time.

the displaced population, such as urban, semi-urban, rural, or camp-based. Robust and ethical data collection methods and appropriate use of the results will assist SRH Coordinators and health program managers make evidence-based decisions when transitioning from Minimum Initial Service Package (MISP) activities to comprehensive SRH services.

5.2 OBJECTIVES

The objectives of this chapter are to:

- Describe the what, when, and why of assessment, monitoring, and evaluation of SRH programs in humanitarian contexts

- Identify appropriate assessment, monitoring, and evaluation methods, tools, and indicators
- Provide guidance on ethical data collection and use and ways to use data for effective policies, programs, and advocacy

5.3 ASSESSMENT, MONITORING, AND EVALUATION

Knowing when to transition from the MISP to comprehensive SRH programming requires a robust and iterative monitoring and evaluation system. As soon as we reach and can sustain MISP service delivery targets, appropriate comprehensive SRH service components should be implemented.

Although assessments can be thought of as one type of evaluation, these terms are separated out in order to identify specific processes in humanitarian settings. The key terms used in this chapter are as follows:

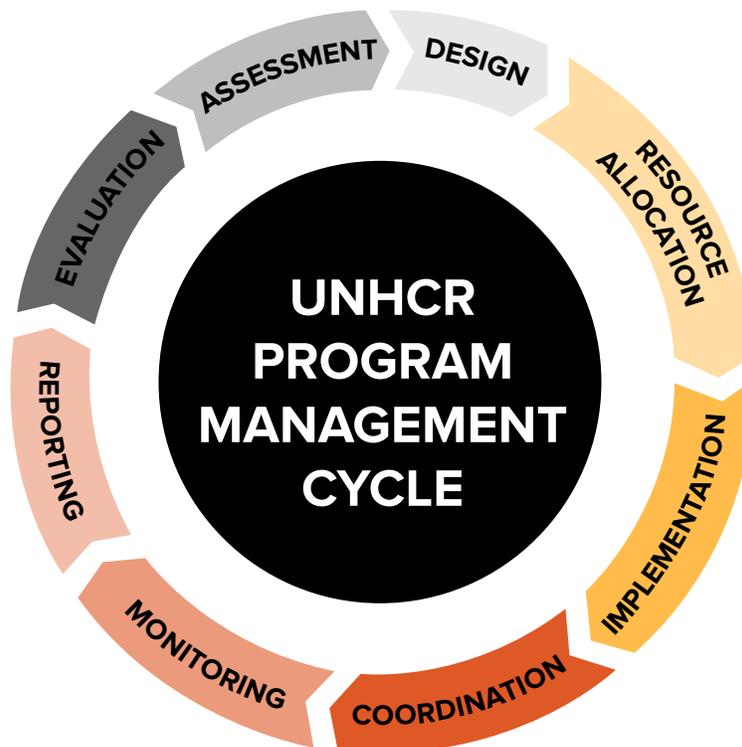
Assessment is a process for determining and addressing needs or “gaps” between current conditions and desired conditions and contributors to those gaps.

Monitoring is the ongoing, systematic collection and analysis of data as a project progresses. It is aimed at measuring progress towards the achievement of program milestones and objectives.

Evaluation is a process for determining whether a program has met expected objectives and/or the extent to which changes in outcomes can be attributed to the program.

A feedback loop called the operations management cycle links these 3 processes (see Fig. 5.1). This cycle shows the critical role data play throughout a humanitarian response in informing, monitoring, and evaluating SRH programming.

FIGURE 5.1: PROJECT CYCLE



The project cycle defines how assessment, monitoring, and evaluation are linked along a continuum of service delivery and program management. It helps SRH Coordinators and health program managers to understand how each can be used to inform decision-making throughout the cycle of program design, planning, and implementation.

The ability to carry out successful and timely reproductive health projects in the challenging environment of a humanitarian response is crucial to ensure SRH needs of the affected population are met. The most successful SRH programs are those which are designed based on an appropriate assessment of needs within the target population. Subsequent program activities should then be monitored using carefully selected indicators to track progress towards clearly stated objectives. Throughout implementation of the program, activities should be adequately evaluated to reflect on what is working well and what is not, and to feed back the results into a continual cycle of program review and improvement.

5.3.1 Assessment

PURPOSE

Identify the SRH needs of the population and contributing factors and determine the capacity of the existing health system to respond to those needs. Throughout the life of a program, we can use periodic assessments to evaluate its progress towards achieving objectives.

