An Operational Manual for Good Practice

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Monitoring and Evaluation in FPA Sri Lanka

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PREFACE

The evolution of the current Monitoring and Evaluation process of FPA Sri Lanka had been a long journey strewn with challenges. With each step taken in the past, we have refined this process to make it an exemplary system for our partners and stakeholders. At the same time, we have striven to create a culture within our organization that is M & E friendly, which embeds related principles from conceptualizing, designing, implementing and assessing of all programmes conducted by us. The advantage of integrating M & E aspects of a programme from design to assessment is the ability to optimize impact in a seamless manner. We have undoubtedly had our share of past mistakes and taken learnings to improve the M & E processes of FPA Sri Lanka. Commencing from a manual system to operationalize the Monitoring and Evaluation process in the organization, we have taken giant strides in implementing the web hosted M & E system to which all outfits of FPA Sri Lanka can enter data from multiple sites.

The Global Fund HIV Round 9 project leveraged this electronic system to collect, collate and evaluate data through a live- tool, to effectively implement the project in 9 districts of the country. Currently we are gearing up the system to accommodate the increasing demands of the New Funding Model of the Global Fund, due to commence in January 2016. Much grander plans are afoot for integrating our system with that of the NSACP for capturing clients' data under unique identification codes, which needless to say, will be classified information.

In this backdrop it is imperative that we improve our M & E processes to be more sophisticated, responsive and pro-active to cater to the ever-changing needs. The first step was taken last year when we developed and adopted our own M & E Policy for the organization. Consequently, numerous chapters were incorporated to project proposals, procedural manuals and reporting structures in order to be compliant. In the early part of 2015 we compiled a module on management of advocacy information through the M & E – IMS, a hitherto missing component of our system.

The Standard Operating Procedure manual we are presenting to you today, will reflect all past efforts to upgrade this system in a comprehensible manner. The readers and users of this manual will hopefully benefit from FPA's wealth of experience in implementing programmes. Understandably, this manual will see periodical revisions in keeping with our policy on systems-upgrading. We hope the initial version will be received with the same enthusiasm that went in to the compilation of it. This SOP manual thus, will not mark the end but the beginning of an exciting phase of a journey that will lead us to be the benchmark for Monitoring and Evaluation in the development sector of Sri Lanka.

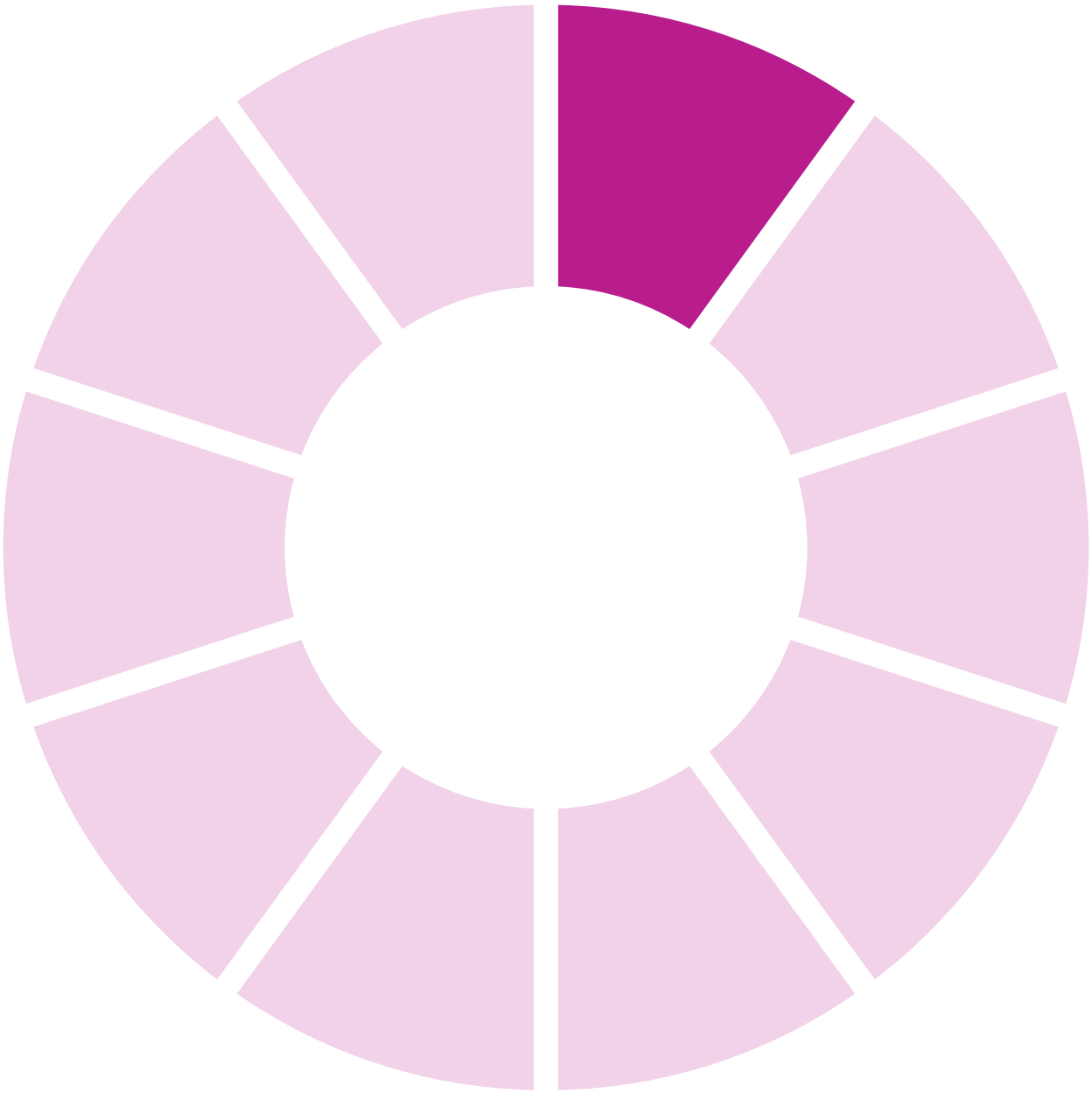
Thushara Agus
Executive Director
17 September 2015

ABBREVIATIONS

AC	-	Associated Clinic
AER	-	Advocacy Expected Results
AIDS	-	Acquired Immune Deficiency Syndrome
AR	-	Annual Reports
BCC	-	Behavioral Change Communication
BPT	-	Branch Performance Tool
CBD	-	Community Based Distribution
CBS	-	Community based services
CIMS	-	Client Information Management System
CIRG	-	Core Indicator Reference Guide
COE	-	Community of Evaluators
COI	-	Core Essential Indicators
CSE	-	Comprehensive Sexuality Education
CYP	-	Couple Year of Protection
DMS	-	Document Management System
ED	-	Executive Director
eIMS	-	electronic Information Management System
FPA	-	Family Planning Association
FSW	-	Female Sex Workers
FU	-	Finance Unit
GFATM	-	Global Fund to fight AIDS, Tuberculosis and Malaria
GIS	-	Geographic Information System
HIV	-	Human Immunodeficiency Virus
HR	-	Human Resource
IC	-	Information Centre
ICPD	-	International Conference on Population and Development
IEC	-	Information Education Communication
IFRC	-	International Federation of Red Cross
IOCOMSA	-	International Organisation for Collaborative Outcome Management in South Asia
IPDET	-	International Programme for Development Evaluation Training
IPPF	-	International Planned Parenthood Federation
IT	-	Information Technology
KAP	-	Knowledge, Attitude and Practices
M&E	-	Monitoring and Evaluation
MA	-	Member Association
MDG	-	Millennium Development Goals

MEIMS - Monitoring and Evaluation Information Management System
MEST - Monitoring and Evaluation system strengthening tool
MFR - Monthly Financial Reports
MIS - Management Information System
MOH - Medical Officer of Health
MoU - Memorandum of Understanding
MoV - Means of Verifications
MSI - Marie Stopes International
MSM - Men having Sex with Men
NC - National Council
NGO - Non-Governmental Organization
ORS - Oral Rehydration Solution
PBF - Performance Based Funding
PE - Peer Educator
PHM - Public Health Midwives
PMSU - Poor, Marginalized, Socially Excluded and Underserved
PMTCT - Prevention of Mother to Child Transmission
PPM&E - Participatory Planning, Monitoring and Evaluation course
QPR - Quarterly Progress Reports
QRM - Quarterly progress review meetings
RBM - Results based management
SBCC - Social and Behavior Change Communication
SDP - Service Delivery Points
SLEvA - Sri Lanka Evaluation Association
SMART - Specific, Measurable, Attainable, Realistic and Time bound
SMP - Social Marketing Programme
SOP - Standard Operational Procedure Manual
SRH - Sexual and Reproductive Health
TAC - Technical Advisory Committee
UIN - Unique Identification Number
UNAIDS - The Joint United Nations Programme on HIV and AIDS
UNDP - United Nations Development Programme
UNICEF - The United Nations Children's Fund
VHA - Volunteers Health Assistance

Table of Contents



1

Introduction and Background

1. Introduction and Background

1.1. FPA Sri Lanka[1]

The Family Planning Association of Sri Lanka, (FPA Sri Lanka) is a Non-Governmental Organisation (NGO) established in 1953 by a group of volunteers comprising medical professionals and philanthropists. Over the years the organisation has evolved to a provider of full spectrum of Sexual and Reproductive Health (SRH) services in the country. Today, FPA Sri Lanka remains an essentially volunteer driven organisation with a National Council (NC) akin to a Board consisting of volunteers at the helm. A team of professionals, who are members of technical advisory committees, assist the NC in formulation of policies and implementation of related activities. The NC appoints an Executive Director to oversee organisational activities and staff.

Conforming to forty nine (49) standards of good governance, FPA Sri Lanka has become an accredited member of the International Planned Parenthood Federation (IPPF). The association has a close and cordial working relationship with the Government of Sri Lanka. It is also working in partnership with many other national and international organisations in implementing its programmes.

With its philosophy based on the principle that sexual and reproductive health rights are fundamental human rights, the organisation now focuses on improving the acceptability and accessibility of SRH facilities through a right-based and gender sensitive approach. The key strategic focus and thematic areas of FPA Sri Lanka are Adolescents, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), Abortion and Access. The Adolescent programme focuses on protecting youth who are vulnerable to health and social hazards. The HIV and AIDS prevention programme attempts to increase awareness, promote usage of condoms and strengthen the Prevention of Mother to Child Transmission (PMTCT) strategies while protecting and promoting the rights of the people living with HIV and AIDS. FPA Sri Lanka implements its activities to prevent unsafe abortions in the country. FPA Sri Lanka also advocates for the amendment of law to include the allowance for legal abortions in cases of severe fetal abnormalities, rape or incest. FPA Sri Lanka aims at increasing access to contraceptives, through its well established Service Delivery Points (SDP), thereby reducing the number of unplanned and unwanted pregnancies leading to abortions. The Access programme draws attention to the inequities in service delivery and the discriminatory practices marginalizing people and denying them the opportunity to seek care while engaging communities and policy makers to focus on emerging issues relating to demographic changes through a process that respects sexual and reproductive rights of individuals.

1 Source: Family Planning Association Website

1.1.1. Vision

"A country with access to Sexual and Reproductive Health as a right to all"

1.1.2. Mission

"To advocate sexual and reproductive health rights and provide services whilst maintaining sustainability and volunteerism to improve quality of life for all."

1.1.3. Core Values[2]

01) Passion

We are passionate about what we do

02) Volunteerism

We believe in the spirit of volunteerism as central to achieving our goals and ideals

03) Accountability

We value participatory, consensus-oriented accountable and transparent decision making

04) Diversity

We believe in diversity and equality in extending our services to everyone who needs them

05) Inclusiveness

We uphold social inclusion and non-discrimination

1.1.4. Strategic Focus

FPA Sri Lanka operates under a strategic framework introduced by the International Planned Parenthood Federation to reach its' vision by achieving four outcomes through eight priority objectives.

This strategic framework underpins the commitment of the IPPF and its member organisations to ensure the universal access of Sexual and Reproductive Health services, as agreed at the International Conference on Population and Development (ICPD); and is explicitly linked to the Sustainable Development Goals (SDG).

2 Source: FPA Sri Lanka Strategic Plan (2016-2022) – First Draft , FPA Sri Lanka

OUTCOME – 1 :-

Sri Lanka Government Respects Protect and fulfill Sexual and Reproductive Rights and Gender Equality.

- **Priority objective one:** Galvanize commitment and secure legislative, policy and practice improvements. To ensure the government commitment to support of sexual and reproductive health and rights, and gender equality, through supportive legislation, policy and funding to transformed people's lives for the better and benefited wider society.

- **Priority objective two:** _Engage women and youth leaders as advocates for change. To strengthen its links with youth and women's organizations and provide pathways for women and young leaders – particularly girls to be at the forefront of efforts to secure policy and practice change from governments as the denial of sexual and reproductive health and rights affects women and young people disproportionately.

OUTCOME – 2 :-

17.15 Million people to act freely on their sexual and reproductive health and rights.

- **Priority objective three:** Enable young people to access comprehensive sexuality education and realize their sexual rights. To Prioritize and scale up the comprehensive sexuality education – which seeks to equip young people with skills, knowledge and values to determine and enjoy their sexuality and protect their health; and focusing on interventions for the most marginalized youth, in and out of school.

- **Priority objective four:** Engage champions, opinion formers and the media to promote health, choice and rights. To implement public campaigns to raise awareness of sexual and reproductive health and rights issues and generate support, with integrated communications strategies and the involvement of public-facing champions, opinion formers and media outlets.

OUTCOME – 3 :-

6.12 Million Quality Integrated Sexual and Reproductive Health Services Delivered

- **Priority objective five:** Deliver rightsbased services including abortion counselling and HIV. To ensure service outlets provide high quality services: not only provide a minimum, integrated package, but must also be client-centered, rights-based, youth friendly and gender sensitive. The services will not be turned anyone away because of inability to pay, or lack of health personnel, and it will be expanded access through a diverse range of delivery channels. Through quality improvements the reputation of the organization will be reinforced as a health provider that is welcoming to all.

- **Priority objective six:** Enable services through public and private health providers. To develop new formal partnerships with public and private providers by delivering pre- and in-service training for medical personnel, integrated sexual and reproductive health services in partner facilities, and strengthening the supply chain management and quality of care.

OUTCOME – 4 :-

A High Performing, Accountable and United Association

- **Priority objective seven:** Enhance operational effectiveness and double national and global income. To remain relevant, responsible and efficient in seeking out funding, translate it into development outcomes and sustain services to meet demand.

- **Priority objective eight:** Grow our volunteer and activist supporter base. To grow and lead the volunteer and activist supporter base for sexual and reproductive health and rights at local levels to present a clear, alternative voice to groups that do not support sexual and reproductive rights

1.2. Concepts and Principles

1.2.1. Results based management (RBM)

RBM is an approach to project/programme management based on clearly defined results, and the methodologies and tools to measure and achieve them.RBM supports better performance and greater accountability by applying a clear, logical framework to plan, manage and measure an intervention, with a focus on the results you want to achieve. By identifying in advance the intended results of a project/programme and how we can measure their progress, we can better manage a project/programme and determine whether a difference has genuinely been made for the people concerned. Results-based management (RBM) is an approach that has been adopted by many international organisations. RBM is explained in more detail in the IFRC Project/Programme Planning Guidance Manual (IFRC PPP, 2010).

Monitoring and Evaluation (M&E) is a critical part of RBM. It forms the basis for clear and accurate reporting on the results achieved by an intervention (projector programme). In this way, information reporting is no longer a headache, but becomes an opportunity for critical analysis and organisational learning, informing decision-making and impact assessment (International Federation of Red Cross, 2011).FPA Sri Lanka adopts results based management concepts and procedures to ensure effective and efficient implementation of its projects and programmes.

1.2.2. Monitoring and Evaluation

Monitoring and Evaluation is a process whose purpose is to measure and assess performance in the overall implementation of a programme/project (FPA Sri Lanka M&E policy, 2013).Its goal is to improve the current and future management of outputs, outcomes and impact. It is mainly used to assess the performance of projects and programmes thereby the organisational achievements. Many international organisations such as the United Nations, the World Bank group and the Organisation of American States have been utilising this process for many years. The process is also growing in popularity in developing countries where governments have created their own national M&E systems to assess development projects, resource management and government activities or administration. The developed countries are using this process to evaluate their own development and co-operating agencies/partners. Please refer annexure 01 for glossary of terms related to monitoring and evaluation available in the FPA Sri Lanka Monitoring and Evaluation Policy.

a) **Monitoring**

Monitoring is the systematic and continuous collecting and using of information for corrective measures during the implementation of the programme. It helps to provide information during evaluations (FPA Sri Lanka M&E policy, 2013). It is a continuous assessment that aims at providing all stakeholders with early detailed information on the progress or delay of the ongoing assessed activities (UNDP, 2012). It is an oversight of the activity's implementation stage. Its purpose is to determine if the outputs, deliveries and schedules planned have been reached so that action can be taken to correct the deficiencies as quickly as possible.

Monitoring helps to answer questions such as:

- ✓ How well are we doing?
- ✓ Are we doing the activities we planned to do?
- ✓ Are we following the designated timeline?
- ✓ Are we over/under-spending?
- ✓ What are the strengths and weaknesses in the project?

(Source: -IPPF (2009), Putting the IPPF Monitoring and Evaluation Policy into practice: A Handbook on collecting, analysing and utilising data for improved performance)

b) **Evaluation**

Evaluation is the systematic examination of a planned, ongoing or completed project / programme. Evaluation aims to answer specific management questions and judge the overall value of an intervention and provide lessons for future actions, planning and decision making (FPA Sri Lanka M&E policy, 2013). So, it is a systematic and objective examination concerning the relevance, effectiveness, efficiency and impact of activities in the light of specified objectives (UNICEF, M&E guide; making a difference). The idea of evaluating projects is to identify in-efficiencies of program implementation, avoiding repetition of mistake and to underline and promote the successful mechanisms for current and future projects. An important goal of evaluation is to provide recommendations and lessons to the project managers and implementation teams that have worked on the projects and for the ones that will implement

and work on similar projects. Evaluations are also indirectly a process of reporting to the donor about the activities implemented. It is a way to verify that donated funds are being well managed and transparently spent (Centre for Global Development, 2013).

Evaluation helps to answer questions such as :

- ✓ How relevant was our work in relation to the primary stakeholders and beneficiaries?
- ✓ To what extent were the project objectives achieved?
- ✓ What contributed to and/or hindered these achievements?
- ✓ Were the available resources (human, financial) utilised as planned and used in an effective way?
- ✓ What are the key results, including intended and unintended results?
- ✓ What evidence is there that the project has changed the lives of individuals and communities?
- ✓ How has the project helped to strengthen the management and institutional capacity of the organisation?
- ✓ What is the potential for sustainability, expansion and replication of similar interventions?
- ✓ What are the lessons learned from the intervention?
- ✓ How should those lessons be utilised in future planning and decision making?

(Source: - IPPF (2009), Putting the IPPF Monitoring and Evaluation Policy into practice: A Handbook on collecting, analysing and utilising data for improved performance)

c) **Difference between monitoring, evaluation and audits**

The common ground for monitoring and evaluation is that they are both management tools. For monitoring, data and information collection for tracking progress according to the terms of reference is gathered periodically which is not the case in evaluations for which the data and information collection is happening during or in view of the evaluation. The monitoring is a short term assessment and does not take into consideration the outcomes and impact unlike the evaluation process which also assesses the outcomes and sometime the longer term impact. This impact assessment occurs sometimes after the end of a project, even though it is rare because of its cost and of the difficulty to determine whether the project is responsible for the observed results (UNICEF, M&E guide; making a difference). Recognising their differences, it is also important to remember that both monitoring and evaluation are integrally linked; monitoring typically provides data for evaluation, and elements of evaluation (assessment) occur when monitoring.

An audit is an assessment to verify compliance with established rules, regulations, procedures or mandates. Audits can be distinguished from an evaluation as the emphasis is on assurance and compliance with requirements, rather than a judgment of worth (International Federation of Red Cross, 2011). Ex: - Financial audits provide assurance on financial records and practices, whereas data quality audits focus on the compliance with data collection, consolidation and reporting procedures. Audits can be internal or external.

1.2.3. Organizational learning through Monitoring and Evaluation

Learning is the process by which knowledge and experience directly influences changes in behaviour. If the information provided by Monitoring and Evaluation is not used, then the exercise is essentially a waste of time and effort. One of the most important tasks of any project manager or evaluator is to ensure that the information is presented in a way that makes it accessible to those who need it to make decisions. Both monitoring and evaluation will be ineffective if they do not lead to learning at the project and organisational level. Evaluation findings, recommendations and learning should also contribute to improved programmes, policies and practices, evidence-based advocacy and effective resource mobilisation (IPPF, 2009).

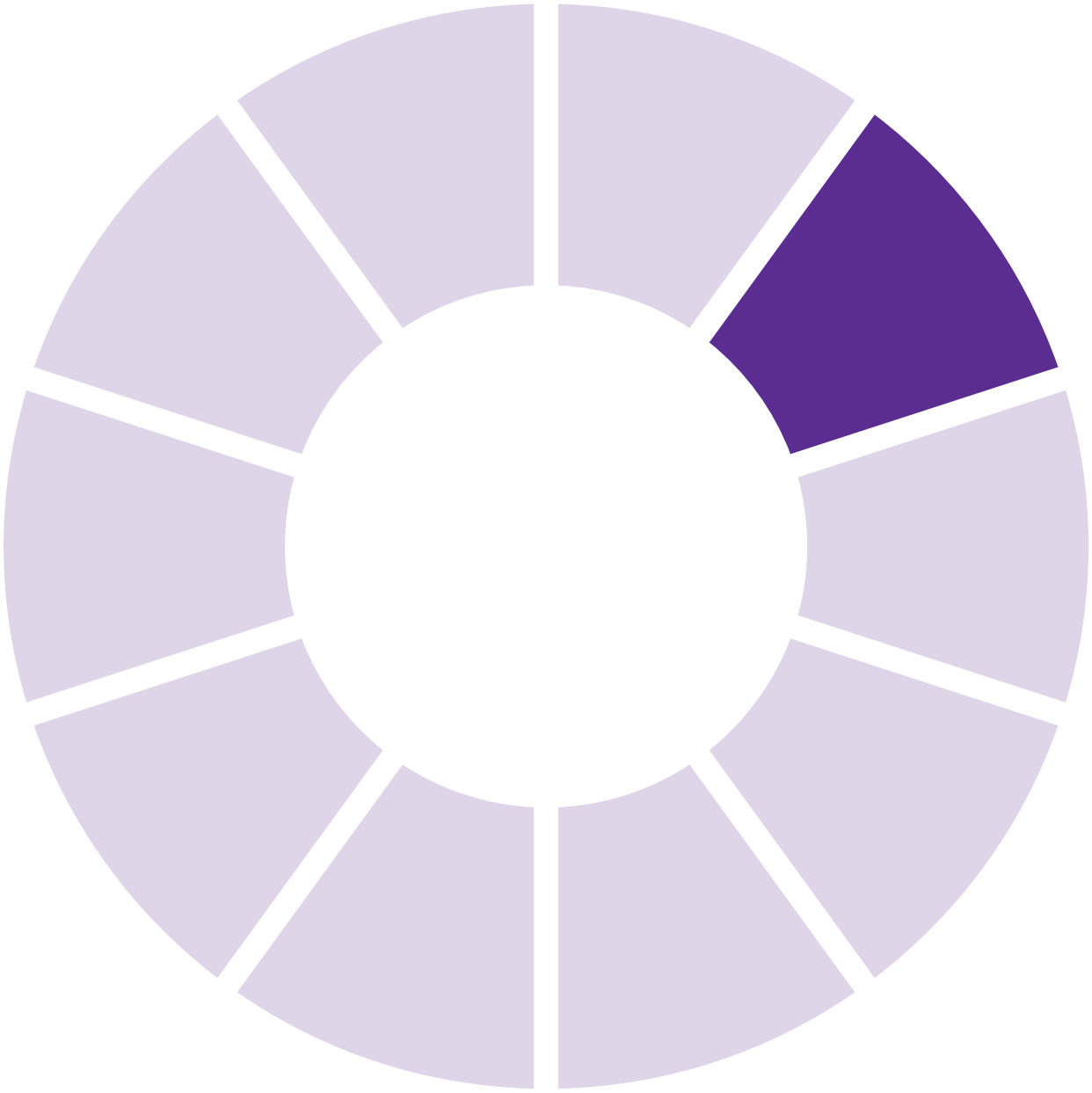
1.3. Pre-requisites for Monitoring and Evaluation

Monitoring and Evaluation process starts with the assessment and planning stage of development projects. A good quality system of programme documentation from planning stage to evaluation is a key requirement of any monitoring and evaluation. Table 1.1 briefly explains essential programmatic documentation requirements at the planning stage for successful monitoring and evaluation. The programme specific pre-requisites will be described under each programme approach in relevant chapters.

Table 1.1:- Programmatic pre-requisites for M&E at project planning

	Requirement	Description	References
01	**SMART project objectives / results**	The project design must start with Specific, Measurable, Attainable, Realistic and Time bound (SMART) objectives / results. For advocacy initiatives, policy level objectives are considered as Advocacy Expected Results (AER).	Annex –02 (Annex 05 for advocacy)
02	**A comprehensive project design and a logical framework with a clear chain of results**	Objectives must be developed as a hierarchy with different levels. Results chain or project logic model represent a programme theory as a linear process with inputs and activities at the front and long-term impact at the end. Eg:- In logical framework approach Inputs→Outputs→Outcome→Impact (Annexure 01 :- Glossary of terms in M&E)	Annex – 02 (Annex 05 for advocacy)
03	**A detailed activity plan with a time frame**	Project activities must be specific, self-explanatory and time bound. Ex: - Conduct 03 mobile clinics in Ampara district to provide 1000 SRH services for 350 differently abled women.	
04	**Community selection criteria and rationale**	The project design must clearly state the target community and how to select this community. What is the basis for selection of the community? Do we have scientific evidence to prove the relevance of project activities for the selected community? Ex: - Which most at risk populations are we focusing on for prevention of HIV and on what basis?	Annex – 03

05	**Geographical Selection criteria and rationale**	The geographical locations (District, MOH area or PHM area) for implementation of the project must be selected based on available data (most probably secondary data). Eg:- Contraceptive prevalence rate, Number of HIV/STI cases detected, Estimated number of female sex workers, Number of teenage pregnancies recorded, Number PHM working in the area	Annex – 05
06	**Beneficiary selection criteria and rationale**	On what basis will the beneficiaries be selected for the project? Eg:- Age, Gender, Economic status, Other specific requirements such as, a person who has injected a drug during the last 12 months PHM who hasn't undergone any abortion related training during the last 3 years	Annex – 04
07	**Service providers (including volunteers and peer educators) or resource person selection criteria**	What are the mandatory requirements (educational or behavioral requirements and previous experiences) of service providers and resource persons? This includes volunteers, peer educators, community mobilisers, etc.	Annex – 04
08	**Rationale for selection of service delivery approach**	Why did we select this service delivery approach over the other service delivery approaches? Please refer FPA Sri Lanka Service Statistic Manual (2013). This is relevant only for service delivery initiatives.	Annex – 03
09	**Target audience and rationale for selection of target audience**	Who are the target end users of our communication messages? What is the rationale for selection of this target audience to achieve expected results of the project? This is relevant only for IEC, BCC and advocacy initiatives	Annex – 06



2

Monitoring and Evaluation Process at FPA Sri Lanka

2. Monitoring and Evaluation Process at FPA Sri Lanka

FPA Sri Lanka needs a cohesive and comprehensive system for measuring and reporting its achievements to the governance, management, donors, and major stakeholders including the IPPF and the Government of Sri Lanka. M&E unit of FPA Sri Lanka shall therefore constitute a management tool that will entail systematic planning, constant follow ups and impact assessment of planned activities. Overall, efforts shall be made to track performance of all programmes of FPA Sri Lanka in order to ascertain whether goals and objectives are being achieved with available resources and on a timely basis.

The Monitoring and Evaluation process should also provide an in depth performance assessment of FPA Sri Lanka in terms of resources allocated to activities, the impact of those activities, effectiveness of strategies employed, gaps identified within different strategies and a continuous learning forum for service improvement. This way the Monitoring and Evaluation system can assess the effectiveness and impact of policies and strategies of FPA Sri Lanka in achievement of its goals.

2.1. Importance of Monitoring and Evaluation for FPA Sri Lanka

The health sector in Sri Lanka has experienced new challenges in implementation of Family Planning, especially Sexual and Reproductive Health projects/programmes over the past decade mainly due to dwindling resources coupled with poor state funding. In response to the challenge, FPA Sri Lanka is geared to develop and implement its' policies, strategies and programmes. These will only provide the road map towards FPA Sri Lanka overall targets and unless their implementation and impact is continuously monitored and measured, the goals might not be realised.

Monitoring and Evaluation should also provide an in depth performance assessment of FPA Sri Lanka in terms of resources allocated to activities, the impact of those activities, effectiveness of strategies employed, gaps identified within different strategies and a continuous learning forum for service improvement. This way the Monitoring and Evaluation system can assess the effectiveness and impact of policies and strategies of FPA Sri Lanka in achievement of its goals.

Lastly, M&E information should be used to enhance accountability to stakeholders through provision of information to respective constituencies whether progress is been made and which strategy works and at what cost or which strategy does not work. In the long run, such practices will promote transparency and good governance.

2.2. Monitoring and Evaluation Roles and Responsibilities[3]

Monitoring and Evaluation is a shared responsibility at FPA Sri Lanka. The corporate objectives are prepared by the focal person of each thematic area/unit and submitted to the ED. The ED proposes to the National Council and gets approval for the objectives and on how these objectives and results should be monitored. FPA Sri Lanka National Council (NC) makes strategic and policy-level decisions. FPA Sri Lanka, its agencies and their partners execute project,

3 Source :- FPA Sri Lanka Monitoring and Evaluation policy, 2013

programme, and portfolios. FPA Sri Lanka M&E unit collaborates with independent evaluation units of the FPA Sri Lanka agencies to enhance collective capacity to fulfill evaluation needs effectively and efficiently. Table 2.1 below contains a brief description of the key roles and responsibilities of each FPA Sri Lanka partner in M&E, outlining their respective mandate and comparative advantage.

2.2.1. National Council (NC)

The National Council of FPA ensures accountability and oversight of FPA Sri Lanka performance and results. NC create the vision, mission and direct the organization to meet external environmental demand by providing the leadership. As such, it review, adopts, and evaluates the operational policies and procedures for FPA Sri Lanka-financed activities; keeps under review the operation of the FPA Sri Lanka with respect to its purposes, scope, and objectives; The National Council provides an enabling environment for M&E activities in line with internationally accepted standards. The National Council promotes transparency, participation, and disclosure in M&E findings, and ensures that sufficient time is dedicated to discussion of M&E findings and issues at National Council meetings.

2.2.2. Executive Director (ED)

The ED shall be the Chief Administrative and Executive Officer for implementing the M&E Policy at FPA Sri Lanka and reports to the National Council on related matters. The ED is responsible for ensuring active use of M&E products for decision making and management through RBM and a related M&E planning system; systematic consideration of findings, conclusions, and recommendations. Similarly, the ED ensures that adequate resources are allocated to enable the responsible parties to perform the monitoring function effectively at the corporate, programme, and project levels. The ED also ensures that FPA Sri Lanka policies and work programme, including operational strategies, programmes, and projects, are monitored and evaluated on a regular basis.

2.2.3. Monitoring and Evaluation Unit

FPA Sri Lanka's Monitoring and Evaluation Unit operates as an organisational unit that is independent of FPA Sri Lanka operational management. The M&E Unit has the central role of ensuring the independent evaluation function within FPA Sri Lanka, setting minimum requirements for M&E, ensuring oversight of the quality of M&E systems on the project and programme levels, and sharing evaluative evidence within FPA Sri Lanka. The Monitoring and Evaluation Unit pursues the goals of improved governance, accountability and learning through three main functions:

a. Evaluative Function—the main function of the M&E Unit is to independently evaluate the effectiveness of FPA Sri Lanka programmes and resource allocations on project, programme, portfolio, and institutional levels.

b. Normative Function—the M&E Unit is tasked to set minimum monitoring and evaluation standards within the FPA Sri Lanka in order to ensure improved and consistent measurement of results.

c. Oversight Function—the M&E Unit provides quality control of the minimum requirements of monitoring and evaluation practices at FPA Sri Lanka, in full cooperation with

relevant units, and tracks implementation of National Council decisions related to evaluation recommendations.

Table 2.1: Key roles and responsibilities in Monitoring and Evaluation

	Partner	Key roles and responsibilities in M&E
01	National Council	- Involved in policy making with regard to M&E, - Approves the Strategic Plan, Annual Work Plan & Budget - Creates an enabling environment for M&E
02	Executive Director	- Oversees the implementation of the M&E policy - Creates an enabling environment for M&E - ensures active use of M&E products for decision making and management through RBM and a related M&E planning system - ED recommends to NC any changes required to the M&E Policy from time to time
03	Monitoring and Evaluation Unit	- conducts independent evaluations of FPA Projects - oversees project and programme evaluations - oversees the relevance, performance and overall quality of the M&E system - sets minimum requirements for M&E
04	FPA Sri Lanka Entity Units/ Sub-units	- Develops and documents pre-requisites highlighted in table 1.1 at the planning stage and provides access to all the programmatic documentation at the time of evaluations - sets results framework at focal areas and corporate level with the assistance of M&E unit - reports unit progress on programme, project and portfolio progress, results and lessons learned in pre agreed formats. - maintains means of verification for data reported against each M&E indicator - adaptive management of project and programme implementation - ensures implementation of M&E at the programme and project levels
05	FPA SL Operational Focal Points (SDPs)	- assist in the implementation of M&E and data collection related to the projects - keeps evidence for data verification on Programme /Project M&E exercises.
06	Other stakeholders (NGOs, CBOs, Civil Societies, Private sector)	-assists FPA Sri Lanka units in conducting field work related to M&E

2.3. Investment for Monitoring and Evaluation

Within FPA Sri Lanka, Monitoring and Evaluation shall be seen as an investment whose critical product is higher quality action emanating from the process. While M & E requirements will vary from project to project, as a rule of thumb, all new projects are required to set aside at least 5-10% of the total budget for M&E whilst ensuring a dedicated budget for M&E in the Annual Programme and Budget.

Provision of training and incentives are efficient enablers in building an M&E culture. It is recommended that all programmes and units of FPA Sri Lanka budget and institute such measures to make M&E relevant and an appreciated tool for improving performance (FPA Sri Lanka Monitoring and Evaluation policy, 2013).

2.4. Development of M&E strategies and M&E plans

The Monitoring and Evaluation strategy provides long term directions for the organisation to implement its' monitoring and evaluation activities. M&E plan is an overall framework of performance and learning questions, information gathering requirements, reflection and review of events with stakeholders, resources and activities required to implement a functional M&E system. A comprehensive M&E framework / performance frame work is an integral part of a good M&E plan. The M&E unit of FPA Sri Lanka shall develop the following M&E strategies and M&E plans for better implementation of M&E activities.

2.4.1. Monitoring and Evaluation Strategic plan / Road map

The Monitoring and evaluation Unit shall develop a five year strategic plan to provide direction to FPA Sri Lanka M&E activities. The M&E strategic plan shall include but not be limited to strengths and gaps of current M&E systems and procedures, new strategic information requirements, long term objectives, higher level action plan (road map) for development of M&E systems and procedures and, roles and responsibilities. The Monitoring and Evaluation strategy will be approved by the National Council along with the corporate strategic plan.

2.4.2. Costed Monitoring and Evaluation activity plan

The Monitoring and Evaluation Unit of FPA Sri Lanka shall develop an annual activity plan and budget based on the M&E strategic plan. The annual M&E activity plan includes the current situation of the M&E function at FPA Sri Lanka, specific objectives, specific time bound action plans, human resource requirements and budget. The M&E action plan will be approved by the National Council along with the Annual Programme and Budget of the organisation. The M&E Unit is responsible for implementation of the M&E action plan under the overall oversight of the Executive Director.

2.4.3. Project specific M&E plans

The M&E Unit in consultation with the operational units will develop project specific M&E plans for each and every project implemented by FPA Sri Lanka. It is the responsibility of the respective operational unit head to ensure that a comprehensive M&E plan is in place before implementation of project activities. Pre-requisites for M&E highlighted in table 1.1 are considered as preliminary requirements to develop a comprehensive M&E plan. The M&E plan includes but is not limited to project objectives, objectively verifiable indicators, Means of Verifications (MoV) or data source, data collection methodology, person responsible

for collection of data, baseline status and targets. A table including all these information is called M&E metrics (Annexure 07 – M&E metrics). The M&E plan may consist of quantitative as well as qualitative indicators. However, it is important to give priority for quantitative indicators to meet donor requirements for performance based funding (PBF). The M&E plans of the core organisational functions will be approved by the National Council along with the organisational activity plan and budget. The M&E unit is responsible for designing data collection formats and systems for implementation of project M&E plans. Relevant units will implement the M&E plan at operational level.

2.5. Monitoring and Evaluation indicators

The M&E programme of FPA Sri Lanka will depend on well-defined indicators. FPA Sri Lanka M&E function will try its best to utilise internationally recognised standard indicators. However, FPA Sri Lanka may identify and define their own organisational indicators, when there are no technically strong and cost effective standard indicators. The M&E plan may consist of quantitative as well as qualitative indicators. However, it is important to give priority for quantitative indicators to meet donor requirements for performance based funding (PBF).

The M&E Unit has defined and published a Core Indicator Reference Guide (CIRG) in line with the Sexual and Reproductive Health Policy and the IPPF to measure progress and impact towards the achievement of FPA Sri Lanka goals at the organisational level. In pursuance of the above tasks, in addition to national requirements, particular attention should be taken to incorporate global indicators for interventions that are ratified by IPPF and GOSL including the Global Millennium Development Goals, Global Disease Surveillance, etc.

The Core Indicator Reference Guide of FPA Sri Lanka is intended for programme and M&E staff of FPA Sri Lanka to use as a reference guide when developing project designs or Monitoring and Evaluation plans/ frameworks. The guide includes indicators at different results levels, in five main programme areas as well as operational indicators. The purpose is that programme and M&E staff can easily mention the indicator number from the reference guide in project proposals and M&E frameworks/ plans without mentioning details as details are mentioned in the guide. The guide can be as an annexure to any project proposal or M&E framework/ plan so that the reader can refer to the guide if any details are needed. The indicators are categorised according to results levels; Impact, Outcome and Output. Impact indicators are mainly corresponding to national indicators in Sri Lanka to which FPA Sri Lanka is also contributing. National Outcome indicators to a greater extent and Output indicators completely have contribution from FPA Sri Lanka programmes. When using indicators for project planning and M&E frameworks, it is advisable to adapt indicators according to project results levels. For example if national level impact indicators are much higher than the project achievements and project contribution is very minimal, selected Outcome indicators can be considered as the project's Impact level. This will ensure the project's attribution to results.

It is advisable that programme staff takes technical support from M&E staff when using the guide for planning so that relevant indicators can be appropriately used. Other than the technical considerations, FPA Sri Lanka shall consider cost effectiveness when selecting indicators at the project design.

2.6. Setting and revising projections / targets

As explained under the project specific M&E plans, the M&E programme of FPA Sri Lanka shall depend on well-defined goals and objectives for which a set of quantifiable and direct indicators are identified to measure positions before and after specified interventions. Baseline values and targets will be identified and agreed on at the time of preparation of the M&E framework / performance framework (Annexure 08 – Template for an M&E framework). The respective programme department will identify the project and annual targets, in consultation with the M&E unit, based on the following guidelines.

a) Projections of the corporate strategic plan. Annual projections must be identified and must be justifiable with the projections of the strategic plan.

b) Forecast based on the achievements of previous years / projects. Projections must be justifiable with the actual achievements of previous project period/s. Cumulative achievement of the previous project period may be considered as the baseline status of the indicator.

c) Projection must be justifiable with the allocated budget and human resources.

d) Target of the output level indicators must be justifiable in order to achieve the intended outcome. Is it possible to increase condom use by FSWs up to 90% by reaching only 40% of the estimated number of FSWs.

   However, one project / program alone cannot achieve the impact. Eg: - It is not possible to decrease the prevalence of HIV among FSWs up to 1% by implementing one project alone.

e) Other documented and evidence based situational factors may use in the absence of above concrete sources of information.

Annual projections for key organisational operations will be identified at the time of preparation of the activity plan and budget and approved by the National Council. Targets will be revised only at the preparation of the half year report. However, targets for donor restricted projects will be identified based on donor requirements and agreed with the donor agency at the time of project design.

2.7. Designing and development of M&E tools and systems

To standardise practice, the M&E Unit shall develop generic formats for M&E work plans, guidelines for project and programme reviews, annual joint reviews, M&E reports and a catalogue of indicators for all levels (FPA Sri Lanka M&E policy, 2013). All the routine data collection formats of the organisation have been presented as an annexure to this procedure manual. However, it is inevitable that the M&E unit needs to develop new data collection tools and formats to cater to emerging development needs and donor requirements. The M&E unit will adopt the following steps / procedure when developing new M&E tools.

01) Identify the new data requirements and assess the current system to identify gaps.

02) Conduct a desk review to identify available data collection tools in other similar agencies, organisations and projects.

03) Develop new data collection tools and share with relevant programme staff for their inputs.

04) Finalise the tool and take action for implementation.

Currently FPA Sri Lanka has a well-established computer based data management system for service sections (Client Information Management System - CIMS) which is under the umbrella of a broader data system (Management Information System- MIS). This Monitoring and Evaluation Information Management System (known as MEIMS) is an online and centralised open source application with several data collection and reporting modules (Ex:- Service Statistic Module, Project Module, SMS client feedback module, etc).The system provides analytical results for programme feedback including inputs for periodic reporting for different donors. All programme units are feeding their data into the system on a regular basis. The M&E Unit shall strength the system time to time, based on changing requirements of routine strategic information of the organisation.

The M&E Unit shall standardise M&E language as used in Sri Lanka through a publication with definitions of common terminologies used in the discipline. In pursuance of this task, care shall be exercised to avoid departure from international terminology (FPA Sri Lanka M&E policy, 2013). A glossary of terms which include the definitions of all the general monitoring and evaluation terms has been presented as annexure 01, in this SOP. Apart from that, the M&E unit has developed (adopted from IPPF and translated into local languages) a service statistic manual which includes definitions of all the service statistics and glossary of terms. Programme staff must utilise these resources to ensure the quality of data.

2.8. Capacity building for Monitoring and Evaluation

FPA Sri Lanka considers that the planned and continued process of capacity building is required for an effective and efficient Monitoring and Evaluation function within the organisation. Purposes of M&E capacity building are to ensure;

01. That the M&E staff in the organisation is able to set up an M&E system (set of components constituting a whole and uniform way of understanding phenomena), manage that system, and produce the results required for M&E from it. The M&E staff must be capable enough to link various related components of work in the organization together, for example, the inputs, processes, activities, outputs, outcomes, and impacts that constitute projects, programmes, and services, so that they form an integrated whole or system. The M&E staff should also be able to manage such a system and enable practitioners to produce data from it for decision-making.

02. That the programmatic staff, FPA Sri Lanka partners and volunteers who report data to the M&E system are able to understand correctly and consistently, the formats and indicators that they are expected to report. They also must be capable enough to maintain proper documentation including support documents (Means of Verifications) to prove what they have reported to M&E system in order to ensure the credibility and the transparency of the organisation.

03. That the users of M&E data have an understanding of the ways in which these tools can be used effectively for informed decision-making and for introducing improvements into future policies, strategic and operational plans. Also be able to assess information collected through the M&E process, and use this information as a tool for the modification of ongoing interventions, as and when necessary, and to improve future interventions through the planning process.

2.8.1. Capacity building of M&E staff[4]

Necessary measures will be taken to strengthen the capacity of M&E staff by providing opportunities for training and linking to national, regional and global networks.

Recommended training for M&E staff;

- ✓ MEASURE Evaluation training on M&E in Health, Population and Nutrition. Training is conducted annually in Delhi, India in addition to other locations.
- ✓ Participatory Planning, Monitoring and Evaluation course (PPM&E) conducted annually by Wageningen University, Netherlands.
- ✓ International Programme for Development Evaluation Training (IPDET) conducted annually in Ottawa, Canada jointly by Carleton University and the World Bank.

The above three training programmes have scholarship facilities for eligible participants. Please note that these three programmes have been mentioned in this SOP only as examples.

M&E networks help to share resources, knowledge and expertise. Particularly sharing with M&E professionals in similar programmes, similar practices are useful for the improvement of FPA M&E function. Recommended networks for M&E staff;

- ✓ National - Sri Lanka Evaluation Association (SLEvA) – Institutional membership to be obtained
- ✓ Regional – Community of Evaluators – South Asia (COE), International Organisation for Collaborative Outcome Management in South Asia (IOCOMSA)
- ✓ Global - mandenews list serve, IPDET list serve

2.8.2. Capacity building of Programme staff on M&E

The M&E unit of FPA Sri Lanka is expected to conduct a series of capacity building programmes for FPA Sri Lanka, staff, volunteers and partners to ensure a smooth operation of the M&E system. The M&E Unit will develop a FPA Sri Lanka M&E capacity building guideline to implement a series of capacity building programmes. This will be reflected in the M&E strategic plan and costed M&E action plans. It is recommended to conduct a need assessment for capacity building once in a five years.