WHEN TO CONDUCT ASSESSMENTS

This depends on the type of information needed and the phase of the emergency. We often conduct some types of assessments, such as situational analyses and rapid assessments, in the acute phase of a humanitarian emergency when time and resources may be limited and a broad picture of the situation may be needed. Desk assessments are appropriate in the acute phase of an emergency to avoid a duplication of effort, but can also be useful throughout the emergency. Methods requiring greater resources, such as surveys and some participatory methods, may be more appropriate in later phases of an emergency in order to gather additional details on needs and gaps for more comprehensive SRH programming.

WHO CONDUCTS THE ASSESSMENT

An assessment team may consist of several people with clinical, research, management, and public health skills. The assessment team can be larger if the context allows for a more thorough assessment to be undertaken. The number of team members required will depend upon the size of the area to be covered, the size of the population being assessed, the prevailing access and security situation, and the assessment methods that will be used.

When selecting a data collection team, gender, age, ethnicity, and social status of its members should be considered. For example, in some cultures it may be inappropriate for a man to ask a married woman questions about her reproductive history. In general, it is good practice to include members of the affected population in the assessment teams, unless participants will be less comfortable disclosing sensitive information to data collectors of the same demographics.

The ideal team members:

- Have appropriate technical skills, training, and

experience

- Have good communication skills in the local languages and are familiar with the population being assessed
- Are comfortable discussing SRH topics
- Have good analytical skills to appropriately interpret the findings

METHODS

Examples of tools used for each of the methods described below can be found in Section 5.5. Note also that the methods described below are not mutually exclusive. For example, a desk review may be part of a rapid assessment. In addition, the list of methods is not meant to be exhaustive, but rather to give a broad range of examples appropriate to humanitarian settings.

Rapid assessments

At the onset of the humanitarian response, humanitarian partners carry out an initial rapid assessment. While the causes of the most important SRH-related morbidity and mortality are already addressed by the MISRP and do not need to be assessed at the onset of the humanitarian response (see the MISRP essential checklist in Chapter 3), there is nonetheless important information to be gathered with a rapid assessment to ensure appropriate strategic planning. Within the health sector/cluster coordination system, SRH Coordinators must ensure that they obtain information on:

- The number and location of people needing access to minimum SRH services
- The number and location of health-care staff providing, or capable of providing, the service components of the MISRP
- SRH medical supply logistic opportunities
- MISRP funding possibilities

Desk review

A thorough review of secondary data sources should be conducted to compile existing SRH information on the affected population (origin and/or host area data as appropriate). Such data will be available from Ministries of Health, United Nations (UN) agencies, and non-

governmental organizations (NGOs). Examples include:

- Demographic and Health Survey (DHS) or other available survey data
- Routine surveillance or health facility data, such as those reported to district or national health information systems
- Availability of SRH services, their geographic distribution, and functionality
- National strategic plans and/or UN Development Assistance Framework (UNDAF) assessments

Situational analysis

A situational analysis should be conducted to understand the legal, political, cultural, and socio-economic context of the locale and how this might impact the SRH needs and availability of services for affected populations. Notes should be made on how different subpopulations might be affected differently. We include guidance for how to review literature and indicators as part of the MISP assessment in Section 5.5.

Key informant interviews

Key informant interviews generate qualitative data from a wide range of people who have firsthand knowledge about the affected population. Key informant interviews ask open-ended questions and can be structured (a set of questions asked in a specific order), semi-structured (a set of questions and suggested probes that can be changed or adapted during the course of an interview), or unstructured (a list of guiding topics used for inductive, open-ended questioning). Key informant interviews should collect individuals' views of pre-existing conditions and SRH practices, the current situation, changes in practices since the onset of the emergency, adequacy of current SRH services, and priority SRH needs of the population.

Focus group discussions

Focus group discussions generate qualitative data about a group's beliefs and attitudes on a particular health issue or problem. Focus group discussions differ from key informant interviews as they allow for interaction among all the members of the group. They are particularly useful in generating information representative of a specific sub-group in the population, such as women of reproductive

age or adolescent males.

Participatory methods

The purpose of participatory methods is to make the assessment process as inclusive as possible of the target communities. Community organizations led by members of the affected population and informal groups of different subpopulations within the affected population should be engaged and involved throughout the process.

Participatory methods can include community members as researchers and/or conducting participatory activities for data collection. For example, involving community members in the development of assessment/evaluation questions, including community members as data collectors, and conducting participatory activities during data collection, including but not limited to the participatory ranking method, community mapping, timeline, photo elicitation, photo documentation, and others. These should be selected based on the study question and constraints. Community members should also be involved in the analysis and dissemination.

Health facility assessments

A health facility assessment is an inventory of the places where health care is provided and the types and quality of services provided at these sites. A structured checklist of topics can help to provide a description of the health facility, including an inventory of SRH services provided, staffing, and coverage and an inventory of SRH equipment and supplies. This can also include reviews of routine statistics on SRH services to determine gaps in service delivery and quality of care.

Mapping

This activity can often be done in conjunction with the health cluster/sector to include health facility assessments. Mapping of relevant stakeholders and service providers includes both those currently providing SRH services to affected populations and those who potentially could, such as government, private sector, international development actors, humanitarian actors, civil society, and community-based organizations (CBOs). Mapping should identify service providers that offer specialized services relevant to different sub-populations. The exercise should also engage local organizations to identify opportunities for referrals,

cost sharing, and other opportunities for linkages between different stakeholders and service providers.

BOX 5.2: USE OF SRH SURVEYS

Surveys can provide useful, population-based data that SRH service providers and program managers can use to improve and more effectively target SRH care services. However, they must be undertaken by those who have training in survey methodology. There are many factors to be taken into consideration when designing a survey. Decisions must be made with regard to sample size, acceptable error levels and sources of bias, availability of resources (time, money, personnel, etc.) and if the information could be collected as or more effectively using another data collection method.

Recognize the limitations of each decision. For example, surveys that are conducted during initial needs assessments often need to be carried out rapidly using small, convenient sampling methods and will not necessarily be representative of the target population. Once the situation stabilizes, more detailed survey questionnaires and more representative sampling methods can be used.

The decision on which survey methodology to use is coordinated with the health sector/cluster to ensure it is appropriate and will produce results that are compatible with other surveys that are conducted as part of the health response. When possible, existing survey instruments that have been tested in humanitarian or low resource settings should be used.

Surveys

Surveys can be useful for gathering population-based information from a sample that can be representative of the larger population of interest. Such surveys should be succinct and only contain questions necessary for the targeted program or intervention. Surveys differ from key informant interviews and focus group discussions as they do not permit participants to give detailed opinions on a topic, resulting in the “what” information rather than the “why” information.

BOX 5.3: NEED TO KNOW OR NICE TO KNOW

It is a common tendency to want to collect lots of information for assessments, monitoring, or evaluation, often with the thought that “it might be important.” However, collecting data requires valuable resources and it is crucial that careful thought go into determining **what** you need to know, **why** you need to know it, and **how** you can collect that information most effectively. If the information is not tied to the outcomes or impacts to be measured, you should not be collecting it.

Regardless of the type of assessment conducted, there are key steps in data collection that we should consider. Refer to ethical guidelines in the resources section for additional guidance:

1) Make sure the information-gathering activity is necessary and justified

- Before starting the activity, clearly define its intended purpose and audience, and make sure that there are sufficient resources to conduct it in an ethical manner
- Only use direct methods if the required information is not otherwise available
- If the information-gathering activity will not directly benefit the target beneficiaries involved or their community, do not proceed

2) Design the activity to get valid information

- Develop a protocol to clarify aims and procedures for collecting, analyzing, and using the information to which all partners agree. Information collected for generalizable knowledge is research and an ethics review board or institutional review board (IRB) should review the protocol, which can add considerable time to a project timeline
- Apply community definitions to set clear criteria for participant inclusion. Use existing records when possible, and recognize social and cultural barriers to participation. For surveys, or any other data collection activity meant to be representative, make sure appropriate sample size is calculated to measure target indicators

- All tools, such as questionnaires and discussion guides, should be developed through discussions with experts. These tools should then be translated locally, back-translated, and field-tested
- The use of a comparison group totally deprived of services is inappropriate with vulnerable groups. Alternative approaches should be explored to strengthen research findings. Comparison groups should be used only under careful ethical supervision and under specific conditions

3) Consult with stakeholder groups

- Consult locally to determine who must give permission for the activity to proceed
- Interviewers must be sensitive that they may be highly visible and a source of local interest. Clarify roles and expectations through stakeholder meetings and honor commitments
- An independent local stakeholder group should monitor activities