2.9. Standard Operational Procedure for programme monitoring

The next four chapters of this book cover the standard operational procedures relevant to M&E in programme management and operation. This SOP does not describe in detail the programme management procedures of the organisation. So, it is recommended that FPA Sri Lanka develops separate standard operational guidelines for programme management (Service delivery, IEC/BCC and Advocacy) and quality of care guidelines in line with this procedure manual. Next four chapters present FPA Sri Lanka's standard operational procedures of,

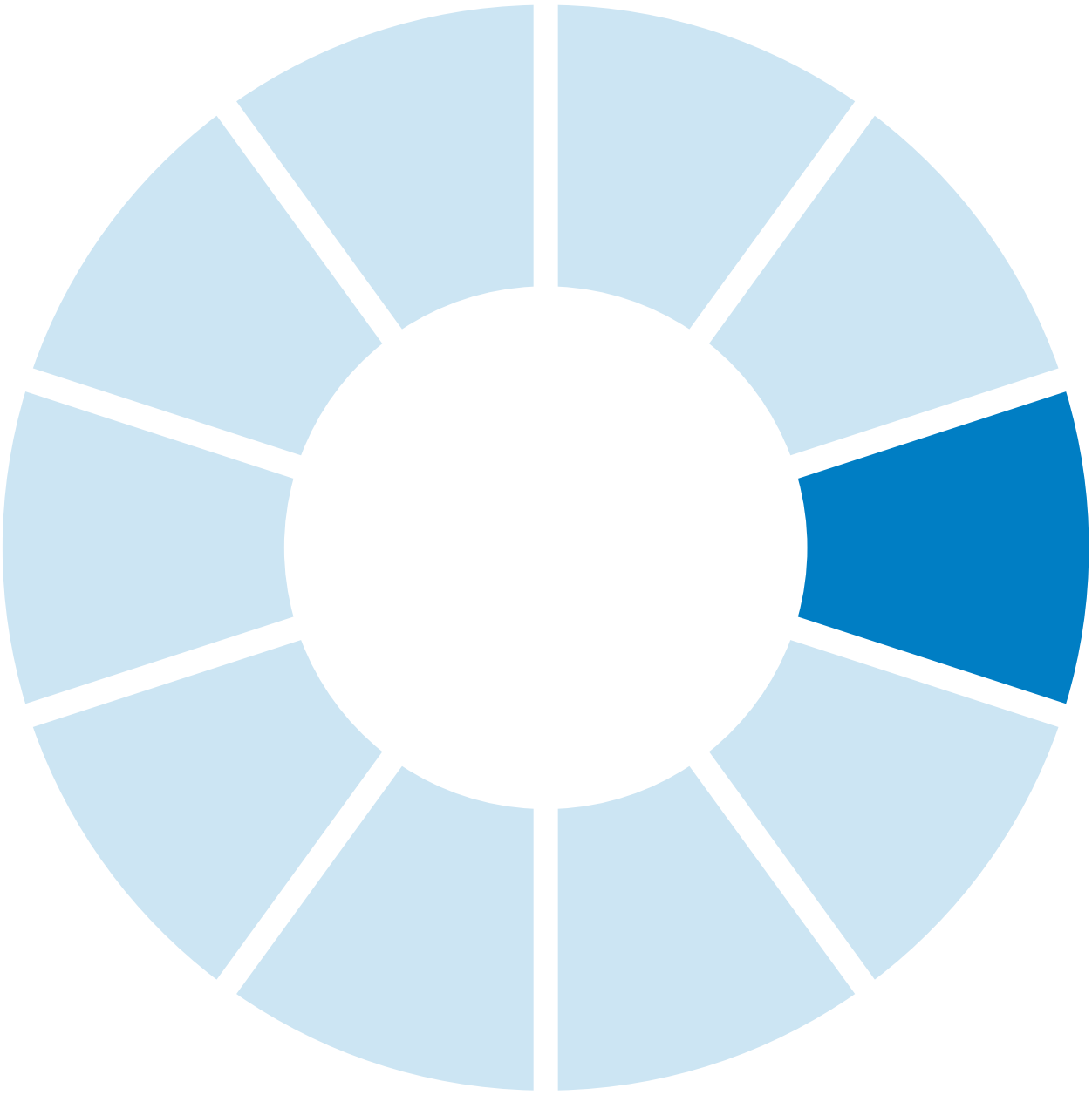
Chapter 01 - Service delivery interventions

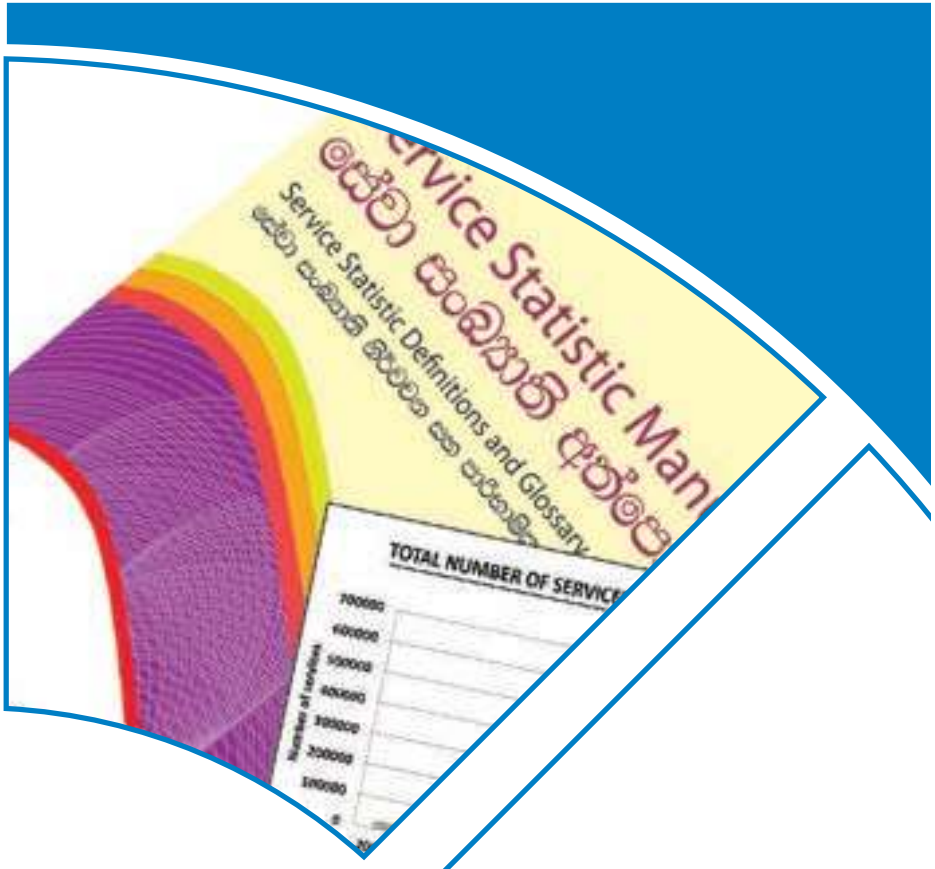
Chapter 02 - IEC/BCC interventions

Chapter 03 - Advocacy interventions

Chapter 04 - Cross cutting and support activities.

4 Adopted from FPA Sri Lanka Monitoring and Evaluation Strategy 2011-2015





3

Monitoring of service delivery interventions

3. Monitoring of service delivery interventions

As described in chapter one, FPA Sri Lanka strategic framework underpins the commitment of the IPPF and its member organisations to ensure the universal access of Sexual and Reproductive Health services, as agreed at the International Conference on Population and Development (ICPD); and is explicitly linked to the Millennium Development Goals (MDG).

FPA Sri Lanka understands that, despite Sri Lanka's impressive macro-economic growth figures, health and demographic indicators, significant levels of socio-economic development disparities across geographies exist. In addition to that, there are serious discrepancies in providing SRH services to special vulnerable groups – such as commercial sex workers, MSM (men having sex with men), drug users, persons affected by HIV and AIDS, and displaced and disabled persons. These differences and inequities violate the fundamental Sexual and Reproductive Health Rights of vulnerable people. FPA Sri Lanka aims on creating space to ensure that all persons – along with vulnerable groups – will have equitable access to Sexual and Reproductive Health services and information without any discrimination, restrictive laws, policies or practices.

The service delivery interventions of FPA Sri Lanka emphasise the quality of programmatic data because it is explicitly evidence based and results oriented. Good data is needed to inform the design of interventions and to monitor and evaluate FPA Sri Lanka's quantitative progress toward pre-determined and agreed targets. Ultimately, FPA Sri Lanka is committed to the accuracy of information for purposes of accountability and more importantly, for use of good quality data to improve its programmes and operations. So, this chapter will describe the standard operational procedure for monitoring various aspects of service delivery interventions implemented by FPA Sri Lanka.

3.1. Service statistic definitions and glossary of terms

An important task that service data collected helps us achieve is the exploration and prediction of national and SDP level trends in the field of Sexual and Reproductive Health and Rights. Any misrepresentation of numbers can have a detrimental effect on these predictions and interpretations. It is therefore, crucial to create a common understanding on the definitions of service statistics and a mechanism to disseminate the agreed definitions across all Service Delivery Points (SDPs) and projects. It is with an intention to fill this void in the organisation that FPA Sri Lanka launched a manual on definitions of service statistics and a Glossary of terms commonly used in this field in 2014.This manual comprehensively covers all services that are likely to be dispensed by any Service Delivery Point of FPA Sri Lanka and glossary of terms related to service delivery. We expect all involved (i.e. service providers, staff and volunteers managers, directors and technical focal points) will effectively utilise the service statistical manual for data collection, reporting and interpretation of outputs. This manual is available in English, Sinhala and Tamil for the convenience of all the users.

3.2. Static Clinics

A Static Clinic is defined as a clinic-base (regular, permanent location), providing Sexual and Reproductive Health services by trained service providers / counsellors. A static clinic operates from fixed premises, managed by the MA and run by full and/or part time MA staff. A static clinic may also provide non-SRH medical services (IPPF glossary of terms).

3.2.1. Registration of static clinic / New entity

The recording and reporting process of static clinics start with registration of entity specific basic data in the Monitoring and Evaluation Information Management System (MEIMS). The SDP manager of the proposed SDP (new SDP) has to submit the following information (with the approval of the unit head) to the M&E unit for registration of a new static clinic in the reporting system. The M&E unit will be responsible for registering a new static clinic in the MEIMS.

01) Justification and rationale for selection of geographical location / district (Please refer the guidance provided in annexure 05)

02) Contact information (Address, Telephone number, Fax number)

03) Detailed activity plan and budget for the current year

04) Service projection for the current year (Number of clients, visits, services, contraceptive items, CYP and referrals)

3.2.2. Registration of Service Providers

Reporting of service statistic data at clinic level starts with the registration of service providers in MEIMS. All the service providers attached to the static clinic (full time, part time, daily pay, volunteer, etc.) must be entered in to the MEIMS using the template and guidelines provided in annexure 09. The SDP manager is responsible for the management of the service provider database in MEIMS.

3.2.3. Client Registration

It is recommended to register all the static clinic clients only during their first visit to the static clinic using the template provided in annexure 10. At the time of registration, each client will receive an identification/registration number. A client registration number must be unique to a particular client and should not be duplicated (Unique Identification Code). The registration number is used to identify the client throughout the life time of the client and one client must receive only one number during this period. The client registration number format appears below.

Code for client registration number:

<SDP Code><S[5]>/<year>/<client sequence number in the year>

The code development method is explained to SDP staff during capacity building events. The receptionist is responsible for the management of client registrations under the overall supervision of the SDP manager. The client registration has to be completed before services are reported in the MEIMS.

5 S= Static clinic, M=Mobile clinic, A=Associated clinic, C=community Based Services

3.2.4. Recording and Reporting of Service Statistics

A) Client history form

The service provider must record all the medical and behavioral information of the client in the client history form (Annexure 11:- A sample client history form). It is expected from the service providers to document all services, referrals and medical items provided to the client (during all the client visits) in the client history form. Please refer FPA Sri Lanka Service Statistic Manual (2014) for service statistic definitions and glossary of terms. One client must have only one client history form irrespective of the type of services that the client received for easy documentation and access. The primary beneficiaries of the information available in the client history form are the service providers who manage clients' medical conditions and the clients' themselves. Any referral to an external service provider must be supported with a referral form. The first part of the referral form is attached to the client history form. The signature of the service provider is considered as a mandatory requirement to ensure the quality of the services provided and for donor accountability.

All FPA Sri Lanka SDPs maintain a client history form for a minimum of seven years for easy access as and when necessary. SDP managers need to take written approval from respective unit heads before destroying any client history forms after completion of seven years or more. Client history forms are maintained under the custody of the SDP manager and must not provide access to any outsider to ensure the privacy and confidentiality of FPA Sri Lanka clients.

FPA Sri Lanka Monitoring and Evaluation system uses client history forms as the primary source for reporting of service statistics and for data quality assessments.

B) Service reporting in MEIMS

At the end of each working day, service providers enter service statistic data into MEIMS in the format available in annexure 12. The data entered to the system is consistent with the client history form. In case the SDP is hiring service providers on a daily pay basis, a trained data entry operator maybe involved in service statistic data entry. The service providers or the data entry operator is the main person responsible for maintenance of data consistency between the client history form and MEIMS; and is expected to review the data entered into the system and do the necessary corrections. Please refer annexure 01 of FPA Sri Lanka core indicator reference guide for glossary of terms.

3.2.5. Client feedback

a) SDP self-assessment of client feedback

FPA Sri Lanka considers feedback given from the clients served by its' SDPs are valuable in helping improve the quality of service provision. Positive feedback is considered as an indication of good quality of care. Adhering to IPPF quality of care guidelines, all the SDPs are expected to conduct client exit interviews and improve the quality of care at SDP level. Client exit interviews are conducted as a part of SDP self-assessment exercise for quality of care. Please refer IPPF quality of care guidelines for more information. Apart from client exit interviews, a SDP may maintain a suggestion box which is also a SDP self-assessment strategy.

b) SMS client feedback

Apart from the SDP self-assessment, FPA Sri Lanka has developed a client feedback collection mechanism using short message service (SMS) of mobile phones. The clients who have given their mobile numbers receive an M&E system auto generated SMS requesting the client to send their status of satisfaction directly to a centralised data base (MEIMS). The SDP manager can access reports which show the number and percentage of clients satisfied with the SDP services. Only the system administrator has access to the names and mobile numbers of the respondents. This system can be considered as a cost effective and transparent mechanism of collection of client feedback with minimum human interventions in clients' decisions. The SDP managers are encouraged to enter the mobile numbers of all the clients who are willing to provide their contact information.

3.2.6. PMSEU client / vulnerable client estimation

As explained in the section on strategic focus; FPA Sri Lanka develops its' strategies to provide services to poor, marginalized, underserved and socially excluded people. So, it is important to estimate the proportion of PMSUE clients served by FPA Sri Lanka static clinics. All the static clinics managed by FPA Sri Lanka need to conduct the PMSUE exercise as a routine activity (Please refer indicator ACC/OP/03 of FPA Sri Lanka core indicator reference guide for more details on PMSUE estimation and data collection tool). The receptionist of the static clinic collects responses from 10 to 20 randomly selected clients per month (120 to 240 responses per year) and submits duly completed questionnaires to the M&E Unit by the 5th of December. The M&E Unit will enter and analyse the data and share findings with the SDP management. All MAs need to report the estimated number of PMSU clients to IPPF annually.

3.3. Mobile Clinics / Clinical outreach teams

Mobile clinics / clinical outreach teams are defined as off-site clinic based SDPs managed by FPA Sri Lanka and run by full and/or part-time FPA Sri Lanka staff. Services are provided through health posts, equipped vehicles and other premises (FPA Sri Lanka Core indicator reference guide, 2014).

Clarifications:

a) Contraceptive and/or other sexual and reproductive health services are provided by FPA Sri Lanka staff through mobile clinics and/or clinical outreach teams.

b) A mobile clinic or clinical outreach team may also provide non-SRH services.

c) Each mobile clinic or clinical outreach team is counted as one SDP. Do not count individuals in the team or the number of communities reached or events as separate SDPs.

Mobile Clinics aim to improve access to local, on the spot Sexual and Reproductive Health care services for people living in under-serviced communities. Having access to a regular health care provider will help people living in these communities receive ongoing Sexual and Reproductive Health care and support close to home. It will also save time and transportation costs for clients by bringing health care services to their community. So, FPA Sri Lanka mobile clinics are expected to reach the most under-served community segments in Sri Lanka, which do not receive services through the government health system and other FPA Sri Lanka service delivery approaches (eg:- Static Clinics, associated clinics).

Selection of locations to conduct series of mobile sessions is based on secondary indicators available in the government health system as per the guidelines provided in annexure 05. The

in-writing approval of the respective unit head for geographical locations is considered as a pre-requisite to conduct mobile clinics.

3.3.1. Registration of a new entity and the project

The recording and reporting process of mobile clinics start with registration of entity specific basic data in the Monitoring and Evaluation Information Management System (MEIMS). The respective SDP manager of the SDP has to submit the following information (with the approval of the unit head) to the M&E Unit for registration of a new entity and the project in the reporting system. The M&E Unit is responsible for registration of a new entity and the project in MEIMS.

01) Project logical framework (Annexure 02)

02) Detailed activity plan and budget

03) Justification and rationale for selection of geographical location / district (Please refer the guidance provided in annexure 05)

04) Service projection (Number of mobile clinics for each location, Number of clients, services, contraceptive items, CYP and referrals)

3.3.2. Registration of mobile session / service session

Reporting of mobile clinic data at SDP level starts with the registration of the service session in MEIMS. Every service session receives a unique identification number (UIN) at the time of registration of the mobile service session. SDP managers may use the following guidelines to develop UIN for registration of mobile service sessions in the MEIMS. Once selected, the same code has to be maintained during the project period for easy reference and report generation.

Guidelines to develop UIN for mobile clinics

<Entity code>/<Year>/<mobile clinic serial number>

<Entity code> /<Year>/<MOH area code>/<PHM area code>/<mobile clinic serial number>

<Entity code> /<MOH area code>/<PHM area code>/<mobile clinic serial number>

<Entity code> /<Project code>/<Year>/<mobile clinic serial number>

The standard template for registration of mobile service sessions is available as annexure 13 of this standard operational procedure manual. Please refer annexure 01 of FPA Sri Lanka core indicator reference guide for glossary of terms.

3.3.3. Recording and Reporting of service data for mobile clinics

Client registration in the MEIMS is considered as an optional requirement for mobile clinics. However, client registrations for mobile clinics enhance the quality of service data. The procedure described for the development of a unique identification number under static clinics must be followed for mobile clinics as well.

The client history forms (as described under static clinics) will be used for mobile clinics as well (Annexure 11:- A sample client history form) for better management of medical conditions of the clients, to avoid under reporting and to increase transparency and accountability.

The data entry operators at SDP level enter service data to the MEIMS using the template provided as annexure 12 of this SOP. The main difference in service data reporting between static clinics and mobile clinics is that the SDP does not need to enter the name of the service provider for mobile clinics. Instead, the mobile clinic UIN is required.

3.4. Associated clinics

An Associated Clinic (AC) may be clinic based or non-clinic based, belonging to private individuals, organisations or the public sector, providing Sexual and Reproductive Health services by skilled health workers. An associated clinic is NOT managed by the MA and services are provided by the associated clinic staff, NOT by MA staff. MAs have a written agreement with the associated clinic. MAs must support quality improvement and assure the quality of services that are reported to IPPF. MAs may or may not provide contraceptives and other Sexual and Reproductive Health commodities to the associated clinic (IPPF, 2014; *new associated clinic definition*).

Points of Clarification: The following guidelines will help ensure that IPPF upholds its commitment to the provision of high quality SRH services. It also helps to ensure that ACs value their partnership with the MA (IPPF, 2014).

A) **Skilled health workers:** Services reported by ACs must be delivered by skilled health personnel. It may be that the MA trains these staff as part of their agreement or that they were trained by another accredited body. Either way, the MA must have a mechanism in place to assess that providers are skilled and this must be done on an on-going basis to account for staff-turnover and loss of skills. Where gaps are identified, the MA must ensure that these are addressed in order to continue reporting services.

B) **Written agreement:** The MA should have a signed written agreement with the ACs. This can be a one-to-one agreement with individual ACs or an umbrella agreement with an organisation (e.g. the District Health Office). The presence of a signed agreement for all ACs will be verified by IPPF at the time of data collection. All agreements should outline the duration of the agreement; the grounds for termination; and the responsibilities of each party including but not limited to those relating to data reporting, service quality, and fee structure (if relevant). Examples of associated clinic agreements are available on request from the IPPF Regional Office. MAs may wish to seek legal advice on the structure and content of the agreement and are advised to include language that indemnifies them against liability or claim arising out of negligence of the AC. The Agreement or MoU must clearly state that the associated clinic management provides access to support documents (client history forms, patient files etc) for responsible staff at the MA for verification of data reported to the FPA Sri Lanka.

C) **Support quality improvement:** MAs support ACs to improve the quality of their services through a range of activities including but not limited to clinical or non-clinical training (may be on or off-site), supportive supervision, the provision of job aids or IEC materials, equipment or infrastructure repair. While the support provided will vary across models, in all cases the MA must play a role in supporting or maintaining high quality of care.

D) **Quality assurance of AC services reported to IPPF:** A mechanism must be in place to ensure that services provided by ACs are delivered in line with IPPF quality standards. This means that periodic specialised quality assurance visits must be undertaken using a standardised checklist or monitoring tool. At a minimum, the tools should assess infection prevention; clinical competence of providers for the services reported (see point above on skilled personnel); availability of essential equipment and supplies; and data quality. Quality assurance may be undertaken directly by the MA or jointly with another organisation such as the Ministry of Health. Each visit should include the development of a quality improvement plan with the AC. It is expected that all AC sites receive a minimum of one quality assurance visit using a standardised tool, every two years.

3.4.1. Registration of associated clinic

Reporting of associated clinic data starts with the registration of the associated clinic in the Monitoring and Evaluation Information Management System (MEIMS). The respective SDP manager or programme coordinator must submit the following documents to the M&E Unit requesting the registration of the associated clinic in MEIMS. The Monitoring and Evaluation Unit of FPA Sri Lanka is responsible for registration of associated clinics in the MEIMS.

1. Justification and rationale for selection of the service delivery approach (Please see the example provided in annexure:- 03)
2. Duly completed associated clinic registration form (Please use the template provided in annexure:- 14)
3. Copy of the MoU or agreement
4. Project and Budget details for current year
5. Service projection (Number of mobile clinics for each location, Number of clients, services, contraceptive items, CYP and referrals) for the current year

3.4.2. Recording and reporting of service statistics

Although maintaining client records is a mandatory requirement, it is expected that the associated clinic management use their own formats to maintain client records/history. However, the formats must keep all the data required for FPA which reflect in Annexure 12. Associated clinic management either directly enters service statistic data into MEIMS (Annexure 12 :- Service statistic data entry template) or submits progress reports to the respective SDP manager or programme coordinator at FPA Sri Lanka at pre-agreed intervals mentioned in the MoU. The reporting templates for associated clinics are developed by the M&E Unit at the request of the respective SDP manager or project coordinator. However, it is expected that all associated clinics report client wise service statistic data to FPA Sri Lanka using a unique client identification number (UIN). The progress report of the associated clinic must be approved by the AC management.

In case the associated clinic does not enter service statistics directly to the MEIMS, the data entry operator at the respective programme unit must enter client wise service statistic data into the MEIMS using the template available as annexure 12.

Guidelines to develop UIN for the clients served through associated clinics

<Entity code> /<UIN of the associated clinic>

Client registration in MEIMS is important but not mandatory for associated clinics, unless there is a special donor requirement. The data entry operator and respective SDP manager is responsible for maintenance of data consistency between the associated clinic progress report and MEIMS. Although associated clinics provide non-SRH services as well, it is expected that associated clinic management reports only SRH services to FPA Sri Lanka.

3.5. Community Based Services / Distributions

Community based services (CBS) or Community Based Distribution (CBD) is a non-clinic based Service delivery point, managed by the MA and distributes contraceptives and other Sexual and Reproductive Health commodities to clients through community-based workers or volunteers (CBDs).

- ✓ CBDs include Sexual and Reproductive Health promoters, educators and health workers and volunteer health assistants
- ✓ CBDs may provide limited types of clinical services (Ex: - Pregnancy test).
- ✓ They may also provide non-clinical services such as education. These should be reported in the project module, not in the service statistics module.
- ✓ They may or may not have a physical space

CBDs or VHAs must be provided with a comprehensive training which includes theoretical aspects and practical sessions on each type of service that they are expected to deliver before field implementation.

3.5.1. Registration of Community Based Distributers (CBD) or Volunteer Health Assistants (VHA)

Similarly as in all other service delivery approaches, reporting of service data for community based services start with the registration of the CBD or VHA in the MEIMS. The respective SDP manager / programme coordinator must submit the following documents to the M&E unit requesting registration of CBD / VHA in the MEIMS. The M&E unit then registers the CBD/VHA in the MEIMS.

1. Justification and rationale for selection of the service delivery approach (Please see the example provided in annexure:- 03)
2. Duly completed CBD / VHA registration form (Please use the template provided in annexure:- 15)
3. Project and Budget details for the current year
4. Service projection (Number of mobile clinics for each location, Number of clients, services, contraceptive items, CYP and referrals)

3.5.2. Recording and Reporting of service data for CBD/CBS

A) Daily record book

Each CBD/VHA maintains a diary/record book to record daily interactions with his/her clients. The daily record book maintains client wise information for the reference of the CBD/VHA using a unique client identification number (UIN). All FPA Sri Lanka SDPs are expected to follow the below code to develop a UIN for CBS/CBD programmes. Annexure 16 shows a sample client record of a daily record book.

Guidelines to develop UIN for the clients served through CBD/CBS

<Entity code> /<MoH area code>/<VHA Serial number>/<Client serial number>

The diary should be made available to the Field Supervisor/ Programme Coordinator and other responsible staff as and when requested. The Field supervisor / Programme coordinator at SDP level randomly verifies the VHA monthly report with the daily record book for data consistency and signs in both the VHA monthly report and daily record book from time to time.

B) CBD / VHA progress report

Based on the daily records maintained in the diary record book, each CBD / VHA prepares a progress report monthly or bi-weekly. The template for the progress report is developed by the M&E Unit on the request of the SDP manager or programme coordinator. The template must ensure client wise reporting of service data using a unique client identification number (UIN).

The CBDs/VHAs and Field Supervisors are trained on how to prepare the progress report. The Field Supervisor has to support CBDs/VHAs having literacy difficulties and ensure that the data is recorded accurately and clearly in the progress report. The completed reports are submitted by the CBDs/VHAs to the respective Field Supervisor/Programme Coordinator at pre agreed intervals. The Field Supervisor / Programme Coordinator randomly cross-checks the data reported in the progress report with the daily record book/diary at the time of submission by the CBD/VHA.

C) Service data reporting in MEIMS

The data entry operator at SDP level has to enter all progress reports to the system (client wise) and the original report is kept under the custody of the SDP manager/programme coordinator. The template for data entry is available as annexure 12. The data entry operator and SDP manager is responsible for data consistency between the progress report and MEIMS.

3.6. Social Marketing Programme

FPA Sri Lanka through its marketing programme has improved access to Contraceptives and choice through its island wide network of outlets that includes pharmacies and groceries. FPA Sri Lanka continues to be the main non-state actor in reducing the barriers and improving access to contraceptives throughout the country. The Social Marketing Unit operates with the objective of providing quality contraceptives to the public at a reasonable price with improved accessibility. As the market leader for contraceptives in Sri Lanka, FPA Sri Lanka effectively markets the following contraceptives through a dealer network comprising more than 5000 dealers in the entire country including the North and the East. FPA Sri Lanka

imports most brands of contraceptives in bulk and does the packaging locally. This has helped the organisation to provide employment to local youth in addition to keeping costs of the product low. The savings thus accrued is passed on to the end customer by a price reduction or through subsidising our services. FPA Sri Lanka reports the service statistics of its social marketing programme (number of contraceptives sales disaggregated by method) under commercial marketing service delivery approach in the electronic information management system (eIMS) of IPPF.