4) Anticipate adverse consequences

- In partnership with the stakeholders, anticipate all possible consequences for the target beneficiaries. Do not proceed unless appropriate responses to potentially harmful consequences can be provided
- Avoid stigma by holding community sensitization meetings and using community terminology when appropriate
- If the safety and security of participants cannot be assured, do not proceed
- Interviewers should have experience working with participants. They should be trained to respond to participant needs and require ongoing supervision and support. If appropriately skilled interviewers are unavailable, do not proceed
- In partnership with the community, determine what kind of follow-up is appropriate to respond to participants' needs, recognizing age, gender, ethnicity, and so on. If appropriate support cannot be assured to meet the participants' needs, do not proceed

- Prepare a reaction plan to anticipate serious needs. If support cannot be assured, do not proceed

There may be instances, such as child endangerment, where study teams should breach confidentiality to provide immediate protection to the participant. We must ensure that participants are aware of this before asking for any information.

BOX 5.4 KEY MESSAGE

The job of ethics review boards is to ensure that consent and data collection procedures protect the participants through established ethical guidelines. The requirements may exceed those listed in this chapter.

5) Conduct consent and interviewing procedures with sensitivity to participants' specific needs

- Participant must give her/his/their consent to participate through verbal or written consent
- Information given to participants must be written/read in clear local language and provide information about the purpose of the data collection, the nature of the questions to be asked, who is involved, what the risks and benefits are, how the participant was selected, and what steps will be taken to ensure privacy and confidentiality of the data collected
- Interviewers should make sure that participants know they can stop or withdraw at any time
- Investigators must provide participants with information about the activity in a manner appropriate to their culture and education. Consent forms and informational tools should be developed with stakeholders and field-tested
- Use an independent advocate to represent the views of children if there is any doubt about the protection provided by their guardian
- Avoid efforts to unduly influence participation by the use of incentives. If incentives are used, they should be in line with local living standards
- Interview procedures should reflect the need to protect the participants' best interests. Since SRH

is often sensitive, care should be taken to conduct interview/survey/focus group discussions in a private setting out of earshot of a participant's spouse, other family members, neighbors, etc.

6) Confirm that all stakeholders understand the limits to the activity and next steps

- Use appropriate procedures to maintain the safety and security of participants
- Share de-identified, aggregate research findings with stakeholders and beneficiaries in an accessible, appropriate format

BOX 5.5: WHAT DATA SHOULD BE COLLECTED IN AN ASSESSMENT?

Chapters 6 to 12 provide recommendations on what data should be collected in assessments for each component of an SRH program.

USE OF ASSESSMENT RESULTS

Team members should analyze data as soon after the data are collected as possible. The results of an assessment must be as specific as possible to allow for timely decisions on interventions to be made. The results must clearly prioritize needs and identify opportunities on how to ensure MISP interventions are sustained and to plan the addition of comprehensive SRH service components.

Share copies of the final report with all organizations involved in the humanitarian response, including the Ministry of Health (MOH), through the health sector/cluster coordination mechanism, as well as with logistics teams and procurement officers. Also communicate findings and decisions to the community in a way that will protect the confidentiality of the participants, such as through aggregated data. It may also be appropriate to share preliminary findings with the community to help validate the interpretation of the findings.

5.3.2 Monitoring

For monitoring and evaluation purposes, it is recommended to work with the existing health care system when possible and appropriate. Ideally, reporting systems and referral systems should align with existing structures; advocacy

may be required to make them more inclusive to displaced populations.

PURPOSE

Regularly collecting, reporting, and analyzing SRH data is essential for monitoring the performance and quality of health service delivery/SRH program and for identifying changes in the health status of the affected population. Monitoring includes the timely dissemination of results so action can be taken.

WHEN TO MONITOR

At the onset of a humanitarian response, a simple information system that collects minimal SRH data is required to monitor implementation of the MISP. As the response evolves and more comprehensive SRH service components are introduced, the monitoring requirements of SRH programs must adapt accordingly.

The periodicity of monitoring (e.g., daily, weekly, or monthly) depends on the stage of the humanitarian response and the requirements of each organization. At least monthly data should be made available to inform regular programming decisions, though more frequent data reports may be necessary depending on the stage (e.g., acute) and type of emergency (e.g., outbreak).

WHO CONDUCTS THE MONITORING

Nurses, midwives, and other SRH service providers working in health facilities are responsible for the routine collection and reporting of service data. In addition, community-based health staff should be involved in gathering community-level data. In order to ensure that data is comparable across different programs, all such staff must receive adequate training on the correct use and application of data collection tools in the field.

The clinic supervisor is responsible for aggregating reports. These are sent to the SRH or health program manager for computer entry and analysis. The clinic supervisor, or another designated supervisor, should conduct quality checks to ensure accurate and consistent data collection.

TOOLS

It is crucial that all health partners use the same tools and methods of data collection across all locations to

ensure that data are standardized, of good quality, and are comparable across locations.

Health data can be collected as part of an existing national health information system (HIS).

Where such a system does not exist or has been disrupted by the crisis, the health sector/cluster will implement an emergency monitoring system in order to support program management and coordination.

Routine SRH data should be collected from a combination of health facility and community sources as part of the wider HIS. Sex and age should always be collected from these sources to enable disaggregated analysis. Sources of routine data include:

- Individual patient records and charts (e.g., partographs, antenatal cards, contraception cards)
- Daily registers and tally sheets (e.g., birth registers, antenatal tally sheets)

- Laboratory forms (e.g., HIV testing or syphilis screening results)
- Maternal and perinatal death review forms
- Near-miss review
- Community-based health workers/midwife reports
- Weekly and/or monthly reporting forms
- Repeated surveys (a useful source of SRH monitoring data when repeated over time)
- Sentinel surveillance
- Commodities/supplies

The above list of tools is not exhaustive. Other methods of routine data collection may need to be maintained alongside the HIS, according to the needs of each program and/or agency.

BOX 5.6: SELECTING AND USING SRH INDICATORS

Indicators are defined as variables that can be monitored over time to track progress toward the achievement of objectives. For example: “coverage of antenatal care.”

An **objective** is the desired end-point to be reached at the end of program implementation. For example: Obstetric risk factors are detected and managed early in pregnancy.

Each indicator should be assigned a corresponding standard target to establish the minimum acceptable level of achievement that is required. For example: 90% of women attend the recommended number of antenatal visits during pregnancy.

If SRH programs implemented by different actors do not utilize the same indicators, they are not standardized, and neither is the health information that they generate. Consequently, the data produced by non-standardized health programs may be incomplete, cannot be aggregated, and are unsuitable for monitoring a situation.

This underscores the importance of participating in coordination mechanisms, such as the health cluster.

The process of indicator selection is not easy. Each indicator should be technically valid, simple, and measurable. Furthermore, the expansion from MISP to comprehensive SRH services within a country will open up new areas for monitoring and implementation that need to be continually taken into consideration. It is therefore recommended that any indicator should meet SMART criteria and should be:

Specific (what and who)

Measurable

Appropriate

Realistic (achievable)

Time bound

The mix of indicators selected for monitoring should also be appropriate

to measure program objectives across different stages of the project cycle. For example:

- Output (or process) indicators measure activities conducted to achieve specified outcomes. For example: the number of midwives trained in ANC protocols
- Outcome (or performance) indicators measure changes that result from program activities, such as changes in knowledge, attitudes and behaviors, or in availability of services. For example: the percentage of women who receive at least two doses of Tetanus Toxoid (TT) prior to delivery
- Goal (or impact) indicators measure changes in morbidity and mortality expected to result from program activities. For example: Incidence of neonatal tetanus

WHAT DATA SHOULD BE COLLECTED IN MONITORING?

Chapters 6 to 12 recommend key indicators used to monitor each component of a comprehensive SRH program. See Box 5.6 for definitions and issues to consider when selecting and using SRH indicators.

USE OF MONITORING RESULTS

Monitoring results enable program managers to analyze trends of specific indicators over time to determine whether the program is adequately serving the affected population. When indicators fall short of their targets, program managers need to use this information to make course corrections so as to achieve the intended objectives.

In order to use data effectively, it is critical to select indicators judiciously and to think of how the data will be used when selecting indicators. Too often, higher-level managers experience information overload and seldom use monitoring data effectively.

Effective use of data also requires regular feedback to lower-level managers and SRH staff. Often lower-level managers and front-line staff rarely receive any feedback from the vast quantities of data they are required to report. SRH program managers must give regular feedback to staff. This can be done by drawing graphs and discussing the trends and implications for programming, as well as by sharing key points from recent health sector/cluster coordination meetings. This engenders accountability and is a powerful motivating tool for lower-level managers, as it enables them to understand how they are contributing to SRH improvements in the general population.

5.3.3 Evaluation

PURPOSE

An evaluation enables SRH program managers to determine whether the SRH program met defined objectives. It compares program activities and services (outputs) with benefits (outcomes) and public health impact (goals).