Commercial marketing is a non-clinic based service delivery point and may or may not be MA owned or managed. The MA provides contraceptives and other Sexual and Reproductive Health commodities which are sold at retail prices that permit profit-making (IPPF Service Statistic definition and glossary of terms).

- ✓ Commercial marketing does not provide clinical Sexual and Reproductive Health services, including counselling
- ✓ The purpose of commercial marketing is to recover cost and generate profit
- ✓ These channels include pharmacies, retail establishments, drug stores and wholesalers
- ✓ A drug store or pharmacy that is managed by an MA static clinic for profit is a commercial marketing SDP. However, only contraceptive items distributed directly to clients from the pharmacy (with no services) should be reported here.
- ✓ Report only number of contraceptive items sold. Since the end customer is a pharmacy or retail shop (not the end user) Client level reporting of service statistics, age and sex disaggregation may not be possible.

3.6.1. Recording & reporting of SMP data

Currently the SMP unit enters aggregated product wise sales data with a monthly income details based on customer receipt into the MEIMS at the end of each month. This aggregated data does not support further analysis other than the 'target Vs achievement' and product wise trend analysis at organisational level. Further, the current manual system does not facilitate data quality verification at any level. Currently, the social marketing unit is in the process of sales force automation which is expected to be completed by the end of 2016. Once the sales force automation is finalised and fully operational, the sales database will be integrated with MEIMS to support the SMP unit with a comprehensive reporting and alert mechanism. However, the following table illustrates the data requirement of the Social Marketing Programme with data structure as an annexure.

Table 3.1:- Data requirement for effective monitoring of the social marketing programme

No	Data requirement	Description	Responsi-bility	Reference
01	Products and unit of measurement	All the basic information of products which includes but is not limited to the fields highlighted in annexure 17. Part of this is currently available in MEIMS.	SMP Unit	Annexure 17.1
02	Marketing officers' data base	Registration of marketing officers with line of command and yearly projections	SMP Unit	Annexure 17.2
03	Annual Projections of the Social Marketing Programme	Sales and income projections at organisational level. This is currently available in the MEIMS	SMP Unit	Annexure 17.3
04	Retail outlet database	Registration of retail outlets in the system which has to be mapped using geographic information system (GIS) technology in the long run.	SMP Unit	Annexure 17.4
05	Disaggregated (raw) sales and income data	Sales and income data disaggregated by sales outlet, marketing officer, product and date.	SMP Unit	Annexure 17.5
06	Periodical goods receipt and goods issued data from the main stores and sub stores (if any)	Goods receipt data disaggregated by product and goods issued data disaggregated by marketing officer (for periodic data quality verification)	Stores	Annexure 17.6
07	Actual income and expenses data from Finance Unit	Income data disaggregated by marketing officer and sales outlet.	Finance nit	Annexure 17.7

3.6.2. Data collection and verification Process

The data requirement highlighted in Table 3.1 is fulfilled through two electronic systems financial system (SAGE) and the sales force automation system. These two systems will be electronically integrated with the MEIMS to avoid duplication of reporting and efforts. Social Marketing unit is responsible for maintenance and update of following primary databases.

01) Products and unit of measurement (Annexure 17.1)

02) Marketing officers' data base (Annexure 17.2)

03) Annual Projections of the Social Marketing Programme (Annexure 17.3)

04) Retail outlet database (Annexure 17.4)

Area sales managers (ASM) and assistant directors (AD) attached with the SMP unit is responsible for internal routine quality checks and overall maintenance. Marketing Officers are considered as the primary reporting unit who initiate and report SMP sales and income data using customer invoice and receipt (Annexure 17.5). These customer invoices then entered in to the finance system by the account assistants after necessary checks and approvals of the SMP unit (This step will be automated after sales system is fully implemented). Internal quality verification and control systems and available which ensure the quality of data entered in to the finance system.

3.6.3. Qualitative assessment of Social Marketing Program

Apart from the routine data collection and reporting system highlighted in above sections M&E unit will be involved in periodic visits to sales outlets to independently assess the quality of the data as well as the program. The sites qualitative assessments will be selected based on the routine programmatic data highlighted in table 3.1. The focus of assessment will also be selected based on the programmatic gaps identified by analyzing the programmatic data (table 3.1) and other secondary data available. Areas for assessment may include but not be limited to,

1. What is the longest distance a person has to cover to obtain contraceptives and what is the average distance?
2. Can FPA be happy with this?
3. What are the competitive brands doing, and are countering this adequately? .
4. Do we have adequate visibility and presence throughout the country and district wise?

However, Specialized areas such as Branding, brand Image, values, consumer mindset (why a customer/consumer buy a certain brands, would they change to another product if the price is increased etc are specialist subjects which is be alien to M & E and therefore have to be outsourced to external research agencies based on the requirement and availability of resources. Please refer chapter 09 and 10 for more details on periodic evaluations.

3.7. Demand generation and community mobilisation for service delivery

Demand generation for service delivery is the focus of targeted programmes to drive awareness and interest of the community on the services offered by the Service Delivery Point. Demand generation increases awareness and demand for health products or services among a particular intended audience through social and behavior change communication (SBCC) and social marketing (SM) techniques. Demand generation can occur in three ways:

1) Creating new clients and changing behaviour– convincing members of the intended audience to adopt new behaviors, products or services. Convincing community to seek health care immediately, instead of not seeking care until their health situation has severely deteriorated or has been compromised (Ex: - increasing health seeking behavior).
2) Increasing demand among existing users– convincing current users to increase or sustain the practice of the promoted behavior and/or to increase or sustain the use of promoted products and services
3) Taking market share from competing behaviors – Eg:- convincing caregivers to use oral rehydration solution (ORS) and zinc instead of other anti-diarrheal medicines

In order to be most effective, demand generation efforts should be matched with efforts to improve logistics and expand services, increase access to commodities, and train and equip providers, in order to meet increased demand for products and/or services. Without these simultaneous improvements, the intended audience may become discouraged and demand could then decrease. Therefore, it is highly advisable to coordinate and collaborate with appropriate partners when forming demand generation communication strategies and programmes (The Health Communication Capacity Collaborative HC3, 2014).

The following sub-sections describe the standard procedure for reporting and documentation of demand generation intervention (and its' outcomes) which use different approaches at community level.

3.7.1. Community based distributors / Community health volunteers / Home visitors / Peer educators

Community health volunteers / Community based volunteers are in general considered as the service providers for community based distribution or services. However, at the same time they can act as the demand generators for static clinics and mobile clinics managed by FPA Sri Lanka, if the programme was designed with the objective of demand generation. Past experience shows that integration of community based distribution with static clinics or mobile clinics generate better health outcomes.

A VHA provides the basic SRH services which the VHA has been specially trained for and then refers/ escorts the client to a FPA Sri Lanka static clinic or mobile clinic for further screening and treatment using a VHA referral form (Annexure 18:- Template for VHA referral form). The receptionist at the static clinic or mobile clinic collects the second part of the referral slip as a support document to measure the performance of the VHAs. Further, the receptionist documents the source of referral as "Referred by a volunteer" with the name and ID of the volunteer at the time of client registration at the static clinic (Annexure 10:- Template for client registration form).

Please refer the indicator ACC/OC/01 of the Core Indicator Reference Guide, FPA Sri Lanka (2014) for further details on measurement of effectiveness of a home visitor approach as a demand generation strategy.

3.7.2. External referral mechanisms though other service providers

Development of an external referral mechanism is one of the most important community driven approaches to generate demand especially for static clinics. Other service providers who do not have capacity to provide Sexual and Reproductive Health services are sensitised on the services provided by FPA Sri Lanka service delivery points and are expected to refer the clients to the FPA Sri Lanka SDP based on the clients' specific need for SRH services.

The receptionist at the static clinic or mobile clinic document the source of referral as "Referred by a doctor or other organisation" with the name of the service provider at the time of client registration at the static clinic (Annexure 10:- Template for client registration form).

Please refer the indicator ACC/OC/08 of the Core Indicator Reference Guide, FPA Sri Lanka (2014) for further details on measurement of effectiveness and coverage of the external referral system as a demand generation strategy.

3.7.3. Community mobilisation through existing clients

FPA Sri Lanka recognises that the existing clientele of FPA Sri Lanka Static clinics are an important asset to mobilise the community for uptake of SRH services through FPA Sri Lanka SDPs. FPA Sri Lanka concentrates its' efforts on satisfying existing clientele and conducting demand generation campaigns through the existing clients which is a community driven approach for demand generation.

The receptionist at the static clinic documents the source of referral as "Referred by a client" at the time of client registration at the static clinic (Annexure 10:- Template for client registration form). Please refer the indicator ACC/OC/09 of the Core Indicator Reference Guide, FPA Sri Lanka (2014) for further details on measurement of effectiveness of existing clientele as a demand generation strategy. This indicator measures the effectiveness of demand generation as well as it shows the level of satisfaction of existing clientele.

3.7.4. Demand generation through Promotional programmes

Well designed and pre-planned community level demand generation programmes and promotional programmes are considered as an inevitable component of any service delivery intervention. It is recommended to conduct an exercise on geographical mapping of existing clientele to identify the demand generation gaps and challenges. It also provides a basis for identification of geographical locations, strategies and audiences for demand generation programmes. The plan for demand generation is considered as a pre-requisite for monitoring and evaluation of demand generation interventions. The demand generation plan must include, but may not be limited to,

- ✓ Geographical locations and basis for selection of geographical locations
- ✓ Target audiences
- ✓ Demand generation strategies (Home visitors, existing clients and referral systems described earlier also can be identified as demand generation strategies. However, those strategies are considered as routine operations rather than especially focused interventions for demand generation).
- ✓ Costed action plan and budget for demand generation.

At the end of each demand generation event, the programme coordinator collects participants' feedback using the template provided in annexure 22 and reports the achievement of the activity using the template provided in annexure 19. The receptionist at the static clinic documents the source of referral as "Demand Generation Programme" at the time of client registration at the static clinic (Annexure 10:- Template for client registration form). Please refer the indicator ACC/OC/02 of the Core Indicator Reference Guide, FPA Sri Lanka (2014) for further details on measurement of effectiveness of demand generation programmes.

3.7.5. Other demand generation approaches

Most of the other demand generation programmes, in general involve Information Education and Communication (IEC) strategies than well focused and pre-planned behavioral change communication interventions.

The following table describes other demand generation strategies and guidelines for reporting.

Table 3.2:- Reporting guidelines for other demand generation activities

	Demand Generation Strategy	Reporting guidelines	Reference
01	Leaflets and promotional materials	Activity Reporting :- Report the activity using IEC/BCC material reporting template Upload a copy of the leaflet / promotional material into the MEIMS Outcome :- Client registration data entry template	Annexure 19 Annexure 10
02	Happy life	Activity Reporting :- Happy Life data entry template Outcome :- Client registration data entry template	Annexure 10
03	Internet / Web site	Activity Reporting :- Report as project narrative information Outcome :- Client registration data entry template	Annexure 10
04	News Paper advertisements	Activity Reporting :- Project narrative reporting Upload a copy of the leaflet / promotional material into the MEIMS Outcome :- Client registration data entry template	Annexure 10
05	Radio / TV programmes	Activity Reporting :- Project narrative reporting Upload any means of verification / support document in to the MEIMS. Outcome :- Client registration data entry template	Annexure 10

3.8. Means of Verification / support document requirement for service delivery interventions

The means of verification tell us where we should obtain the data necessary to prove the objectives defined by the indicator have been reached. Most of the information would be available from programme documentation and survey reports. FPA Sri Lanka Core Indicator Reference Guide describes in detail the means of verification requirement for all standard indicators at all levels. This SOP provides means of verification that comes out from operational procedures which are mandatory requirements to ensure improved quality and transparency.

Table 3.3:- Reporting requirements and means of verifications of different service delivery interventions

	Reporting requirement	MoV / Support document	Reference
Static Clinic	Number of clients, clients' age and gender	Client registry	Annexure 10
	Sources of referrals	Client registry	Annexure 10
	Services,	Client history form	Annexure 11
	New Users	Client history form	Annexure 11
	Contraceptive Items	Client history form Stock registry / Bin Card	Annexure 11
	Referrals	Client history form First part of the referral slip	Annexure 11
Mobile Clinics	Number of mobile clinics conducted	Mobile clinic registry	Annexure 13
	Number of clients, clients' age and gender	Client registry or Client history form	Annexure 10 Annexure 11
	Services,	Client history form	Annexure 11
	New Users	Client history form	Annexure 11
	Contraceptive Items	Client history form Stock registry / Bin Card	Annexure 11
	Referrals	Client history form First part of the referral slip	Annexure 11
Associated Clinic	Associated clinic registration	Memorandum of Understanding (MoU)	N/A
	Number of clients, clients' age and gender	Client registry or Client history form	Annexure 10
	Services,	Client history form	Annexure 11
	New Users	Client history form	Annexure 11
	Contraceptive Items	Client history form Stock registry / Bin Card	Annexure 11
	Referrals	Client history form First part of the referral slip	Annexure 11

	Reporting requirement	MoV / Support document	Reference
Community Based Distribution	Number of VHAs /CBDs	VHA / CBD registration	Annexure 15
	Number of clients, clients' age and gender	VHA daily record book	Annexure 16
	Services,	VHA daily record book	Annexure 16
	New Users	VHA daily record book	Annexure 16
	Contraceptive Items	VHA daily record book Stock registers /Bin cards	Annexure 16
	Referrals / Escorts to FPA Sri Lanka SDPs	VHA daily record book VHA referral slip	Annexure 16
	Referrals / Escorts to other service providers	VHA daily record book Referral slip signed by the external service provider	Annexure 16
Social Marketing Programme	Number of SMP outlets	SMP outlet database	Annexure 17
	Contraceptive Items	Customer invoice Stock registers /Bin cards	Annexure 17
Demand generation programmes	Number of participants for demand generation programmes	Annual Demand generation programme plan	N/A
		Programme Agenda	Annexure 23
		Attendant sheet	Annexure 21
		Participants' Feedback form	Annexure 22
	Outcome of the demand generation programme	Static clinic client registry	Annexure 10
Leaflets / Promotional Materials	Number of leaflets / promotional materials developed	Original copy of the demand generation programme	N/A
	Number of leaflets / promotional materials distributed	Distribution sheet	Annexure 24
Newspaper advertisement	Number of newspaper advertisements	Original copy of the news-paper advertisement	N/A
	Outcome of the advertisement	Static clinic client registry	Annexure 10
Radio / TV programme / advertisement	Number of broadcastings	Letter from the media com-pany / channel	N/A
	Outcome of the advertisement	Static clinic client registry	Annexure 10

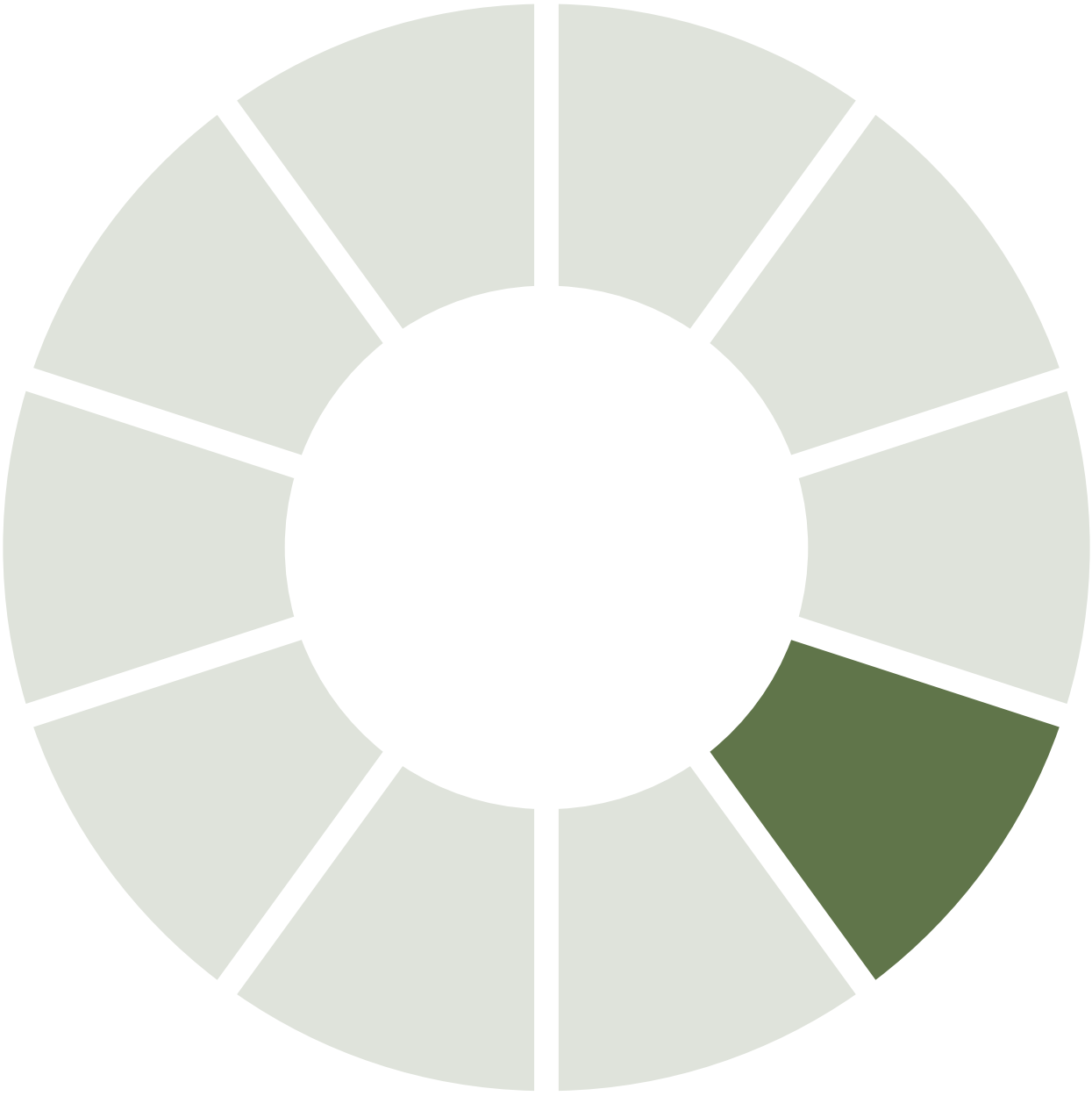
3.9. Efficiency analysis and SDP performance comparisons

FPA Sri Lanka uses the IPPF Branch Performance Tool (BPT) for efficiency analysis and performs SDP comparisons based on relative efficiencies. The Branch Performance Tool (BPT) allows Member Associations (MAs) to visualise the operating performance of individual branches, compare across branches, and use the resulting information to guide performance improvements. To do this, the tool estimates relative efficiency, as well as key operational ratios, across a set of branches or clinics. Additionally, where data permits, a user can visualise more detailed statistics (e.g., cost and service mixes) to understand differences in branch performance. The goal is to use this data to facilitate a small number of performance improvements in specific branches that will significantly benefit the MA's ability to deliver quality Sexual and Reproductive Health (SRH) services. However, while the BPT can raise important questions regarding performance and can help guide discussions around operational improvements, the unique environment in which each branch operates should be taken into account when making any management decisions. Results from the BPT are therefore intended to serve as one component of a broader evaluation of branch performance, including factors such as location, client demographics, community involvement, and others. In addition, users should ensure that improving service statistics does not come at the expense of providing high quality care, which is a core value of the IPPF (IPPF, 2013).

The Branch Performance Tool needs three types of SDP wise data; Service Statistics data, Costing data and HR (permanent, daily pay and volunteer) data in order to perform efficiency analysis. The M&E Unit, Finance Unit and Human Resource Units are responsible for development of relevant data capturing mechanisms and provision of high quality data for these three areas respectively. Please refer the IPPF Branch Performance Tool manual for more details on methodology, data requirement and assumptions. Descriptions of efficiency indicators are provided in FPA Sri Lanka Core Indicator Reference Guide-2014. Indicator reference numbers are OI/05, OI/06, OI/07, OI/08 and OI/12.

3.10. Estimation of Impact of Family Planning Programmes

FPA Sri Lanka uses the impact estimation tool developed by Marie Stopes International (MSI) and recommended by IPPF to estimate the impact of its family planning programmes. The current tool developed in 2009 facilitates impact calculation from 2010 to 2020. This tool has been updated in March, 2015 with latest data. There is no extra data requirement for this tool other than the already available data in the MEIMS. Please refer the MSI impact calculation user manual for the methodology and assumptions (Corby *et al,* 2009. Descriptions of family planning impact indicators are provided in FPA Sri Lanka Core Indicator Reference Guide - 2014. Indicator reference numbers are ABT/IM/01, ABT/IM/02, ABT/OC/01 and ABT/OC/02.



4

Monitoring IEC / BCC / SBCC interventions

4. Monitoring IEC / BCC / SBCC interventions

Information, Education, Communication (IEC), Behavior Change Communication (BCC), Social and Behavior Change Communication (SBCC) refers to a substantial set of cross-cutting strategies whose emphasis, regardless of name, is on improving health and social outcomes through positive influence.

Information, Education, Communication (IEC) refers to a public health approach aiming at changing or reinforcing health-related behaviors in a target audience, concerning a specific problem and within a pre-defined period of time, through communication methods and principles. Sexual and Reproductive Health (SRH) projects often develop posters, flyers, leaflets, brochures, booklets, messages for health education sessions, radio broadcast or TV spots, etc. as a means of promoting desired, positive behaviors in the community. These initiatives are commonly referred to as "Information, Education and Communication (IEC)" activities (World Health Organisation).

Behavior Change Communication (BCC) is an interactive process of any intervention with individuals, communities and/or societies (as integrated with an overall programme) to develop communication strategies and to promote positive behaviors which are appropriate to their settings. This in turn provides a supportive environment which will enable people to initiate, sustain and maintain positive and desirable behavior outcomes (United Nations Population Funds, 2002).BCC is the strategic use of communication to promote positive health outcomes, based on proven theories and models of behavior change. BCC employs a systematic process beginning with formative research and behavior analysis, followed by communication planning, implementation, and monitoring and evaluation. Audiences are carefully segmented, messages and materials are pre-tested, and both mass media and interpersonal channels are used to achieve defined behavioral objectives.

Social and behavior change communication (SBCC) reflects a strategic shift from providing Information, Education and Communication (IEC) in order to influence individual behaviors toward a multifaceted process that addresses the broader social systems and environments that influence behavior (World Health Organisation).

4.1. Pre-requisites for M&E

The above definition helps emphasise the need for IEC/BCC/SBCC initiatives to:

- ✓ Address a "specific problem" (e.g., offering increased fluids and continuing feeding a child with diarrhoea), rather than attempt to address many problems at the same time;
- ✓ Have a clear objective; the specific behaviour to change or reinforce (Annexure 02 :- Template for project logical framework)
- ✓ Target a specific audience (Annex 03:- Rationale for selection of the community);
- ✓ Well defined beneficiary selection criteria (Annex 04:- Development of beneficiary selection criteria)
- ✓ Set a timeframe within which the results ("change in behaviour") are expected to occur.

The “problem” must be well defined, as that is what the IEC/BCC/SBCC intervention aims to address. Thorough understanding of what people do, what prevents them from following the desired practices (“barriers”) and what facilitates them (“enabling factors”) is essential before designing a communication intervention. It is obvious that this requires a detailed plan, the implementation of which needs to be monitored closely according to pre-set indicators (Annex 07:- Template for M&E metrics and Annex 08:- Performance framework), and then properly evaluated.

Only the activities following these principles and meeting the above definitions can be considered IEC/BCC/SBCC initiatives, with a higher potential to achieve the stated objective than the others. Thus, for example, the development of a poster without the following elements would not be a structured IEC/BCC/SBCC initiative: audience analysis ((Annex 03:- Rationale for selection of the community); testing; a plan with objectives (Annexure 02:- Template for project logical framework), indicators (Annex 07:- Template for M&E metrics) and targets (Annex 08:- Performance framework); a clear target audience criteria (Annex 04:- Development of beneficiary selection criteria); a distribution plan with follow-up (Annex 04:- Template for distribution list); plan for regular feedback through monitoring; and a formal evaluation.

4.2. Project registration in MEIMS

The Monitoring and Evaluation process of IEC/BCC/SBCC interventions start with the project registration in MEIMS. Respective project coordinators initiate a request for project registration with the following documents (pre-requisites) to the M&E Unit for registration of the project in MEIMS.

- ✓ Project log frame (Annexure 2)
- ✓ Project detail activity plan and budget
- ✓ Community selection criteria(Annexure 3)
- ✓ Rationale for selection of geographical locations (Annexure 5)
- ✓ Peer and peer educator selection criteria(Annexure 4)
- ✓ Project targets / Projections(Annexure 7 and 8)

The M&E Unit reviews the documents and uploads the project details in the MEIMS within 07 days of submission of the above documents in given format. The project design phase is complete only after the project registration in MEIMS and the programme unit does not begin project implementation until the registration is complete.

4.3. Client registration for IEC/BCC/SBCC interventions

The data collection process of IEC/BCC/SBCC interventions begins with client / beneficiary registration. It is recommended to register all the static clinic clients at the time of joining with the project. Unlike in service delivery interventions, IEC/BCC/SBCC intervention required more comprehensive details which includes but not limited to demographic details, knowledge, attitudes and current practices, risk behaviors, health seeking behaviors and etc. Client registration form must be prepared by a technical expert in the related field and finalised by the M&E unit. Refer annexure 25 for a sample client registration form for IEC/BCC/SBCC interventions.

At the time of registration, each client receive an identification/registration number which must be unique for a particular client and should not be duplicated (Unique Identification Code). The registration number is used to identify the client throughout the life time of the client or project and one client must receive only one number during his/her life time. The standard format for theclient registration number appears below.

Code for client registration number:

<Project code>/<year>/<client sequence number in the year>

The code development method is explained to related project staff during capacity building events. The project coordinator or data entry operator (under the supervisor of project coordinator) is responsible for management of client registration under the overall supervision of the project manager. Client registration has to be completed before reporting any interventions in the MEIMS.

4.4. Recording and reporting of IEC/BCC/SBCC interventions

The following sub topics briefly explain standard procedures for recording and reporting of different types of IEC/BCC/SBCC interventions. However, this list may not be exhaustive and present only the key IEC/BCC/SBCC approaches considering a wide range of complex SRH programmes. So, it is recommended that programme staff get the support of the M&E Unit when designing complex IEC/BCC/SBCC programmes.

4.4.1. Peer Education Programmes

Peer Education is one of the most important behaviour change approaches in a community outreach service delivery model. Peer Education is an approach to health promotion, in which community members are supported to promote health-enhancing change among their peers. Peer Education is the process of teaching or sharing health information, values and behavior in educating others, who may share similar social backgrounds or life experiences. Rather than health professionals educating members of the public, the idea behind peer education is that ordinary lay people are in the best position to encourage healthy behavior to each other. Peer Education is the most suitable and effective approaches to reach hidden or stigmatized populations including sex workers, injecting drug users and MSM.

a) Registration of peer educators

Data collection for peer education programmes begins with registration of Peer Educators in the MEIMS. The project coordinator initiates a Peer Educator registration request using the template provided in annexure 15. The M&E Unit reviews the registration request and registers the peer educators in the MEIMS within 3-5 working days of the request.

b) Peer Educator Diary

Each Peer Educator (PE) maintains a diary/record book to record daily interactions with his/her peers. The diary should be made available to the field supervisor and other project staff at all levels when requested. Field supervisors verify the peer calendars (PE monthly reports) with the peer educator diary and sign in both the peer calendar and peer educator diary before taking over the peer educator calendar.

c) Peer Educator Report / PE Calendar

Based on the daily records maintained in the diary/record book each Peer Educator fills a Peer Educator calendar (Annexure 26 standard template for PE calendar) bi-weekly. For each day, the PE records his/her daily activities in the calendar using a project specific coding system. The Peer Educators and Field Supervisors are trained on how to record data in the calendar with use of these codes. The Field Supervisor has to support PEs having literacy difficulties and ensure that the data is recorded accurately and clearly in the PE calendar. The completed calendars are submitted by the Peer Educator to the respective Field Supervisor at the end of 15 days of implementation. The Field Supervisor cross-checks the data reported in the PE calendar with the Peer Educator's daily record book/diary at the time of submission by the Peer Educator. The project coordinator or the data entry operator (under the supervision of the project coordinator) has to enter all PE calendars to the system using the template provided in annexure 12.

d) Service delivery by the Peer Educators

In some cases, peer educators get involved in service delivery (selected basic services), distribution of safe sex commodities (condoms, lubricants) among their peers and escorts their peers for uptake of Sexual and Reproductive Health services based on the individual need of the peer. However, it must be noted that peer education is not a service delivery approach. So, the peer educators must not consider as service providers unless they are especially trained to provide basic services. The information provided by the peer educators and education sessions (individual or group) should not be reported as services in the service statistic module. Standard procedures explained under community based services (CBS)/ community based distribution (CBD) must be followed for reporting of service statistics of Peer Educators.

4.4.2. Comprehensive Sexuality Education(CSE) workshops

A rights-based approach to Comprehensive Sexuality Education seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality – physically and emotionally, individually and in relationships. It views 'sexuality' holistically and within the context of emotional and social development. It recognises that information alone is not enough. Young people need to be given the opportunity to acquire essential life skills and develop positive attitudes and values. The IPPF framework for Comprehensive Sexuality Education describes seven essential components; Gender, Sexual and Reproductive health and HIV, Sexual rights and sexual citizenship, Pleasure, Valiance, Diversity and Relationships (IPPF, 2010). Comprehensive Sexuality Education must help young people to :

- ✓ **Acquire accurate information :-** On sexual and reproductive rights; information to dispel myths; references to resources and services
- ✓ **Develop life skills** :- Such as critical thinking, communication and negotiation skills, self-development skills, decision making skills; sense of self; confidence; assertiveness; ability to take responsibility; ability to ask questions and seek help; empathy

- ✓ **Nurture positive attitudes and values :-**Open-mindedness; respect for self and others; positive self-worth/esteem; comfort; non- judgmental attitude; sense of responsibility; positive attitude toward their Sexual and Reproductive Health (IPPF, 2010)

Each project develops (or adopts from existing resources) a curriculum for the CSE programme based on gender and age of the target audience. A separate questionnaire must be developed to conduct pre and post-test for training programmes. Annexure 27 provides the template for pre and post-test forms and tips to develop pre and post-test questions. Both the training curriculum and questionnaire must be developed by a technical expert in the field of Sexual and Reproductive Health. At the end of the training programme, the programme coordinator or the data entry operator (under the supervision of programme coordinator) reports the progress using the template provided in annexure 19. Details of the participants along with the pre and post-test marks are also entered to the system at the end of each CSE programme. An event / training completion report will be prepared as per the template provided as annexure 28 and shared with all stakeholders and participants.

Indicator ADL/OP/06 of FPA Sri Lanka Core Indicator Reference Guide describes more details on measuring performance of CSE programmes with essential requirements.

4.4.3. SRH Workshops

FPA Sri Lanka may conduct formal workshops and conferences on Sexual and Reproductive Health as a part of a comprehensive IEC/BCC/SBCC intervention. As explained in the section on IEC/BCC/SBCC, SRH workshops or conferences alone do not serve the purpose of IEC/BCC. SRH workshops and conferences build knowledge, change attitudes and develop necessary skills of the target audience. Even though, there are similarities, the programme staff must differentiate the SRH workshops and conferences with demand generation activities in service delivery interventions and capacity building workshops at the time of project design.

Each project develops (or adopts from existing resources) a curriculum for the workshop/ conference, based on the target audience and project objectives. A separate questionnaire must be developed to conduct pre and post-test at the beginning and end of the workshop or conference. Annexure 27 provides the template for pre and post-test forms and tips to develop pre and post-test questions. Both the training curriculum and questionnaire must be developed by a technical expert in a related field. At the end of the training programme, the programme coordinator or the data entry operator (under the supervision of programme coordinator) reports the progress using the template provided in annexure 19. Details of the participants along with the pre and post-test marks are also entered to the system at the end of each workshop/conference. An event / training completion report will be prepared as per the template provided as annexure 28 and shared with all stakeholders and participants.

4.4.4. SRH awareness sessions

SRH awareness builds awareness and sensitises the target audience on community issues, responsiveness, project objectives, and the responsibilities of community in project implementation. SRH awareness sessions are conducted in order to create an enabling environment to implement IEC/BCC/SBCC projects. In general SRH awareness sessions are implemented within less than one day. The programme staff must differentiate the SRH awareness sessions with SRH workshops / conferences, demand generation activities, and sensitization programmes of advocacy projects at the time of project design.

The Project coordinator develops an agenda for each awareness session as per annexure 23. The training curriculum and pre-posttest forms are not required for SRH awareness sessions unless there is a special project requirement. However, it is important to collect participants' feedback for future improvements (Annexure 22:- Template for participants' feedback form). At the end of the awareness session, the programme coordinator or the data entry operator (under the supervision of the programme coordinator) reports the progress using the template provided in annexure 19. Reporting participants details are not required for SRH awareness sessions unless there is a special project requirement.

4.4.5. Development and distribution of IEC/BCC materials (posters, flyers, leaflets, brochures, newsletters, booklets)

All most all IEC/BCC/SBCC interventions develop IEC/BCC materials to convey specifically developed messages to a target audience. IEC/BCC materials include, but are not limited to posters, flyers, leaflets, broachers, newsletters, booklets and leaflets. As explained in the previous section, just development of a poster without the following elements would not be a structured IEC/BCC/SBCC initiative: audience analysis; testing; a project plan with objectives, indicators and; a clear target audience; a distribution plan with follow-up; plan for regular feedback through monitoring; and a formal evaluation. IEC/BCC materials must differentiate with demand generation materials and advocacy materials at the time of project design.

The project coordinator distributes IEC/BCC materials using a distribution list. Annexure 24 provides a standard template for a distribution list. At the end of the activity, the programme coordinator or the data entry operator (under the overall supervision of programme coordinator) reports the progress in the MEIMS using the template provided in annexure 20 of this SOP. Upload a copy of the IEC/BCC material into the MEIMS.

4.4.6. Other IEC/BCC/SBCC interventions

Other than the above focused interventions, SRH projects may rally on less focused but well-planned interventions to cover a wider audience. Even though the effectiveness is relatively low in terms of behavior change, these interventions are cost effective to cover a wider audience. Table 4.1 briefly describes other IEC/BCC/SBCC interventions with reporting requirements.

Table 4.1:- Reporting guidelines for other IEC/BCC/SBCC activities

	Intervention	Reporting guidelines	Reference
01	Street drama and other open access sessions / interventions (Ex:- Mobile exhibitions)	Report the progress of the activity and output immediately after completion of the activity Collect and report feedback from selected participants	Annexure 19
02	Tele-drama, films and short films	Report as project narrative information Upload a copy of the script into the MEIMS	N/A
03	Printed media interventions (newspapers, journals and periodicals)	Report as project narrative information Upload a copy of the article into the MEIMS	N/A
04	Electronic mass media interventions (Radio / TV programmes)	Report as project narrative information Upload any relevant means of verifications / support document into the MEIMS	N/A

4.5. Mini-KAP Survey

Unlike in service delivery interventions, it is recommended to conduct periodic Knowledge, Attitude and Practices (KAP) surveys among primary beneficiaries / clients for IEC/BCC/SBCC interventions. This is considered part of routine monitoring systems rather than a comprehensive final evaluation. The mini KAP survey includes (but may not be limited to) questions to measure the following programmatic areas. A sample questionnaire / tool for mini KAP survey is provided as annexure 29 of this SOP.

- ✓ Verification of clients with client registration form
- ✓ Measure adherence to beneficiary selection criteria
- ✓ Measure interaction with the project staff and volunteers for service uptake
- ✓ Measure knowledge attitudes and practices of the client in the light of project objectives and scope of the project
- ✓ Data quality audit – Verification of reported data (for uptake of services, commodities, etc) with actual field observations for a selected period of time Eg:- One month

The general recommendation is to conduct the mini KAP survey among 10 to 20 percent

of randomly selected beneficiaries at least once in two years. Mini KAP surveys consume substantial amount of human and financial resources. So, sufficient amount of human and financial resources must be allocated at the time of project design. Practical experience of FPA Sri Lanka is that one trained interviewer can conduct 10 to 20 interviews per day (excluding travel time) based on the target community, population density, literacy level, and other practical aspects. A Mini KAP survey is conducted by the M&E Unit. The respective field staff is responsible for providing access to source documents and making suitable field arrangements.

4.6. Means of Verification / support document requirement for IEC/BCC/SBCC interventions

The means of verification tell us where we should obtain the data necessary to prove the objectives defined by the indicator have been reached. Most of the information would be available from programme documentation and survey reports. The FPA Sri Lanka Core Indicator Reference Guide describes in detail, the means of verification requirement for all standard indicators at all levels. This SOP provides means of verification that comes out from operational procedures which are mandatory requirements to ensure the improved quality of data and transparency.

Table 4.2:- Reporting requirements and means of verifications of IEC/BCC/SBCC interventions

Type of intervention	Reporting requirements	Means of Verification / Support document requirement	Reference for MoV
Peer Education Programmes	Number of peer educators in position / being active	Peer educator registration form Peer educator monthly report	Annexure 15 Annexure 26
	Number of peers served by peer educators	Peer / client registration form Peer educator daily record book	Annexure 25 N/A
	Service delivery / uptake	Peer educator daily record book	N/A
	Item distribution	Peer educator daily record book Item distribution list	N/A Annexure 24
	Escorts / Referral	Referral slip or back referral verification slip	Annexure 18
Comprehensive Sexuality Education (CSE) workshops	Number of participants who successfully completed the CSE programmes disaggregated by number of components completed	Training Curriculum	N/A
		Training agenda	Annexure 23
		Attendance sheet	Annexure 21
		Event completion report	Annexure 28
		Completed Pre-posttest forms	Annexure 27
		Participants feedback forms	Annexure 22
SRH Workshop / Conferences	Number of participants from target audience who successfully completed the workshop or conference	Workshop agenda	Annexure 23
		Attendance sheet	Annexure 21
		Event completion report	Annexure 28
		Completed Pre-posttest forms	Annexure 27
		Participants feedback forms	Annexure 22
SRH awareness sessions	Number of participants from target audience who successfully completed the SRH awareness session	Workshop agenda	Annexure 23
		Attendance sheet	Annexure 21
		Participants feedback forms	Annexure 22

Type of intervention	Reporting requirements	Means of Verification / Support document requirement	Reference for MoV
4Development and distribution of IEC/BCC materials (posters, flyers, leaflets, brochures, newsletters, book-lets)	Number of IEC/BCC materials developed	A copy of the IEC/BCC material	N/A
	Number of IEC/BCC materials distributed	Distribution list	Annexure 24
Street drama and other open access sessions / interventions (Eg:- Mobile exhibitions)	Number of sessions conducted Estimated number reached	A copy of the script	N/A
		Programme schedule	N/A
		Event completion report	Annexure 28
		Participant feedback form	Annexure 22
Tele-drama, films and short films	Number of materials developed Number of sessions broadcast	A copy of the script	N/A
		Programme schedule	N/A
		Confirmation letter from a third party	N/A
Printed media in-terventions (news-papers, journals and periodicals)	Number of interventions / sessions	A copy of the article which includes general information of the publication	N/A
Electronic mass media interventions (Radio / TV programmes)	Number of interventions / sessions	A confirmation letter from the media channel which include date/s and time/s of broadcast	N/A

5

Monitoring advocacy interventions

5. Monitoring advocacy interventions

Advocacy is a set of political actions implemented according to a strategic plan and aims to focus the attention of the community on a specific problem and guide decision makers towards a solution (IPPF, 2010). So, it is a political process by an individual or group which aims to influence decisions within political, economic, and social systems and institutions. Advocacy can include many activities that a person or organisation undertakes including media campaigns, public speaking, commissioning and publishing research or conducting exit polls or the filing of an amicus brief. Lobbying (often by lobby groups) is a part of advocacy where a direct approach is made to legislators on an issue which plays a significant role in modern politics. It has been accepted worldwide that advocacy is one area which is challenging to monitor and evaluate due to the following reasons.

1. **Contribution vs. attribution:** Since multiple actors campaign simultaneously for and against any given policy, it is difficult to ascertain attribution. Evaluating contributions is preferred in this case as it allows multiple actors to influence the degree of success.
2. **Long term nature of advocacy:** Since many advocacy goals are long term, measuring impact can be a challenge. Instead, outcomes, interim progress, and intermediary goals are the preferred measures of influence. Measurement of process indicators is important in advocacy.
3. **Shifting strategies:** Since the context that advocates work within is ever-changing, advocates adapt their strategies, which create a difficult environment in which to monitor progress.
4. **Complexity and theories of change:** logic models and theories of change for advocacy campaigns are inherently complex; for example: protests+lobbying+media campaigns -> contribution to policy change. These kinds of theories of change have so many layers, nuances, and uncontrollable factors to them that intra and inter organisational agreement is difficult, making strategic planning, and evaluation all the more challenging.

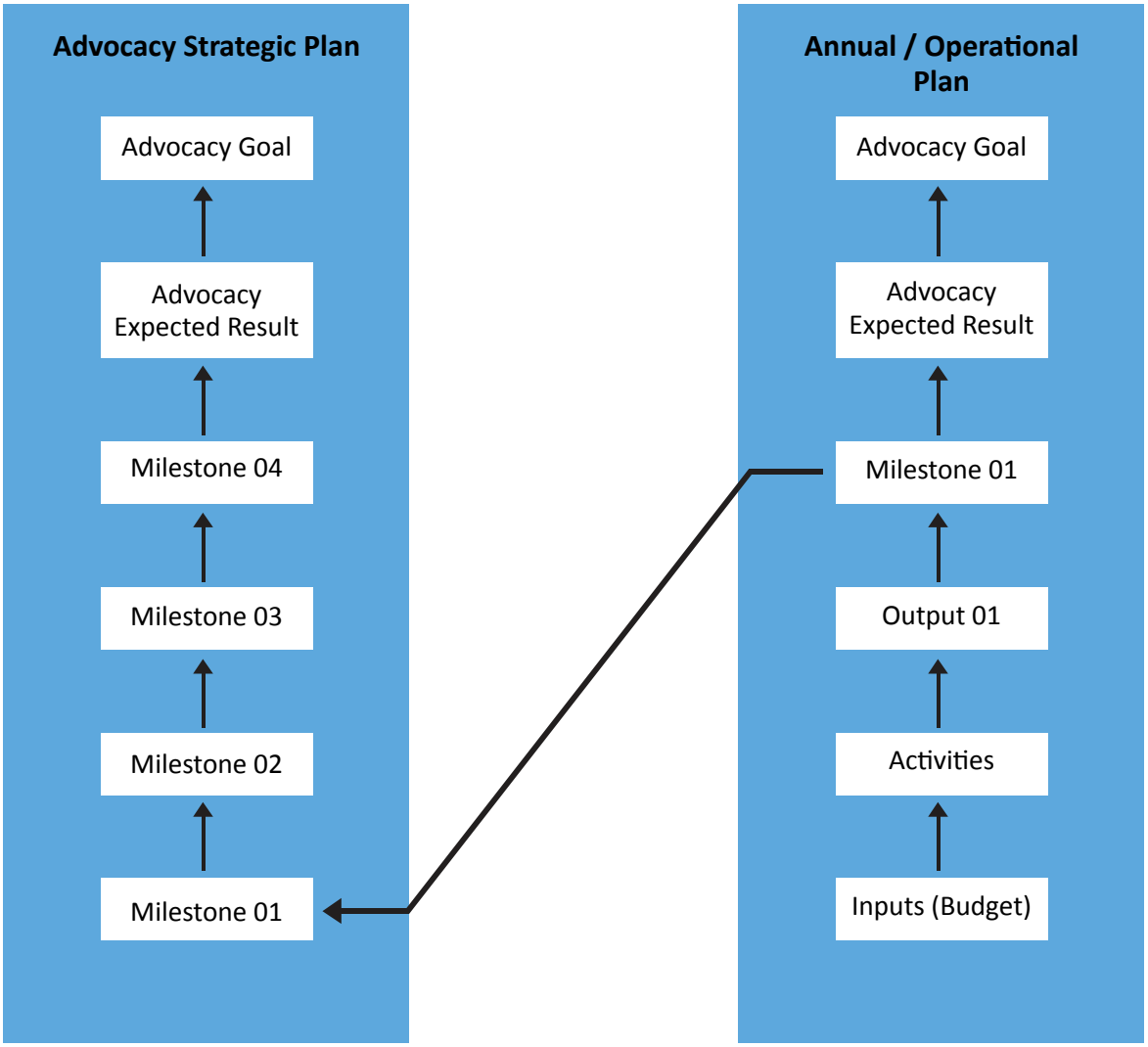
5.1. Advocacy planning and Pre-requisites for M&E

As described earlier, the term advocacy must be identified as a series of activities aiming at bringing about sound political and legislative change that will benefit the population. Advocacy is different from other strategies such as IEC, BCC, SBCC, demand generation and social mobilisation. IPPF has introduced (in 2010) a comprehensive advocacy model which includes advocacy planning, strategies for implementation of advocacy activities, strategies to maintain the accountability and institutional development strategies. The IPPF advocacy planning model which describes all the steps of advocacy planning is the most important part of the comprehensive advocacy model. FPA Sri Lanka uses the advocacy planning model introduced by the IPPF for planning of advocacy projects. Recognising the world accepted fact that any legal and political change is unlikely to happen unless there is a comprehensive plan for advocacy; FPA Sri Lanka expects all the advocacy initiatives to be started only after completion of the following advocacy planning steps. Figure 5.1 illustrates the chain of results that comes out from the advocacy planning process.

Table 5.1: Components for advocacy planning

	Description	An Example
Information gathering	Collect all the information required for advocacy planning and use it for planning and defining advocacy programmes.	N/A
Definition of the problem	Identify the topic or question that might be solved or improved through a specific political change. Problem analysis includes analysis of current policies which effect the problem	Annexure 06.1 (a,b,c and d)
Stakeholder analysis	Stakeholder analysis in advocacy planning is the process of identifying the individuals or groups that are likely to affect or be affected by the identified problem and sorting them according to their impact on the action and the impact the action will have on them. This information is used to assess how the interests of those stakeholders should be addressed in the advocacy project and policy.	Annexure 06.1 (e)
Definition of the advocacy expected results and milestones	Clearly specify the political (or legal) change that will be promoted by means of the advocacy project, as well as the decision maker who will constitute its target audience. Identify and clearly describe milestones for achievement of advocacy expected result.	Annexure 06.2 (a, b, c, d, e, f)
Organisational self-assessment	Identify the organisations' strengths, weaknesses, opportunities and threats regarding the achievement of advocacy expected result.	N/A
Audience analysis	Determine target (primary) and secondary audiences. Assess their power level; position regarding the advocacy expected result and interest in achieving it.	Annexure 06.3 (a and b)
Development of the advocacy project	Define the basic components of an advocacy project at operational level Eg:- Project goal, advocacy expected result, milestones, objectively verifiable indicators, detail action plan and budget.	N/A
Political analysis	Reach a thorough understanding of the political setting where the project will be implemented.	N/A

Figure 5.1:- Chain of results to develop advocacy plans; Linkage between the strategic plan and operational or annual project plans.



5.2. Uploading advocacy plans into the MEIMS

As described earlier, a properly designed advocacy plan is the basis for monitoring and evaluation of advocacy initiatives. As explained in the figure 5.1, the link to an advocacy strategic plan must be clearly explained in the advocacy operational plans (annual plans). Data collection process of advocacy initiatives starts with the registration of the advocacy plan (which includes the strategic plan as well as the operational plan) into the MEIMS. The project coordinator initiates a request to register the advocacy plan in the MEIMS once the plan is finalised and agreed on. The advocacy plan must be prepared as per the template provided in annexure 06 of this SOP.