PROGRAMMATIC EXAMPLE 5.1: MONITORING AND EVALUATION IN A REMOTE HUMANITARIAN SETTING

ORGANIZATION: CARE

LOCATION: Syria

INTRODUCTION: In northern Syria, CARE collaborates with local NGOs to provide both facility-based and community-based sexual and reproductive health services. Continuously rising levels of insecurity in Syria, unpredictable border restrictions, and CARE's determination to reach more remote and underserved areas, all result in a reliance on remote management, including third party monitoring of its activities.

PROJECT DESCRIPTION: CARE sub-contracts monitoring and real-time evaluation activities to independent firms with a proven track-record of methodological rigor who have access to project implementation areas and a strong team of staff on-the-ground in Syria. Using tools designed jointly between CARE and third-party firms, the third-party monitoring team verifies and triangulates data from clinical records with assessments it conducts on quality of care, supplies and equipment inventories, and patient exit interviews. The third-party monitoring firm then reports preliminary results at a joint meeting with both CARE and implementing partners before finalizing their findings.

In conducting third-party monitoring, the priority is selecting quality data sources and conducting effective triangulation that produces "good enough" information without putting partners under pressure and/or risk to provide evidence that is not available or unsafe to collect. The scope of monitoring is agreed with partners as part of planning, including discussion on the level of data that is appropriate, manageable and safe that will best demonstrate the effect of the project.

The feasibility of third-party monitoring is explored for each target area individually, taking into consideration security constraints. Where third-party monitoring is not feasible for security reasons, CARE and partners explores alternatives, such as peer monitoring. In some cases, CARE also contracts local groups based inside Syria to conduct independent monitoring of specific activities.

LESSONS LEARNED: One of the key lessons learned to date is that tri-partite planning between CARE, implementing partners, and the third-party monitoring firm is essential. Ensuring a common understanding of scope, purpose, and logistical and security implications of third-party monitoring activities is a key element of both successful implementation of third-party monitoring exercises and also maintaining effective, trusting working relationships among all partners.

WHEN TO CONDUCT AN EVALUATION

As defined above, evaluations require a sufficient amount of time in order to measure program outputs and impacts. Therefore, evaluations are not appropriate in acute situations where assessments and monitoring can provide feedback on emergency actions. However, 3 to 6 months post-acute phase, a comprehensive package of MISP process evaluation tools are available (see Section 5.5). As we plan and design more complex and comprehensive SRH programming, it is important to build in the framework for evaluations. Evaluations happen throughout the life of a project, not just at the end, and are timed according to the stages of project implementation and the needs of the affected population, implementing organization, and sometimes partners and coordinating bodies. We often use a mix of data sources and methods in order to measure process, outcomes, and impacts.

WHO SHOULD CONDUCT EVALUATIONS

External evaluators generate the most objective and unbiased evaluations. If the evaluator is involved in program coordination or management, it can sometimes be difficult for this person to remain a neutral participant and view the program in an impartial manner.

METHODS

Secondary data review

A review of available documents, such as monitoring reports and operational documents (such as site reports, mission reports, supervision reports, training records).

Primary data collection

Quantitative and qualitative methods, including those described in the assessment section. All stakeholders, including users of the services within the target population, should be included.

WHAT DATA SHOULD BE COLLECTED IN AN EVALUATION?

Typical questions that should be considered in evaluating an SRH program include:

- What were our goals?
- What was our logic frame?

- What did we do?
- What did we achieve?
- Did we achieve what we intended?
- What worked and why? What target group(s) did it work best for and why?
- What didn't work and why? What target group(s) did it work least for and why?
- What lessons have we learned?
- What else is needed to achieve our desired impact?

USE OF EVALUATION RESULTS

We use evaluation results to improve program planning and design. As such, they should reflect both on what is working well and what is not working well. Feedback should be provided to program managers and service providers as the program continues and not just at the end to ensure that issues identified in the evaluation are dealt with promptly before they become problems or risks. We should share the final evaluation report with all organizations involved in the emergency response, including the MOH, and disseminate the report at health sector/cluster coordination meetings. We should also share the findings and decisions directly with the community with consideration of confidentiality and privacy issues.