Then, M&E unit review and upload the advocacy plan in to the MEIMS. Advocacy plans in the system can be edited within first three months after which the system will be closed for any further editing. Once the advocacy plan is uploaded in MEIMS, respective programme unit prepare advocacy operational planes in consultation with other supportive units. Ex: - M&E unit, Finance unit

Once the operational plans are finalised, the respective programme coordinator initiate a request to upload the operational plan in MEIMS. Operational plan includes, but may not be limited to,

- ✓ SMART objectives and a project design with a clear chain of results from inputs (budget) through activities to strategic objectives (Advocacy Expected Results, Milestone in strategic plan) as illustrated in figure 05.1.
- ✓ Key performance indicators and targets
- ✓ Detailed activity plan with time frame
- ✓ A realistic budget

5.3. Advocacy databases

FPA Sri Lanka recognises that well managed information systems are the key to success in advocacy activities. Considering the long term nature of advocacy initiatives, all related databases must be properly maintained and updated with accurate data in order to keep a track of changes in political and legal environment. Other than that, a well-managed system of advocacy data facilitates smooth operation of project activities especially at the time of staff turnover. So, it is expected for all staff members who handle advocacy projects to maintain the following databases (see table 5.2) with accurate information. These data bases are available in MEIMS and are integrated with other components of the advocacy module.

Table 5.2: Advocacy databases and guidelines to maintain the database

	Description	Template
Advocacy audience database	This database provides all the information related to advocacy audiences (primary and secondary) which are identified at the planning stage and thereafter.	Annexure 30.1 (a and b)
Advocacy partner database	This database manages all related information of advocacy partners for each AER	Annexure 30.2
Mass media database	This database manages all related information of mass media personal and organizations	Annexure 30.3
Participants log	This database manages all related information of participants for advocacy activities and their stand on AER and tracks changes over time	Annexure 30.4

5.4. Reporting and documentation of advocacy activities

Once the advocacy strategic plan and operational plans are uploaded in the MEIMS and finalised, MEIMS will be opened for reporting the progress and achievements of advocacy activities. Advocacy activities must be reported in the system by the programme coordinator (or by the data entry operator under the supervision of the programme coordinator) in an agreed format, as and when the activity is completed. Table 5.2 summarises different types of advocacy activities with their reporting guidelines. Further, table 5.2 provides links to relevant reporting templates that the report must adhere to.

Table 5.3:- Advocacy activities and reporting guidelines

Advocacy activity	Reporting guidelines	Reporting templates
Policy Brief	Report the activity completion and achievements within 05 days of completion of the activity.	Annexure 31.1
Sensitisation programmes	Report the activity progress and number of participants within 15 days of completion of the activity. Completion of the participant log and commitment scores based on the commitment sheets completed by the participants are required	Annexure 31.2 Annexure 30.4 Annexure 32
Media workshop / Press conference	Report the activity progress and number of participants within 15 days of completion of the activity. Completions of the participant log and commitment scores based on the commitment sheets completed by the participants are required. The direct and immediate outcomes of the activity (Eg:- newspaper articles published, TV/Radio programmes broadcast) must be reported (separately) within 3 months of implementation of the activity using templates provided. Upload a scanned copy of the newspaper article in the MEIMS in PDF format.	Annexure 31.3 Annexure 30.4 Annexure 32 Annexure 31.10
Lobbying / One-on-one meeting	Report the activity progress and number of participants within 05 days of completion of the activity. Completion of the participant log and commitment scores (based on the perceived commitment) of the participants are required	Annexure 31.4 Annexure 30.4
Focus group discussions	Report the activity progress and number of participants within 05 days of completion of the activity. Completion of the participant log and commitment scores (based on the perceived commitment) of the participants are required	Annexure 31.5 Annexure 30.4
Consultative meetings	Report the activity progress and number of participants within 15 days of completion of the activity. Completion of the participant log is required.	Annexure 31.6 Annexure 30.4
One minute message	Report the activity progress and number of participants within 05 days of completion of the activity. Completion of the participant log and commitment scores (based on the perceived commitment) of the participants are required	Annexure 31.7 Annexure 30.4
Fact sheet	Report the activity progress within 10 days of completion of the activity. Upload a soft copy of the fact sheet in the MEIMS in PDF format.	Annexure 31.8

Advocacy activity	Reporting guidelines	Reporting templates
Advocacy materials	Report the activity progress within 10 days of completion of the activity. Upload a soft copy/ copies of the advocacy material/s in the MEIMS in PDF format.	Annexure 31.9
Newspaper articles / press release	Report the activity progress within 10 days of completion of the activity. Upload a scanned copy of the newspaper article in the MEIMS in PDF format.	Annexure 31.10
TV / Radio Programmes	Report the activity progress within 05 days of completion of the activity.	Annexure 31.11
Tele-drama or street drama	Report the activity progress within 10 days of completion of the activity. Upload a scanned copy of the newspaper article in the MEIMS in PDF format.	Annexure 31.12
Advocacy campaigns	Report the activity progress within 10 days of completion of the activity. Upload support documents and other advocacy materials used for campaign in the MEIMS in PDF format.	Annexure 31.13

5.5. Data collection procedures to measure the changes over time

The political and legal environment of the country/society where the advocacy activities are being implemented is highly dynamic in nature. Most of the legal and political changes are led by the attitudes and opinions of the community / stakeholders. Some of these attitudes of the audience, legal and political changes can be attributed as direct outcomes of advocacy activities, but some are not. However, irrespective of the cause, any attitudinal change of the people of advocacy audiences and any changes to the political and legal environment of the country affect favorably or unfavorably the implementation of advocacy activities of the organisation and achievement of advocacy expected results. Hence, a good advocator always collects information identified by the above changes that happen over time and takes responsive action to obtain advantage from the environmental changes. FPA Sri Lanka M&E system utilises these programmatic data to measure the achievements of the interim targets of the operational projects at outcome level. Further, this provides alerts for programme personal to take remedial action at the first opportunity to avoid a negative impact. So, collection of information / data and reporting as and when the information is collected is important for smooth implementation of advocacy projects. Table 5.4 provides guidelines for data collection to measure changes in the social, political and legal environment.

Table 5.4:- Data collection requirements to measure changes in the social, political and legal environment

	Requirement and Reporting guidelines	Template
Commitment sheets	Measuring and monitoring the attitudinal changes of the primary and secondary audience of the advocacy initiatives is one of the most important aspects of advocacy initiatives. Commitment sheets completed by the key personal in primary and secondary audience provide data on attitudinal changes over time which can be utilised to steer the project (Development of advocacy messages, organizing campaigns, etc). Commitment sheets are distributed at the end of the sensitization programme, media workshops and consultative meetings and entered into the MEIMS within 15 days of completion of the activity. The data entry operator is responsible for updating thesystem under the supervision of the respective project coordinator.	Annexure 32
Newspaper articles or press release	All newspapers articles (favorable and unfavorable) related to the advocacy issue and advocacy expected result are collected and report in the MEIMS as a routine activity. Upload a scanned copy of the newspaper article in the MEIMS in PDF format. The data entry operator is responsible for updating the system under the supervision of the respective project coordinator. The system must be up to date before preparation of quarterly progress reports.	Annexure 33.1
TV or Radio Programme / News	All TV and Radio programmes (favorable and unfavorable) related to the advocacy issue and advocacy expected result are collected and reported in the MEIMS as a routine practice. The data entry operator is responsible for updating the system under the supervision of the respective project coordinator. The system must be up to date before preparation of quarterly progress reports.	Annexure 33.2
Public speeches	Information on public speeches (favorable and unfavorable) conducted by the key personal in primary and secondary advocacy audiences is collected and reported in the MEIMS as a routine activity. The data entry operator is responsible for updating the system under the supervision of the respective project coordinator. The system must be up to date before preparation of quarterly progress reports.	Annexure 33.3
Legislative and policy changes	Information on legislative and policy level changes which are related to the advocacy issue and advocacy expected results are collected and reported in the MEIMS as a routine practice. Upload a scanned copy / soft copy of the legislative change in MEIMS as a support document. The system must be up to date before preparation of the quarterly progress report.	Annexure 33.4

5.6. Progress update of the strategic objectives

As explained earlier, since many advocacy goals are long term, measuring impact can be a challenge. Instead, outcomes, interim progress, and intermediary goals are the preferred measures of influence. On the other hand, since the context that advocates work within is ever-changing, advocates adapt their strategies, which create a difficult environment in which to monitor progress. So, it is important to report the progress of strategic objectives (Achievement of advocacy expected results and milestones) every year, before the 15th of January of the following year. FPA Sri Lanka uses these details along with activity level progress to complete the IPPF global indicators survey which takes place every year. Please use the template provided in annexure 36 to report annual progress update in the MEIMS.

5.7. Means of verification / Support document requirement for advocacy interventions

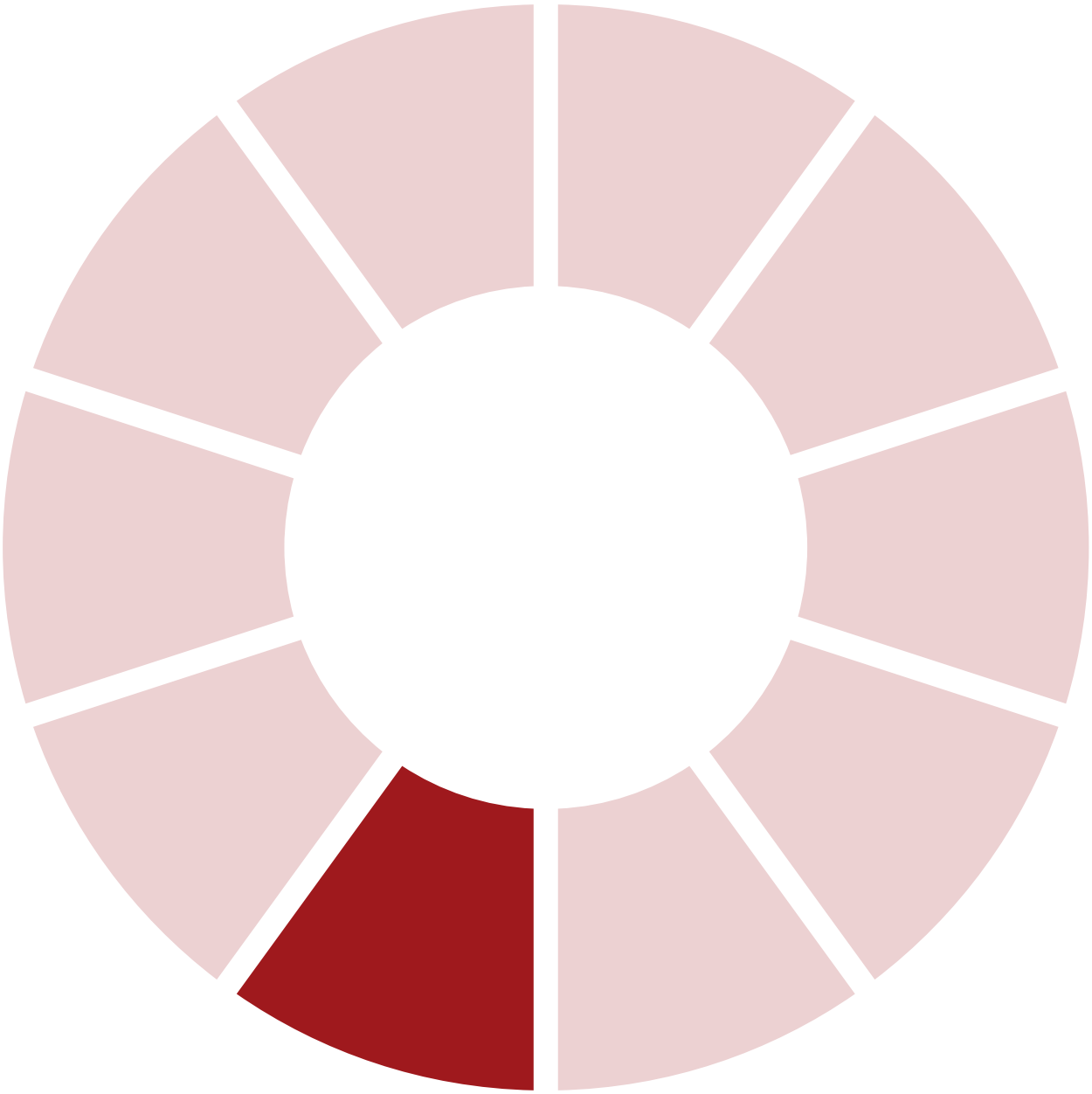
As explained earlier, since multiple actors' campaign simultaneously for and against any given policy, it is difficult to ascertain attribution. Evaluating contributions is preferred in this case as it allows multiple actors to influence the degree of success. Unlike other types of interventions (Ex: - IEC/BCC, Service Delivery) where mostly, one party conducts interventions, demand for programme documentation is comparatively high for advocacy interventions. Support documents facilitate evaluating the contribution of the organisation for legislative changes that the country has achieved and enhances transparency.

The means of verification tell us where we should obtain the data necessary to prove the objectives defined by the indicator have been reached. Most of the information would be available from programme documentation and survey reports. FPA Sri Lanka Core Indicator Reference Guide describes in detail the means of verification requirement for all standard indicators at all levels. This SOP provides means of verification that comes out from operational procedures which are mandatory requirements to ensure the improved quality of data and transparency.

Table 5.5:- Reporting requirements and means of verifications of IEC/BCC/SBCC interventions

	Means of verification / Support documents	Template
Advocacy activities		
Policy brief	Workshop agenda	Annexure 23
	Attendance sheet	Annexure 21
	Feedback forms	Annexure 22
Sensitisation Programmes	Workshop agenda	Annexure 23
	Attendance sheet	Annexure 21
	Commitment sheets	Annexure 32
	Event completion report	Annexure 28
Media Workshop / Press conference	Workshop agenda	Annexure 23
	Attendance sheet	Annexure 21
	Commitment sheets	Annexure 32
	Event completion report	Annexure 28
Lobbing / One- on-one meeting	One to one meeting log	Annexure 34
Focus group discussion	Attendance sheet	Annexure 21
	Focus group discussion log	Annexure 35
Consultative meetings	Meeting agenda	Annexure 23
	Attendance sheet	Annexure 21
	Feedback forms	Annexure 22
	Meeting minutes with evidence of sharing with the participants and other relevant parties	N/A
One minute message	Meeting log	Annexure 34
	Any other relevant support documents (follow-up e-mail correspondents, etc)	N/A
Fact sheet	Original copy of the fact sheet	N/A
	Distribution list	Annexure 24
Advocacy materials	Original copy of the advocacy materials	N/A
	Distribution list	Annexure 24
Newspaper articles / Press release	Newspaper article (Full page which includes the article, name of the publisher, name of the author, date and volume number)	N/A
TV/Radio Programmes	A copy of the programme	N/A
	A letter of acknowledgment / confirmation from the channel	N/A
	Any other relevant support documents (e-mail correspondents, etc)	N/A
Tele-drama / Street drama	Drama script	N/A
	Letter of approval to conduct the street drama	N/A
	Any other relevant support documents (e-mail correspondents, etc)	N/A

	Means of verification / Support documents	Template
Advocacy campaigns	Any relevant support document to confirm the activity progress and the achievements Eg:- E-mail correspondence Letters from third party Copies of the advocacy materials used for the campaign Attendance sheets Social media activity log Photo gallery	N/A
Social, Political and Legislative changes		
Newspaper articles / Press release	Newspaper article (Full page which includes the article, name of the publisher, name of the author, date and volume number)	N/A
TV/Radio Programmes	Any relevant support document (optional)	N/A
Public Speech	Any relevant support document to confirm the activity progress and the achievements Eg:- Hansard reports, Newspaper articles Third party organisational web sites	N/A
Legislative changes	A copy of the legislative, policy or programme change /amend-ments, etc.	N/A



6

Cross-cutting and support activities

6.1.	Capacity building programmes / Training and development programme
6.2.	Development of organisational policies, tools, guidelines and procedure manuals
6.3.	Operational research and studies
6.4.	Reporting project lesson learnt
6.5.	Documentation of stories of change and case studies
6.6.	Field supervision and Supervisory field visits
6.7.	Other programmes and events
6.8.	Financial reporting and monitoring at project level
6.9.	Income generation activities

6. Cross-cutting and support activities

Chapter 3, 4 and 5 of this Standard Operational Procedure manual covers the standard operational procedures for routine project monitoring aspects of the following key areas of interventions.

- ✓ Service delivery interventions
- ✓ IEC/BCC/SBCC interventions
- ✓ Advocacy interventions

Activities such as capacity building, planning meetings with stakeholders, field supervision and supervisory field visits, financial monitoring at project level, operational research and studies, etc. were identified as common areas / sub-interventions of the above major interventions. So, those common sub-interventions were not discussed in the above three chapters to avoid duplication and repetition. Further, this chapter describes the routine monitoring procedures of organisational support activities such as resource mobilisation / income generation

6.1. Capacity building programmes / Training and development programme

Capacity building is an ongoing process through which individuals, groups, organisations and societies enhance their ability to identify and meet development challenges. It is an inevitable sub section of any development initiative such as service delivery, IEC/BCC, advocacy. FPA Sri Lanka recognises in its' HR policy, capacity building of the staff as a long term investment rather than an expense to the organisation. However, unplanned and loosely focused capacity building interventions do not contribute to achieve organisational objectives and waste staff time and organisational resources.

In general, any capacity building (or training and development) programme starts with a comprehensive exercise on capacity gap analysis, capacity building need assessment and plan of action. Capacity assessment and plan of action must include but may not be limited to,

- ✓ Capacity gap analysis
- ✓ Capacity building need assessment
- ✓ Costed plan of action with long term focus (at least three years)
- ✓ Projected improvement at programmatic level (Eg:- Service delivery, implementation of advocacy interventions, project implementation, etc) with verifiable indicators
- ✓ Follow-up actions and way forward

FPA Sri Lanka encourage its' programme arm to conduct capacity gap analysis and training need assessment as a participatory process with a long term focus to align with the strategic objectives of the relevant unit / department. Just doing a training programme without a capacity assessment and plan of action is not considered as a capacity building programme.

Data collection for capacity building programmes starts with registration of the project in the MEIMS. The respective programme coordinator / project manager initiates a request to register the capacity building project (this can be a sub section of a large project/intervention) in the MEIMS with the following documents.

1. Capacity building need assessment and gap analysis
2. Capacity building plan of action and budget for the current year
3. Performance indicators and projections

The above documents are considered as pre-requisites for the M&E of capacity building initiatives. The M&E Unit is responsible for uploading the capacity building project in the MEIMS. The respective officer at the M&E Unit reviews the document and uploads the project in the MEIMS within 5-10 working days. Just after completion of the training programme or activity, the respective programme coordinator (or data entry operator under the supervision of the programme coordinator) reports the progress in the MEIMS using the template provided in annexure 19 within 15 days of completion of the activity. If programmes are conducted on two consecutive days or more, the details of the participants are entered into the MEIMS using the template provided in annexure 30.4. Further, it is expected that the relevant programme officer maintains the support documents described in the table 6.1 as means of verification.

Table 6.1:- Support document / means of verification requirement for training programmes

	Programme type	Standard Template
Programme agenda	All programmes	Annexure 23
Training manual	For the training programmes conducted two days or more	N/A
Attendance sheet	All programmes	Annexure 21
Participants' feedback forms	All programmes	Annexure 22
Pre-test and post-test forms	For the training programmes conducted two days or more	Annexure 27
Training / Event completion report	For the training programmes conducted two days or more	Annexure 28

6.2. Development of organisational policies, tools, guidelines and procedure manuals

FPA Sri Lanka expects its programmatic arm to develop relevant policies, tools, guidelines and procedure manuals for smooth operation of its programmes. All staff and partners are expected to adhere to these standards in all business activities once agreed and approved by the relevant authorities. All these documents are initially developed in English and translated to local languages based on the requirement and are widely shared with all relevant stakeholders. FPA Sri Lanka recognises that any policy, tool, guideline or procedure manual developed must have clearly defined objectives, costed plan of action for implementation with responsible unit/s or personnel and plans for follow-up.

The respective project coordinator reports the progress of the activity using the template provided in annexure 20 of this SOP. Further a soft copy of the finalised document is uploaded into the MEIMS. A finalised copy of the document with approval of the relevant authoritative body is considered as a support document / means of verification.

6.3. Operational research and studies

The success of any development intervention depends on the availability of strategic information as and when required. So, FPA Sri Lanka expects its' programme units to develop and design all interventions (service delivery, IEC/BCC, advocacy) based on scientific evidences. FPA Sri Lanka conducts scientific studies and research to develop a knowledge base to implement its' activities.

At the end of the research study, the respective programme coordinator reports the progress of the activity using the template provided in annexure 37 of this procedure manual. Further, a soft copy (pdf version) of the finalised research paper is uploaded into the MEIMS.

Completed data collection tools, ethical approval letter from a recognised technical body, completed consent forms, final research paper and original copies of publication (if peer reviewed) are considered as support documents or means of verification.

6.4. Reporting project lesson learnt

"Relying on luck is not a viable project strategy; however, this is what we do when we ignore lessons learned." (Duncan Haughey). So, FPA Sri Lanka recognises lesson learnt as a smart tool for organisational learning and knowledge management rather than as a one-time reporting activity as a donor requirement. The purpose of lessons learned is to bring together any insights gained during a project that can be usefully applied during future projects. Lessons learned can make all the difference in future projects and help them succeed, but first, they must be documented correctly.

So, FPA Sri Lanka expects all relevant project staff to capture and document the lesson learnt at the end of the project period (for CORE projects, it is end of the year). Lesson learnt must include, but may not be limited to (International Planned Parenthood Federation, eIMS),

- ✓ **What are the main achievements?** – Please provide the main achievements of the project. These should include significant outputs, key areas of success, performance and/or progress made.

- ✓ **What worked well? Why?** – Please provide information on specific project strategies, approaches and/or processes that worked well and thus contributed to the main achievements of the project. The reasons why they worked well may be internal (for example, low staff turnover, strong planning, monitoring and evaluation etc.) or external (strong levels of community participation, national government support etc.)

- ✓ **What did not work so well? Why?** – Please provide information on specific project strategies, approaches and/or processes that did not work well. The reasons why they did not work well may be internal (for example, poorly trained staff, high staff turnover etc.) or external ((funding arrived late, community resistance to project etc.).

- ✓ **What will you do differently in future as a result of this learning?** – Based on both the positive and negative experiences from the project, please provide information on how the lessons learned will be applied to this and/or other projects in the future.

6.5. Documentation of stories of change and case studies

Case studies are one technique that can be used as a tool to measure the qualitative changes at individual, community or organisational levels. Case studies typically examine the interplay of all variables in order to provide as complete understanding of a person, an event or situation as possible. This type of comprehensive understanding is arrived at through a process known as thick description, which involves an in-depth description of the case being studied, the circumstances under which it is used, the characteristics of the people involved in it, and the nature of the community in which it is located.

As an organisation which is engaged in much social activities, FPA Sri Lanka has to deal with these kinds of qualitative information collection techniques to capture and communicate the change at individual and community level. Due to the confidential and sensitive nature of the SRH field, most of the time only the front line workers (service providers, peer educators, volunteers , field supervisors) of the organisation get a chance of exposure to the real issues and situations at a personal level. In a situation where the involvement of a third party is limited, it is obvious that the capacity building of the front line staff to capture and document case studies is important. The Monitoring and Evaluation Unit conducts a series of 'training of trainers programme' to build the capacity of the programme staff to capture stories of change.

FPA Sri Lanka expects all programme units to motivate their front line staff (service providers, community health assistants, peer educators, youth leaders, etc.) to capture stories of change from all the interventions that they are implementing and document them in any language (English, Sinhala or Tamil). Completed case studies are required to be uploaded into the MEIMS with the name, designation and contact information of the author. The correct name or any other contact information of the subject must not be mentioned in any write up of any case (even with consent) considering the privacy and confidentiality of the personal information.

The M&E Unit utilises case studies to support quantitative data submitted by the programme units at periodic evaluations using qualitative analysis techniques. Eg:- most significant change Communication unit / experts may use case studies available in the MEIMS to develop audience specific corporate communication messages to showcase FPA Sri Lanka activities. Eg:- FPA Sri Lanka Puwath, FPA Sri Lanka annual report, e-newsletters, website, etc. the Advocacy Unit and other programme units may use the case studies available in the MEIMS for sensitisation programmes, donor reporting, etc as and when required. In any case, it is required to acknowledge the initial author of the case study, as and when the case study is published.

6.6. Field supervision and Supervisory field visits

Field supervision is considered as an important role of senior staff attached to the programme and operational units. Adherence to donor and organisational compliance such as quality of care, supply and management, financial and administrative aspects, human resource utilisation, volunteer engagement etc. are closely supervised and remedial actions are taken during supervisory field visits. Senior project implementation staff at head office level attached to all operational units will conduct regular field supervision visits with/without prior notification to the field staff in order to ensure smooth operation of the programme / projects at grass root level. These Field Supervisory visits will focus on the following key areas at field level.

- ✓ Conduct meetings with staff of the SDPs / field offices / partners to identify key challenges and threats to the smooth operation of project activities
- ✓ Check project documentation at SDPs / field offices / partners including attendance sheets, minutes of meetings, logistics including distribution of contraceptives, maintenance of stocks, client registers, client history forms, etc.
- ✓ Conduct meetings with secondary project implementers such as volunteer health assistants, Peer Educators, youth leaders etc. and check their daily record books, distribution of condoms, payments and validation of records submitted by the SDP / field office / partners.
- ✓ Visit static, mobile and associated clinics and interview randomly selected clients in order to assess the quality of the service provided to the clients.
- ✓ At the end of the supervisory visits, the person who conducted the field visit must share the positive points, gaps, key improvement possibilities, challenges, and recommendations with the staff at the SDP / field office / partners being assessed, head of the unit, respective M&E officer, finance unit and other relevant key stakeholders. Please use the template provided in annexure 38 of this Standard Operational Procedure manual.
- ✓ It is the responsibility of the staff at the SDP /field office / partners being assessed to respond to field visit reports, in case there is any discrepancy with the field situation or reports being impractical/not practicable. Otherwise it is considered as a document agreed to by all parties
- ✓ The recommendations provided and agreed to in the supervisory visit reports will be followed up at the next respective field visit and progress review meetings.

6.7. Other programmes and events

Any other programmes and events such as planning meetings, mobile exhibitions etc. which this SOP has not specifically mentioned, should be reported using the template provided in annexure 19. All these activities are not specifically mentioned and listed-out in this SOP to avoid duplication and to keep the document brief. However, the programme staff must consult the M&E Unit when reporting progress of the other type of events which this SOP has not specifically mentioned. The means of verification / support document required for these programmes may vary depending on the indicators. However the exact means of verification requirement should be mentioned in the log frame (annexure 02) at the time of project design.

6.8. Financial reporting and monitoring at project level

The organisational financial management procedure has been described in the FPA Sri Lanka financial and procurement manual in detail. This SOP describes the routine financial information requirement for project monitoring and management. The following sub topics describe the specific requirement for financial reporting for project management, monitoring and evaluation.

6.8.1. Burn Rate

The burn rate of any project is defined as the rate at which the project budget is being burned (spent) during the reporting period. As described in FPA Sri Lanka Monitoring and Evaluation Policy, the monthly financial status of income and expenditure report shall be

produced by the Finance Unit (FU) for each Centre/Unit/SDP which will consolidate the information to depict the financial picture and disseminate to all Programme Managers. The MEIMS has been developed to facilitate the monthly financial reporting through the system.

6.8.2. Cost effectiveness analysis

As much as practically possible, activity monitoring and financial monitoring shall be linked and formatted for collection of the information and reporting shall be developed in consultation with all stakeholders (FPA Sri Lanka Monitoring and Evaluation Policy). Analysis of cost effectiveness is one such important analysis where the inputs of both programmatic and finance data are required. So, the Finance Unit is required to provide the necessary financial figures to the M&E Unit to conduct periodic evaluations and cost effective analysis. Ex: - Branch comparison analysis as described under service delivery interventions.

6.8.3. Financial figures as the progress of the specific indicator

Apart from that, financial figures /reports (Eg:- Income, Income over expenses, Cost recovery radio) are utilised to measure the progress of some specific indicators. Most of the income generation and resource mobilisation activities require finance related indicators to measure the success. So, the Finance Unit (FU) is required to provide inputs to report these indicators at pre agreed intervals. Audited accounts and the finance system are considered as the means of verification of the progress of the indicator.

6.9. Income generation activities

Generating income is more than fundraising. It is about making the organisation sustainable by establishing a range of funding (diversifying your sources of income), so that the organisation is not dependent on one source. The income generation plan must ensure that:

- ✓ The organisation raises sufficient level of income to enable the organisation to deliver the services that meets organisation's mission, while covering all costs incurred.
- ✓ The organisation has taken into account any restrictions imposed by funders on how the organisation can apply the funds received.
- ✓ The organisation has a sufficiently diverse source of income to avoid the high level of risk associated with dependence on one source.

Sustainability ideally means managing the income streams in such a way that if or when one stream comes to an end, the work can be repositioned, making it suitable for funding by another stream. Opportunities available to diversify income streams range from donations and grants to service level agreements or contracts to deliver services, to trading in goods and services. Diversification also has costs associated with it, such as increased management effort. The organisation must therefore recognise at what point the benefits of diversification are outweighed by costs.

FPA Sri Lanka is currently engaged in several in-house income generation activities such as the social marketing programme, Chinthana training centre, SRH institute and Centre for Family Health in addition to the donor funds. The reporting templates for each income generation activity may differ from others depending on the process involved. However, one similarity of reporting is that all income generation projects must report their income and expenses to the M&E Unit at pre-agreed interval. The M&E unit verifies the data with financial reports as explained in the section 6.8.3.

7

Data management process

7. Data management process

"Without a good data management system, there can be no Monitoring and Evaluation (M&E). A comprehensive data management system is one aspect of an M&E plan that often gets overlooked, and as a result, many good M&E plans will quickly come undone. Your M&E system is as good as your data management system!". Managers are hired to make effective decisions leading to efficient performance of activities and optimal achievement of an organisation's output, goals, and mission. Managers rely heavily on both formal channels of communication and informal channels in their organisations as sources of data to arrive at these decisions. Functionally, an effective management information system supports monitoring, supervision, evaluation, operations research, resource allocation, and performance appraisals. An MIS is a set of processes or a system designed by organisations to collect, tabulate, and interpret data and information in an organised manner to provide a comprehensive picture of the services a programme renders and to guide management decisions.

With this focus, FPA Sri Lanka developed a Management Information System (MIS) to collect, analyse and report data relating to key performance indicators called Monitoring and Evaluation Information Management System (MEIMS). Responsibility for development and administration of the MEIMS is borne by the Monitoring and Evaluation Unit of FPA Sri Lanka. Further, FPA Sri Lanka Monitoring and Evaluation system depends on the Management Information Systems administrated by other programme and support units. For example the M&E function requires inputs from the Financial Management system, Human Resource Management system, Logistic Management system and Sale Force Automation system. These systems are administered by the respective operational units. However, the administrators of these systems must provide limited access to M&E staff on 'need basis' to capture relevant data for Monitoring and Evaluation of organisational activities. FPA Sri Lanka focuses on integrating these management systems at a later stage to enable smooth operation of organisational activities.

7.1. Data collection and aggregation

FPA Sri Lanka M&E system is always focused on collecting raw data which facilitates automated data aggregation and report generation. With its' long term focus on developing a donor / project independent organisational data management system, FPA Sri Lanka M&E system has developed all most all reporting templates described in previous chapters in the MEIMS. Data aggregation and reporting is automated to the extent of being able to create user friendly and live software.

MEIMS is a web based, open source, centralised application where the users can enter data from any location in the pre-agreed format. Relevant reports have been prepared for use of data quality verification and evidence based decision making. Procedures (guidelines) for data aggregation / analysis are presented for all the key performance indicators in Monitoring and Evaluation Core Indicator Reference Guide (2014).

7.2. User administration

FPA Sri Lanka focal person for Monitoring and Evaluation or a junior person with delegated authority under the overall supervision of M&E focal person may act as the administrator of the MEIMS. MEIMS is developed with role based authentication facilities to maintain privacy and confidentiality of the data entered into the system. Role maintenance, user maintenance, project maintenance and other key system administration roles are conducted only by the administrator.

7.2.1. Activation and inactivation of MEIMS users

All staff who needs access to the M&E system must submit an application form to the M&E unit with the approval of the respective unit head or junior staff member who has delegated authority of the unit head. If the applicant is a head of a unit, the Executive Director must authorise the application form. Then, the system administrator creates a user account for the applicant with necessary roles for data entry screens and/or reports. The roles which the MEIMS users receive are decided by the system administrator or the M&E focal person based on the job role of the applicant. However, the Executive Director can take the final decision for any exceptional reason on a case to case basis.

After resignation/transfer or end of the project, the respective head of the unit or a person with delegated authority of the unit head must initiate a user in-activation request. However, the system administrator can deactivate the user account, if the M&E unit comes to know that the user is no longer using the system to maintain the privacy, confidentiality and quality of the data available in the system.

7.2.2. User responsibility agreement statement

All the MEIMS users are required to agree on the below user responsibility agreement statement prior to commencement of use.

“I am responsible for log on/log off, all actions pertaining to the use of my assigned log on ID, and will not provide my log on ID to another person, for any reason. I know that I am responsible for all the actions and transactions that will be take place using the log on ID assigned to me. I agree that, I will use all the information in the M&E information management system only for FPA Sri Lanka business purposes and will not use it for any other purposes and will not provide any information in this system to any person outside of the organisation without prior-approval from the Executive Director”

It is strongly recommended for all the users to re-set the password during the first log in and change the password every three months thereafter. Using a strong password will enhance the password protection strength.

7.3. System administration

FPA Sri Lanka Information Technology (IT) unit is responsible for all functions (described below) related to administration of the MEIMS system. All the system administration requirements described in the FPA Sri Lanka IT policy is applicable for MEIMS also.

7.3.1. System maintenance, up-time and front line service

System maintenance can be done either internally by the IT unit or by an outsourced company / consultant under the overall supervision of the IT unit. The IT unit is required to allocate a sufficient amount from the budget for maintenance of the MEIMS. However, for restricted donor funded projects, a special budget line must be allocated to cover the additional cost of system maintenance.

The MEIMS must function during the working hours of FPA Sri Lanka both at FPA Sri Lanka premises and outside (through internet). However, the M&E unit may require a 24x7 up time, if there is a special project operating where outside users require accessing the system even after office hours. If the IT unit is required to 'down the system' for maintenance purposes during office hours, prior notice must be given to the system administrator to take necessary actions. In case of an unexpected system breakdown, necessary action must be taken within two working days. Although, the IT unit is not directly responsible for system development, the IT unit is required to provide necessary support at the time of system developments. Ex: - installation of new WAR file

7.3.2. Data security and back-up

FPA Sri Lanka IT unit is responsible for development of data security systems for MEIMS and routine back up. Routine data backup must be created at least once a day in a separate server within the FPA premises. Off-site data base back up (outside FPA premises) must be created at least once a week to ensure data security. The IT unit is responsible for monitoring and protecting the regular backup system. In case the maintenance of MEIMS is being out-sourced, the agreement must clearly indicate that the external service provider is solely responsible for data security. However, the IT unit must closely monitor all the activities of the external service provider.

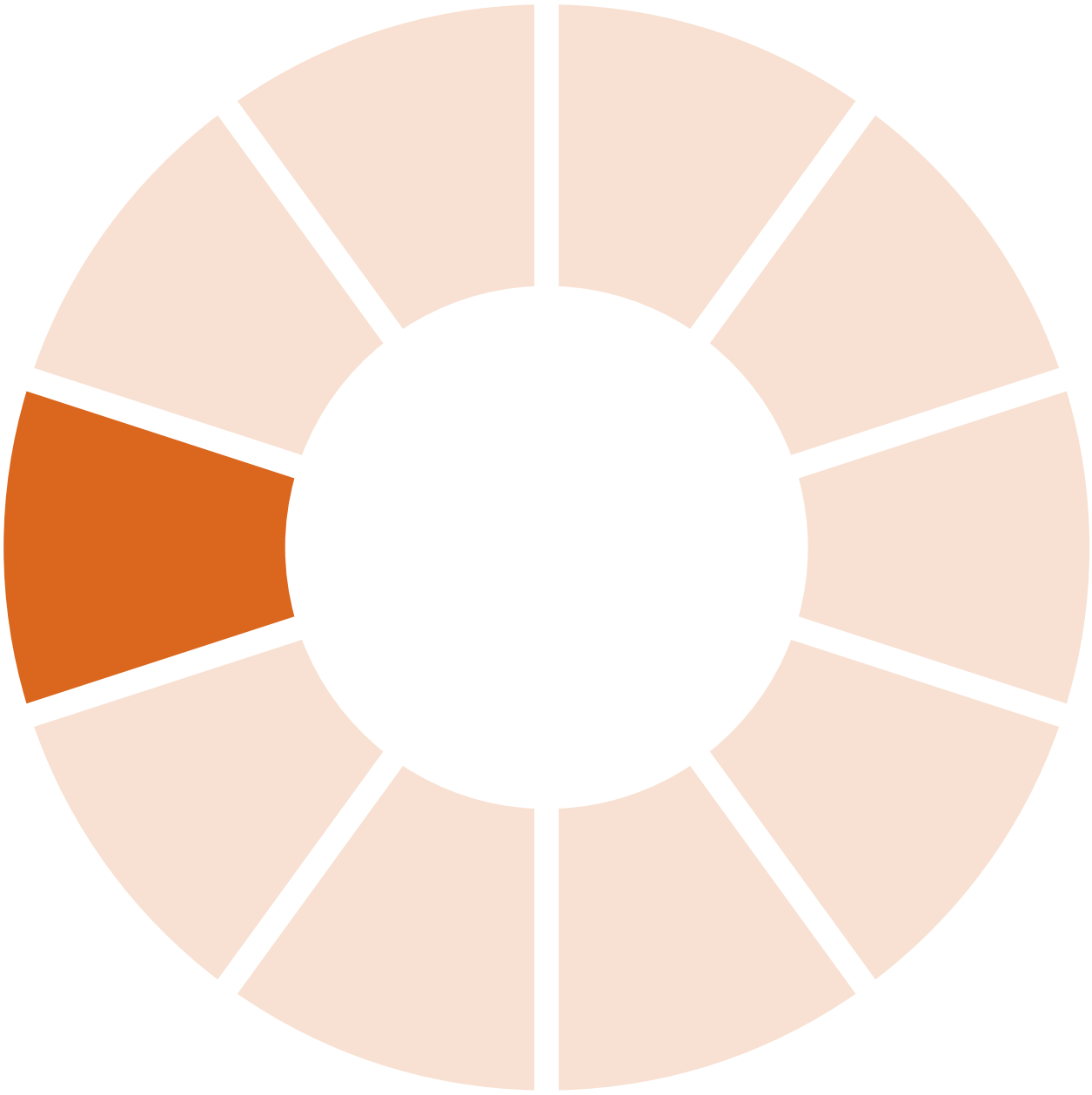
7.4. Private and confidential data

FPA Sri Lanka Monitoring and Evaluation process must ensure the privacy and confidentiality of data which is collected from the operational units. It must ensure a functioning system of role based authentication to access the confidential information. As mentioned earlier, at the operational level, the focal person for Monitoring and Evaluation or the MEIMS administrator will provide necessary authentication for all staff and partners to access required data to perform their duties assigned by the Executive Director / Unit Heads. The Executive Director has the authority to take the final decision regarding any issues related to confidentiality and privacy of M&E information (FPA Sri Lanka Monitoring and Evaluation policy, 2013).

The MEIMS may contain private and confidential data such as clients' personal information, sales data, etc. Any confidential data must not be accessed by any person unless otherwise, it is a part of his/her duty within the organisation. User passwords and confidential data must be encrypted to avoid unwanted access and misuse of data. Further, all the online applications including MEIMS use https// to avoid unauthorised access (Ex: - https://me.fpasrilanka.org/login.htm). Any unauthorised access and/or misuse of data is considered as a misconduct and the HR Unit is responsible for initiation of disciplinary actions.

7.5. Maintenance of Source documents, means of verifications and support documents

Respective programme focal persons, SDP managers and project officers are responsible for maintenance of source documents and must be available for data quality audits and periodic evaluations. All the projects implemented by FPA Sri Lanka must adhere to national and international guidelines on private and confidential information. (Ex: - Maintenance of client cards in a locked cupboard). As a rule, all source documents must be kept in a safe place for at least 07 years from the report date under the custody of the respective programme focal person unless there is a project specific special arrangement. The HR Unit must develop a proper 'handing over' procedure to ensure smooth transfer of programmatic documentation at the time of resignations/acceptance of duties.



8

Data quality assurance

8. Data quality assurance

There are many definitions of data quality but data is generally considered high quality if, "they are fit for their intended uses in operations, decision making and planning". Alternatively, data is deemed of high quality if it correctly represents the real-world construct to which it refers.

In its most basic sense, data quality means that the information collected as part of the Monitoring and Evaluation system adequately represents the programme's activities and achievements. Adequately represents means that the information is accurate and reliable. Accurate information is interpreted as measuring what we intend to measure (that the information is correct), and reliable information implies that it has been collected and measured in the same way (consistently) by all programmes during all reporting periods.

All the interventions conducted by FPA Sri Lanka emphasise quality of programmatic data because it is explicitly evidence based and results oriented. Good data is needed to inform the design of interventions and to monitor and evaluate FPA Sri Lanka's quantitative progress toward pre-determined and agreed targets. Ultimately, FPA Sri Lanka is committed to accuracy of information for purposes of accountability and, more importantly, for use of good quality data to improve its programmes and operations.

In order for targets to be meaningful and realistic, the quality of data on which they are based, must meet minimum standards of acceptability. Similarly, progress reports will only offer stakeholders a concise and accurate reflection of whether the current programmes are achieving its objectives, only if the supporting data is of high quality. So, attention to data quality leads to improved programme performance and to a more efficient resource management.

8.1. Seven data quality dimensions

Other than the validity and reliability, there are another five dimensions of data quality which are explained in table 8.1. So, it is important to pay attention to these data quality dimensions at the time of planning and designing the Monitoring and Evaluation system. On the other hand there is a tradeoff between amounts of data collected as well as the quality of data. So, collection of data for large number of indicators does not necessarily mean a good M&E system. A properly designed Monitoring and Evaluation system must collect good quality data to measure least number of indicators which describe the progress of the project to a larger extent. It is also important to note that, there is always an associated cost of data quality. So, it is important to agreeat the time of project planning, what level of data quality control and verification is needed and at what cost. It depends on various factors such as, the importance of management decisions that are going to be taken using these data, availability of resources to allocate for data quality verification at different levels, margin of error that can be accepted, capacity of the staff involved at all levels etc.

Table 8.1. Seven dimensions of data quality

Dimensions of Data Quality	Operational Definition
Accuracy	Accurate data is considered correct: the data measures what it is intended to measure. Accurate data minimises error (e.g., recording or interviewer bias, transcription error, sampling error) to a point of being negligible.
Reliability	The data generated by a programme's information system is based on protocols and procedures that do not change according to who is using them and when or how often they are used. The data is reliable because they are measured and collected consistently.
Precision	This means that the data has sufficient detail.
Completeness	Completeness means that an information system from which the results are derived is appropriately inclusive: it represents the *complete* list of eligible persons or units and not just a fraction of the list.
Timeliness	Data is timely when they are up-to-date (current), and when the information is available on time. Timeliness is affected by: (1) the rate at which the programme's information system is updated; (2) the rate of change of actual programme activities; and (3) when the information is actually required and used.
Integrity	Data has integrity when the system used to generate them is protected from deliberate bias or manipulation for political or personal reasons.
Confidentiality	Confidentiality means that clients are assured that their data will be maintained according to national and/or international standards for data. This means that personal data is not disclosed inappropriately, and that data in hard copy and electronic form are treated with appropriate levels of security)

8.2. Ensuring data quality at FPA Sri Lanka

FPA Sri Lanka CORE programmes and donor-funded projects are working towards achieving ambitious goals related to Sexual and Reproductive Health and Rights. Measuring success and improving the management of these initiatives is dependent on strong Monitoring and Evaluation (M&E) systems that produce quality data related to programme implementation. So, FPA Sri Lanka invests resources and maintains the quality of data at high standards enabling the management to make correct and timely decisions. The following sub topics describe key management practices to improve the quality of data reported.

Based on these dimensions of data quality described in table 8.1, FPA Sri Lanka data quality management process comprises two components: (1) self-assessment of data management and reporting systems; and (2) verification of reported data for key indicators at selected sites. The following sub topics describe the standard procedure of FPA Sri Lanka data quality management system relating to the above two aspects. This data quality management procedure was developed using the 12 component M&E system strengthening tool (MEST) developed by UNAIDS, data quality audit tool developed by MEASURE evaluation and data quality audit tool developed by Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM).

8.2.1. Self-assessment of data management and reporting system

The purpose of self-assessment of data management and reporting system is to identify potential challenges to data quality created by the data management and reporting systems at three levels:

- ✓ Monitoring and Evaluation Unit,
- ✓ The Service Delivery / Project Sites
- ✓ Intermediary Aggregation Level (at which reports from Service Delivery Sites are aggregated prior to being sent to the M&E Unit or report in MEIMS. However, with the implementation of primary data capturing through Monitoring and Evaluation Information Management System (MEIMS), requirement for data aggregation at intermediate levels are minimal.

The M&E self-assessment must cover five functional areas. The assessment questions for those five functional areas are described in table 8.2. FPA Sri Lanka expects its M&E Unit to conduct M&E self-assessment at least twice per strategic period (before preparation of the organisational strategic plan for Monitoring and Evaluation and at the time of strategic plan review). Annexure 39 provides the complete tool to conduct M&E self-assessment. FPA Sri Lanka M&E unit may use 12 component M&E System Strengthening Tool (MESTT) developed by UNAIDS to conduct M&E self-assessment.

Table 8.2. Key functional areas and evaluation questions to conduct M&E self-assessment for the data management and reporting system.

Functional Areas	Assessment questions[6]
M&E Structures, Functions and Capabilities	Are key M&E and data-management staff identified with clearly assigned responsibilities?
	Have the majority of key M&E and data-management staff received the required training?
Indicator Definitions and Reporting Guidelines	Are there operational indicator definitions meeting relevant standards that are systematically followed by all service points?
	Has the programme/project clearly documented (in writing) what is reported to who, and how and when reporting is required?
Data Collection and Reporting Forms and Tools	Are there standard data-collection and reporting forms that are systematically used?
	Is data recorded with sufficient precision/detail to measure relevant indicators?
	Is data maintained in accordance with international, national or organisational confidentiality guidelines?
	Are source documents kept and made available in accordance with a written policy / procedure?
Data Management Processes	Does clear documentation of collection, aggregation and manipulation steps exist?
	Is data quality challenges identified and are mechanisms in place for addressing them?
	Are there clearly defined and followed procedures to identify and reconcile discrepancies in reports?
	Are there clearly defined and followed procedures to periodically verify source data?
Links with National Reporting System	Does the data collection and reporting system of the programme/ project link to the National Reporting System?

6 Options for answers → 1) Yes, Completely 2) Yes, Partly 3) No 4) Not applicable

8.2.2. Routine data quality assessment by programme staff / Supervisory staff

FPA Sri Lanka recognises that the immediate supervisor of the person / staff who report data in the MEIMS is the primary person responsible for the quality of the data reported by the subordinate. So the supervisory staff attached to all programmatic and support units are expected to log into the system and verify the data reported by the junior staff before preparation of the quarterly progress reports. Any data quality issue identified at the verification must be informed to all responsible parties in writing, so that necessary action can be taken before the deadline of the quarterly progress review meeting. The process must be documented and be available for audit and evaluation. For the programmes implemented by the partners, the programme focal person of FPA Sri Lanka is responsible for the smooth operation of the data recording, reporting and quality assurance system. The respective heads of the units are responsible for the smooth operation of data reporting and quality assurance system.

FPA M&E Unit starts preparation of Annual Reports from the 15th of January of the following year. All programme staff at field level; supervisory staff, unit heads and programme focal persons for thematic areas must conduct final data verifications and do necessary corrections. All the supervisory staff, unit heads and programme focal persons for thematic areas must provide feedback in-writing on data quality issues to respective field level staff / data entry operators to do necessary corrections before the deadline. The Human Resource Management Unit of FPA Sri Lanka is responsible for inclusion of these roles in the job descriptions and performance indicators in annual performance appraisals.

8.2.3. Data quality verifications by M&E staff

The purpose of onsite data verification is to assess, on a limited scale, if service delivery and intermediate aggregation sites are collecting and reporting data to measure the audited indicator(s) accurately and on time — and to cross-check the reported results with other data sources. To do this, the M&E Unit will determine if a sample of Service Delivery Sites have accurately recorded the activity related to the selected indicator(s) on source documents. It will then trace that data to see if it has been correctly aggregated and/or otherwise manipulated as it is submitted from the initial Service Delivery Sites through intermediary levels to the M&E Unit. Data quality verification is conducted in three steps.

A. Desk review and secondary data assessment at the M&E Unit

   This is an on-going process which takes place during the project period. The frequency and sample size depends on availability of human resources and may vary with the donor requirement.