5.4 HUMAN RIGHTS AND ETHICAL CONSIDERATIONS

5.4.1 Human rights standards

Service providers and others who collect health-related data are obligated to keep health information confidential. The right to privacy under international human rights law protects the right to privacy and confidentiality of health information, including about a person's reproductive health, reproductive functions, sexual life, or sexuality. We include key ethical guidelines in Section 5.5. Key points to keep in mind to ensure respect for the right to privacy include:

- The confidentiality of an individual who provides information about his or her reproductive health status, including incidents of gender-based violence,

must be protected at all times. Anyone providing information about her/his/their reproductive health status, including incidents of gender based violence, must give informed consent before participating in data-gathering activity

- The right to privacy also applies to children, including within the health-care setting. Although information on the health status of children should not be disclosed to third parties, including parents, without the child's consent, this, of course, is subject to the age and maturity of the child, as well as to a determination of her/his/their best interests
- Information must be kept confidential at all times including when it is collected, stored, analyzed, shared, and otherwise used. In a healthcare setting, information about the health status of a patient may be shared with those directly involved in the treatment of a patient if this is needed for treatment
- A person's right to privacy is violated if a service provider discusses her/his/their reproductive health status with someone else without her/his/their authorization. Not only would this breach of confidentiality infringe on that person's right to privacy, but it could also cause significant protection problems for the person concerned. Disclosure of confidential health information has been known to lead to rejection by family members or the community, violence or threats of violence, or discriminatory treatment in accessing services

5.4.2 Ethical considerations of data collection

Privacy risks in data collection relate to the identifiability of participants and the potential harms they, or groups to which they belong, may experience from the collection, use, and disclosure of personal information - particularly sensitive SRH information. All health and humanitarian workers must be familiar with national laws and regulations on collection, storage, and use of health information.

Careful advance planning is crucial. Those responsible for data collection are responsible for thinking through all possible consequences, both intentional and unintentional, of the information-gathering activity and for anticipating the effect of the activity on participants and their families.

If there is any question about whether the data collection could be harmful to subjects, only begin the activity if services are in place to address possible consequences. If the information-gathering activity is not associated with a service, prepare referral information for subjects to reach the required support. If appropriate safeguards cannot be put into place, the activity should not proceed.

Discussions should be held with stakeholders and host community members, including children and adolescents, whenever possible. Community meetings at different stages of the information-gathering activity can serve a variety of purposes, including sensitization, review, and interpretation. These discussions can serve the dual purpose of improving adherence to ethical standards and improving the quality of the information gathered.

INFORMED CONSENT

Collection and use of data for purposes other than routine monitoring often requires informed consent of the person providing the information. This includes data collection where the information will be anonymized and delinked from the name and other identifiers of the respondent. In such cases, an ethics review board should be consulted for appropriate guidelines for informed consent. The aim of the informed consent process is to ensure that respondents are given information about and understand each of the following in a "statement of consent": 1) the purpose and content of the data collection; 2) the procedures that will be followed during the course of the data collection; 3) the risks and the benefits of their participation; and 4) their rights.

All potential participants should also be informed that they have the right to not participate in the data collection or to refuse to answer particular questions, and that doing so will not affect their ability to access services. If, for a specific purpose, information concerning an individual's health status needs to be disclosed to a third party, the person concerned needs to be contacted for their informed consent.

In the case of children, informed consent must be provided by a parent or guardian unless local laws state otherwise. In addition, children who are of an age to be able to understand the nature and implications of the information gathering and disclosure (i.e., are developmentally capable) must also give their consent.

BOX 5.7: KEY CONCEPTS

<i>Privacy</i>	<i>Confidentiality</i>	<i>Security</i>	<i>Identifiable information</i>	<i>Patient-identifiable data</i>
<p>Privacy refers to an individual's right to be free from intrusion or interference by others. Individuals have privacy interests in relation to their bodies, personal information, expressed thoughts and opinions, personal communications with others, and spaces they occupy. Research affects these various domains of privacy in different ways, depending on its objectives and methods. An important aspect of privacy is the right to control information about oneself.</p>	<p>The ethical duty of confidentiality refers to the obligation of an individual or organization to safeguard entrusted information. The ethical duty of confidentiality includes obligations to protect information from unauthorized access, use, disclosure, modification, loss or theft. Fulfilling the ethical duty of confidentiality is essential to the trust relationship between researcher and participant, and to the integrity of the research activity.</p>	<p>Security refers to measures used to protect information. It includes physical, administrative and technical safeguards. An individual or organization fulfils its confidentiality duties, in part, by adopting and enforcing appropriate security measures. Physical safeguards include the use of locked filing cabinets, and the location of computers containing research data away from public areas.</p>	<p>Where researchers seek to collect, use, share and access different types of information or data about participants, they are expected to determine whether the information or data proposed in research may reasonably be expected to identify an individual.</p>	<p>Patient-identifiable data refer to any personal data that can be used directly or indirectly to identify an individual (e.g., name or postcode). This also includes encrypted data if the solution for decryption is still in existence.</p>

LIMITS TO CONFIDENTIALITY

In some settings, national laws require service providers to report to authorities people testing positive for HIV, women who have undergone abortion, or certain cases of sexual violence. While official justifications for these policies and laws may include crime prevention or public health concerns, it is important to note that they may not be in accordance with international human rights standards and may violate the right to privacy.

Service providers need to be familiar with such laws and policies and their obligations. As part of the informed consent process, patients must be informed of any relevant limits to confidentiality. Where mandatory reporting rules are in place, service providers should explain the reporting mechanism to the patient and tell them what they can expect after a report is made.

5.5 FURTHER READING AND ADDITIONAL RESOURCES

GENERAL MONITORING AND EVALUATION RESOURCES

Better Evaluation. (n.d.). *Better Evaluation: Various Free Evaluation Tools and Guidance as well as Other Resources*. Retrieved from: <http://www.betterevaluation.org/en/blog/2016-top-evaluation-resources>

IAWG. (2017). *MISP Process Evaluation Tools*. Retrieved from: iawg.net/resource/misp-process-evaluation-tools-2017

Sphere. *Sphere Project: Sphere for Monitoring and Evaluation, Sphere for Assessment, Sphere for Urban Settings*. (n.d.). Retrieved from: <http://www.sphereproject.org/resources/download-publications/?search=1&keywords=&language=English&category=56&subcat-22=0&subcat-29=0&subcat-31=0&subcat-35=0&subcat-49=0&subcat-56=0&subcat-60=0&subcat-80=0>

DATA COLLECTION AND INDICATORS

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MEASURE Evaluation. (n.d.). *Family Planning and Reproductive Health Indicators Database*. Retrieved from: https://www.measureevaluation.org/prh/rh_indicators

UNHCR. (2010). *Health Information System (HIS) Toolkit*. Retrieved from: <http://www.unhcr.org/protection/health/4a3374408/health-information-system-toolkit.html>

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RESEARCH AND ASSESSMENTS

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IAWG. (2013). *Tool for the Assessment of Countries' Readiness to Provide Minimum Initial Service Package for SRH during a Humanitarian Crisis*. Retrieved from: http://iawg.net/wp-content/uploads/2016/08/EECA-MISP-Readiness-Assessment-Tool_Final-Revised_December-2013.pdf

UNHCR. (2006). *Standardized Health Information System (HIS)*. Retrieved from: <http://www.unhcr.org/45810f5f1.pdf>

Women's Commission for Refugee Women and Children. (2003). *Monitoring Implementation of the MISP: A Check List*. Retrieved from: <http://gender.care2share.wikispaces.net/file/view/MISPChecklist.pdf/60994068/MISPChecklist.pdf>

Women's Refugee Commission. (2017a). *Service Provision Mapping Tool: Urban Refugee Response*. Retrieved from: <https://www.womensrefugeecommission.org/gbv/resources/1353-urban-gbv-tools>

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

UNFPA, & Save the Children. (2010). *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings*. Retrieved from: http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_ASRHtoolkit_english.pdf

COMPREHENSIVE ABORTION CARE

Healy, J., Otsea, K., & Benson, J. (2006). Counting Abortions so that Abortion Counts: Indicators for Monitoring the Availability and Use of Abortion Care Services. *International Journal of Gynaecology and Obstetrics*, 95(2), 209–220.

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Elrha: Research for Health in Humanitarian Settings. (n.d.). *Research Ethics Tool*. Retrieved from: <http://www.elrha.org/r2hc>

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MEASURE Evaluation. (n.d.). *Guidelines for Integrating Gender into an M&E Framework and System Assessment*. Retrieved from: <https://www.measureevaluation.org/resources/publications/tr-16-128-en>

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MATERNAL AND NEWBORN HEALTH

WHO. (2011). *Evaluating the Quality of Care for Severe Pregnancy Complications: The WHO Near-Miss Approach for Maternal Health*. Retrieved from: http://apps.who.int/iris/bitstream/10665/44692/1/9789241502221_eng.pdf

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