B. In-depth verification at service delivery / project sites (on-site data verification) On-site data verification is conducted annually for selected sites. This involves data triangulation and other data verification techniques. Sample size and frequency of data verification depends on the availability of financial and human resources and donor requirements. However, it is recommended that the M&E Unit conducts on-site data verifications once a year for recently started projects / SDPs until the quality of data comes to the expected level (i.e. Consider organisational or donor standards for data quality).

C. Follow-up meetings and verifications at intermediate aggregation levels (if any), programme units at headquarters and the M&E unit. This includes development of recommendations and report writing.

Table 8.3 describes the standard procedure for data quality verification by the M&E Unit with the above three steps.

Table 8.3 Standard procedure for data quality verification by the M&E Unit

Verification level		Procedure	Stage /Timeline
A) Desk review and system assessment at M&E unit	01	Review randomly selected secondary data reported in the MEIMS and provide feedback, if the M&E Unit finds any inconsistencies / inaccuracies in the data reported by programme units. Programme units are required to do necessary corrections before the deadline for quarterly reports or the Annual Report. Respective unit heads are responsible for smooth operation of the process.	Continues throughout implementation.
	02	Review all the secondary data reported by the programme units and reject inconsistent data and inaccurate data before preparation of final reports. Calculate percentage of inconsistent and inaccurate data and share with the respective programme units after completion of the on-site data quality verification exercise. Provide time bound recommendations for improvement of data quality. Respective programme staff and unit heads are responsible for implementation and follow-up of recommendations.	Annual – Before preparation of Annual Report
B) In-depth verification at service delivery / project sites	03	Review availability and completeness of all indicator source documents of selected sites for the selected reporting period. Quality gaps of source documents (availability and completeness) are identified with recommendations.	At the time of onsite data verification
	04	Trace and verify reported numbers Ex: - Re-count the reported numbers from available source documents; Compare the verified numbers with on-site reported number, Identify reasons for any differences. Re-count may not be applicable for electronic reporting systems. It is sufficient to verify randomly selected cases and identify gaps, in case the project / SDP is using the MEIMS.	At the time of on-site data verification
	05	Perform “cross-checks” of the reported totals with other data-sources / support documents as and when applicable (e.g. inventory records, laboratory Reports, registers, etc.).	At the time of on-site data verification

Verification level		Procedure	Stage /Timeline
	06	Perform "spot-checks" to verify the actual delivery of services and/or commodities to the target populations, if feasible. Ethical and right issues must be strongly considered when conducting spot checks. Spot checks may not be applicable for all the cases. However, conducting spot checks is strongly recommended, if the evaluators find serous quality and transparency issues in source documents / means of verifications. The respective programme staff is responsible for field arrangements, if the evaluators decide to conduct spot checks. It is recommended that the M&E team develop data quality assessment tools based on the project requirements to conduct spot checks (See annexure 29). The sampling procedure and the sample size for the "spot checks" depend on the availability of financial and human resources, donor requirement and nature of the target population. Our practical experience is that the two interviewers can perform 10-20 spot checks per day depending on the target population and geographical location.	At the time of onsite data verification
	07	Conduct in-depth interviews with service providers, data entry operators and SDP/project management to identify reasons for data quality gaps and recommendations.	At the exit meeting of the on-site data verification
C) Follow-up meetings and verifications at intermediate aggregation levels (if any), programme units at Headquarters and M&E unit	08	Based on the requirements, conduct follow-up meetings with senior programmatic staff at intermediate aggregation levels (if any) and headquarters.	After completion of the desk review and on-site data verification
	09	Collect any supportive information from the MEIMS, finance unit and HR unit requirement basis for further verification.	After completion of the desk review and onsite data verification
	10	Carry out the report compilation of the final report which includes observations and recommendation and share it with the Executive Director, the respective programme unit and unit heads. The respective programme staff and support staff must respond to the data quality verification report, if there is any recommendation which is not practical to implement (or an observation which is not agreed on) within three months of the report. If no such response, the recommendations are considered as accepted by all the parties. The respective programmatic and supportive units are responsible for implementation of the recommendations under the overall supervision of the unit head.	After completion of the desk review and on-site data verification

8.2.4. External data quality audits

All the data quality control and maintenance steps described earlier are implemented as internal procedures of the organisation. Conducting data quality audits which includes the M&E system assessments using external evaluators is strongly recommended based on availability of financial resources and donor requirements. This provides an opportunity for the organisation to identify the gaps in the systems and processes, implement at system level and do major organisational changes. The methodology to conduct the data quality audit will be selected by the external consultant in consultation with FPA Sri Lanka (Ex:- Trace and verification model). It is recommended to conduct an organisational level external data quality audit at least once per strategic period, based on availability of financial resources.

8.3. Linkage with Human Resource Management procedures and policies

Performance monitoring and management is a shared responsibility in the organisation which all staff at all levels must contribute to. So, reporting of quality data is considered as an important responsibility and a job role for all relevant staff at FPA Sri Lanka. So, the Human Resource Management Unit is required to take the following actions to build a performance driven culture within the organisation.

1) Include the submission of all required data, reports and information to be of a high quality standard in the job descriptions / terms of references of all programmatic and supportive staff.

2) Include the follow-up, quality verification and smooth operation of the reporting and quality assurance system in the job descriptions / terms of references of all senior supervisory staff and unit heads.

3) Include the maintenance of job related documents including means of verifications of performance indicators (as per the M&E SOP) and availability of data quality audits in the job descriptions of the programme and support staff at all levels.

4) Consider the above requirements as key performance indicators (KPIs) and include it in the performance appraisal formats. Consider late, incomplete, inaccurate, and missing reports as factors which result in lower performance.

5) Consider submission of reports (or data entry) with purposeful manipulations as misconduct and take necessary disciplinary actions to reduce such cases.

6) Documentation and management of the attendance of all the staff (permanent, contract, locum basis and daily pay) with high quality standards and support documents and provide necessary information for periodic evaluations and audits. Ex: - Branch Comparison and efficiency indicators.

7) Provide necessary training and capacity building facilities to the M&E and programmatic staff in consultation with the Executive Director and respective unit heads to address the performance gaps identified in the monitoring process, data quality audits and periodic evaluations.

8) Take necessary disciplinary action against misuse of organisational data (Please see the chapter 07).

9) Provide annual increments and promotions based on documented performance in consultation with the Executive Director and respective unit heads.

10) Establish a proper handing over process for programmatic and support documents at the time of resignation and new recruitments. Eg:- Effective safe transfer of documents along with the duties and responsibilities.

9

Periodic evaluations

9. Periodic evaluations

Evaluation is the systematic examination of a planned, ongoing or completed project / programme. Evaluation aims to answer specific management questions and judge the overall value of an intervention and provide lessons for future actions, planning and decision making. (FPA Sri Lanka M&E policy, 2013). So, it is a systematic and objective examination concerning the relevance, effectiveness, efficiency and impact of activities in the light of specified objectives (UNICEF, M&E guide; making a difference). Apart from the routine monitoring activities described in previous chapters, FPA Sri Lanka conducts periodic evaluations in different scales. The procedures for planning and implementation of evaluations depend on the evaluation type, evaluation methodology, evaluation scope, availability of resources and other practical circumstances. So, this chapter explains guidelines for planning and implementation of evaluations including post evaluation action points.

9.1. Guiding principles for evaluations [7]

Evaluations in FPA Sri Lanka will be guided by the following principles. These principles are not minimum requirements, but are internationally recognised professional ideals that need to be applied to the specific evaluations that FPA Sri Lanka undertakes, or in which FPA Sri Lanka partners collaborate.

a. **Independence: -** Members of evaluation teams should be independent from both the policy-making process and delivery and management of assistance. In particular, they should not have been engaged in the activities to be evaluated or been responsible in the past for the implementation, or supervision of the project, programme, or policy to be evaluated.

b. **Impartiality: -** Evaluations must give a comprehensive and balanced presentation of strengths and weaknesses of the policy, programme, project, or organisational unit being evaluated. The evaluation process should reflect impartiality at all stages and take into account views of all stakeholders. Units commissioning evaluations should endeavor to ensure that evaluators selected are impartial and unbiased.

c. **Transparency: -** Transparency and consultation with the major stakeholders are essential at all stages of the evaluation process. This involves clear communication concerning the purpose of the evaluation activity, the criteria applied, and the intended use of the findings. Evaluation reports shall provide transparent Information on sources, methodologies, and approach

d. **Disclosure: -**The lessons from the evaluation shall be disseminated by establishing effective feedback loops to the governance, management, operational staff, project beneficiaries, the policy-makers and the general public. In the spirit of partnership, the FPA Sri Lanka partners shall share FPA Sri Lanka related evaluation reports, and other internal periodic reviews of progress and implementation and make findings and lessons available to project management for improved effectiveness.

e. **Ethical: -**Evaluations shall provide due regard for the welfare, beliefs, and customs of the clients/beneficiaries, avoiding conflict of interest. Evaluators must respect the right of institutions and individuals to provide information in confidence. If evidence of wrongdoing

7 Adopted from FPA Sri Lanka Monitoring and Evaluation Policy (2013)

is uncovered, the evaluator or manager shall report such cases discreetly to the FPA Sri Lanka focal person of the M&E Unit, who will take appropriate action such as informing the Executive Director of FPA Sri Lanka. Ethical evaluation requires that the management and/or consultants of evaluations remain open to the findings and do not allow vested interests to interfere with the evaluation.

f. **Partnership: -**FPA Sri Lanka activities are being implemented through various partnerships of international organisations and national or non-governmental entities. The FPA Sri Lanka M & E Unit and the FPA Sri Lanka partners shall actively explore the possibility of joint evaluations which would provide FPA Sri Lanka with insights and feedback that might not be realised through a stand-alone evaluation.

g. **Competencies and Capacities: -** The M & E Unit shall be responsible for selecting independent-minded, experienced, and sufficiently senior evaluators, and adopting a rigorous methodology for the assessment of results and performance. Evaluations of FPA Sri Lanka activities shall make the best possible use of local expertise, both technical and evaluative. The FPA Sri Lanka partners shall, as feasible, cooperate to stimulate evaluation capacity development at the local level, with a specific focus on Sexual and Reproductive Health evaluation concerns.

h. **Credibility: -**Evaluations shall be credible and based on reliable data or observations. This implies that evaluation reports shall reflect consistency and dependability of data, findings, judgments, and lessons learned, with reference to the quality of instruments and procedures and analysis used to collect and interpret information.

i. **Utility: -**Evaluations must serve the information needs of intended users. Partners, evaluators, and units commissioning evaluations shall endeavor to ensure that the work is well informed, relevant, and timely, and is clearly and concisely presented so as to be of maximum benefit to stakeholders. Evaluation reports should present in a complete and balanced way, the evidence, findings or issues, conclusions, and recommendations.

9.2. Evaluation Criteria and Questions applicable for FPA Sri Lanka

This sub topic describes the evaluation criteria and questions applicable to the five programmatic areas (Adolescents, AIDS/HIV, Access, Abortion, and Advocacy) that FPA Sri Lanka is working for. Please consider these evaluation questions as examples which may change based on the evaluation type, evaluation scope and objectives.

a) Relevance

- ✓ Is the programme/ Project consistent with the needs and priorities of its target group?
- ✓ Is the programme/ Project design in line with national needs and priorities?
- ✓ Is the overall programme design intuitive and logical? Does it efficiently enable desired project outputs? Do the stated needs of the beneficiaries appear to have been accurately assessed?
- ✓ How well does the programme / Project align with the vision, mission and core values of the organisation (FPA Sri Lanka)?
- ✓ Is the design of the programme/ Project aligning with the strategic directions and objectives of the strategic plan?

b) Effectiveness

- ✓ Have the inputs and activities led to the outputs and outcomes (or is there reason to believe the activities will do so during the remainder of the programme / Project)?
- ✓ Have the planned geographical areas and target groups been successfully reached?
- ✓ How are the SDP (service delivery point) / Project level interventions tailored to the specific needs of the districts /beneficiaries and to what extent is the SDP level approach effective?
- ✓ What are the constraining and facilitating factors and the influence of context on the achievement of results?

C) Efficiency

- ✓ What is the quality of outputs and outcomes achieved in relation to the expenditure incurred and resources used?
- ✓ Are the resources spent as economically as possible; could a different intervention have addressed the same needs at a lower cost? Could more results have been produced with the same resources?
- ✓ To what extent has the programme/ Project utilised the capacity and expertise of FPA Sri Lanka staff/human resources?
- ✓ Is the staffing setup of FPA Sri Lanka head office and sub offices (Service Delivery Points, Centre for family health, project offices, Social Marketing Programme) appropriate for effective and efficient implementation of the programme?
- ✓ Is the programme / Project budget realistic and efficiently managed?
- ✓ Are the programmes / project supportive functions (Finance and logistics, transport and maintenance, information technology, etc.) of FPA Sri Lanka efficient and effectively integrated with project implementation?
- ✓ How are FPA Sri Lanka programme units integrated to achieve higher outputs with same or reduced costs?

d) Impact

- ✓ Have long-term results been achieved or are likely to be met?
- ✓ To what extent does FPA Sri Lanka intervention contribute to capacity development and the strengthening of the community and institutions in Sri Lanka?
- ✓ What has happened or is likely to happen as a consequence of FPA Sri Lanka efforts?

e) Sustainability

- ✓ Will the programme/ Project have lasting results after the programme/ Project termination? If so, what evidence supports this conclusion?
- ✓ Have programme/ Project activities been integrated into current practices of counterpart institutions and/or target population?
- ✓ How effective are the partnerships that FPA Sri Lanka has established with government, private and other NGOs?
- ✓ Did programme / Project design include strategies to ensure sustainability?
- ✓ Are FPA Sri Lanka resource mobilisation approaches effective and sustainable?
- ✓ How have the programme / Project activities contributed to build the capacity of staff members of FPA Sri Lanka and partners.

f) Compliance with Core Values of the organisation

- ✓ Is the programme / Project design and implementation in compliance with the core values (Quality, Choice, Good Governance, Volunteerism, Sustainability, Diversity and Equality) of the organisation?

9.3. Evaluation Requirement and Resource Allocation

FPA Sri Lanka recognise periodic evaluations as opportunities for learning and improvement. FPA Sri Lanka CORE activities driven by the strategic plan must include both internal and external evaluations. It is recommended that the organisational strategic plan must conclude with a comprehensive evaluation which must be carried out by a team of independent external evaluators. Other than the external evaluation, FPA Sri Lanka M&E Unit must plan and implement especially focused evaluations based on the requirements. Good evaluations are both resource and time consuming. So, a comprehensive analysis on requirement and use of findings must be carried out before planning and implementing any evaluation. Human and financial resources to conduct evaluations for CORE FPA Sri Lanka activities must be allocated in the Annual Programme and Budget under the Monitoring and Evaluation Project.

All unit heads, programme focal persons and project managers are strongly recommended to include sufficient amount of resources to conduct evaluations at the design stage of restricted projects. Conducting evaluations for restricted projects will depend on donor requirement and the funding must be done by the donor agencies.

9.4. External Evaluations

In certain situations, hiring an external evaluation consultant or evaluation team may be appropriate and/or required. Generally speaking, expertise, impartiality, cost, and time are key considerations for employing an external consultant/team for an evaluation. That is, the scope and complexity of the evaluation may demand the expertise of an external consultant; the politically sensitive nature of a programme or project may require the

impartiality of an external evaluator; or, where personnel resources and timeframe are more scarce than funding, an external evaluator may be the better choice. Following advantages and disadvantages must be considered when deciding to go for an external evaluation (Bernice Taylor & Associates, 2009).

a) Advantages of external evaluations

- ✓ An external evaluation provides a more objective view of the programme.
- ✓ An external evaluation provides more credibility for people outside of the programme/ project (funding partners, stakeholders, etc.).
- ✓ An external evaluator or team, when carefully selected, may possess certain evaluation research skills and knowledge that the internal evaluator may not. S/he may also have exposure to a wider range of issues, methods, and practices that would be useful to incorporate.
- ✓ External evaluations involve less or no internal staff time and save limited personnel resources.
- ✓ There may be a perception of bias if the internal evaluator is 'too close' to the subject matter; this may result in risking the credibility of the evaluation and hindering its use.
- ✓ External evaluators can analyse the situation by thinking by 'out of the box'

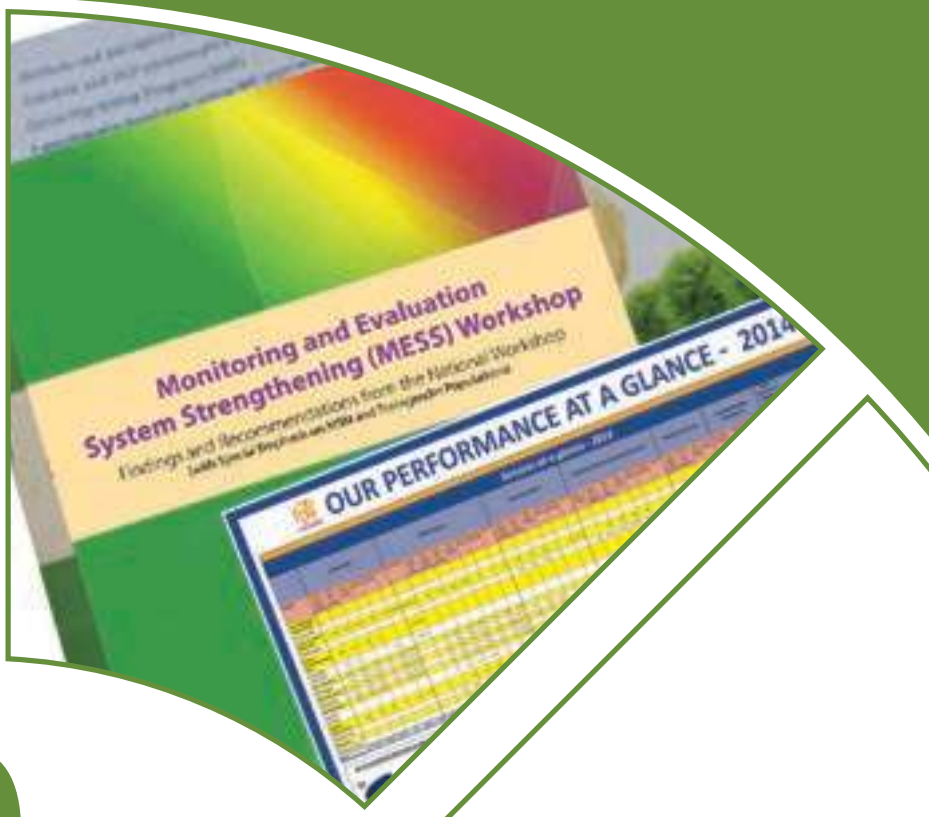
b) Disadvantages of external evaluations

- ✓ External evaluations can be expensive.
- ✓ It may be difficult to manage an evaluation conducted by an external evaluator.
- ✓ It may be difficult to find evaluators who understand the organization, region or programming area
- ✓ External evaluators are often less familiar with the staff, community, issues, and resources associated with the project/programme.

So, the use of consultants is recognised as a valid alternative when comprehensive evaluations cannot be conducted using internal resources or when an independent external evaluation is specifically requested by Donor Agencies. Comments from the Monitoring and Evaluation Unit should be sought when Terms of Reference for evaluations are prepared (FPA Sri Lanka Monitoring and Evaluation Policy, 2013).One good option can be to include internal and external people on the evaluation team. This would combine the benefits of each type of evaluation—that is, external expertise and impartiality can be maintained without losing the benefit of the internal person's first-hand knowledge of the project/programme (Bernice Taylor & Associates, 2009).

9.4.1. Procedure to hire external evaluators

The M&E Unit or the operational unit must strongly consider the guiding principles for evaluations when hiring external evaluators. Eg:- Those who have a conflict of interest and those who are involved in the project implementation should not be included in the evaluation team. The evaluators must process necessary qualifications and previous experience on the subject area. The consultancy must be offered on an open and competitive basis unless there is a justifiable reason which is acceptable and approved by FPA Sri Lanka senior management.



10

M&E Product dissemination and use

10. M&E Product dissemination and use

Once data collection and analysis is completed, there are two major steps in finalising the evaluation process: dissemination and utilisation of the findings. The purpose of evaluation is to ultimately make decisions that improve the quality of the project. Although this can be done through small programmatic alterations or major policy changes, neither can ultimately occur without the proper dissemination and utilisation of findings. The following bullet points describe the importance of utilisation of M&E results.

- ✓ **M&E results help improve your programme interventions -**Using M&E results keeps you and your staff in a "learning mode" as you gain understanding about how and why your programme is working.
- ✓ **M&E results strengthen your programme institutionally -** Sharing results can help ensure social, financial and political support and help your programme establish or strengthen the network of individuals and organisations with similar goals.
- ✓ **M&E results can be used to advocate for additional resources and policies -** M&E results often shape donors' decisions about resources in terms of what and how many to allocate. Results can also be used to lobby for policy or legislative changes that relate to Sexual and Reproductive Health by pointing out unmet needs or barriers to programme success.
- ✓ **M&E results contribute to the global understanding of "what works." -** By sharing M&E results, you allow others to learn from your experience. The dissemination of M&E results—both those that show how your programme is working and those that find that some strategies are not having the intended impact—contributes to our global understanding of what works and what doesn't work in improving young people's reproductive health.

Monitoring and Evaluation provides information and facts that, when accepted and internalized, become knowledge that promotes learning. Learning must therefore be incorporated into the overall programming cycle through an effective feedback system. Information must be disseminated and available to potential users in order to become applied knowledge. Effective monitoring can detect early signs of potential problem areas and success areas. Programme Managers must act on the findings, applying the lessons learned to modify the programme or project. This type of on the job project learning serves the immediate needs of the programme or project, and it also may provide feedback for future programming (UNDP, 2002). With the above theatrical aspects, this chapter describes FPA Sri Lanka standard procedures for dissemination and use of M&E findings.

10.1. Routine programmatic and financial reporting

10.1.1. Monthly Financial Reports (MFR)

Financial monitoring for both recurrent and capital expenditure shall be conducted in collaboration with the Financial Unit (FU). Monthly financial status of the income and expenditure report shall be produced by the FU for each Centre/Unit/project which will consolidate the information to depict the financial picture and disseminate to

all Programme Managers. As much as practically possible, activity monitoring and financial monitoring shall be linked and formats for collection of the information and reporting shall be developed in consultation with all stakeholders (FPA Sri Lanka Monitoring and Evaluation Procedure Manual, 2013).Aligned with the M&E policy, finance staff feed the expenditure of each budget line for all projects which will develop into a project wise finance report that includes burn rates. Project officers and managers may log into the MEIMS as and when they need financial data and do necessary adjustments to align the activities as per the budget availability.

10.1.2. Quarterly Progress Reports (QPR)

QPR shall be developed at the end of every quarter of the Financial Year (FY) which will contain both programmatic and financial progress. The M&E unit shall utilize programmatic and financial data available in the MEIMS to develop the QPR of the organisation. The exercise shall be comprehensive and inclusive to cover all programmes and projects of FPA Sri Lanka. QPR must include the progress of activities and outputs to a larger extent and outcomes up to some extent. The Quarterly Progress Report is shared with all FPA Sri Lanka staff and uploaded into the document repository in the MEIMS. A sufficient amount of time must be allocated to discuss the issues that come out of the QRP in the quarterly unit level progress reviews by the respective unit heads. Special decisions must be shared in-writing with all the stakeholders.

10.1.3. Annual Reports (AR)

FPA Sri Lanka M&E Unit develops various types of Annual Reports which include but may not be limited to FPA Sri Lanka's performance at a glance. Annual Service Statistic Report, Annual Progress Report of IPPF Global Indicators, Annual Programmatic Update in IPPF Electronic Information Management System (eIMS), Annual Branch Comparison Exercise and Annual Impact Estimates of FPA Sri Lanka Family Planning Programmes. The M&E Unit may utilise several sources of information to prepare Annual Reports which includes MEIMS, progress review meetings, evaluation and assessment reports, etc. Annual Reports shall be shared with all stakeholders and shall be uploaded into the document repository of the MEIMS.

10.2. Routine progress review meetings

10.2.1. Quarterly progress review meetings (QRM) at unit level

Quarterly progress review meetings are planned with the objective of capturing project activity and SDP level progress of each management unit separately. The meetings take place with the participation of all staff of each operational unit. The Executive Director, finance staff and M&E staff may participate in the QRM at the request of the respective head of the unit or for a special reason. A sufficient amount of time must be allocated to discuss issues that come out from the QRP in the quarterly unit level progress reviews by the respective unit heads. The emphasis is made on programme strategic aspects based on the findings from analysis of programmatic data available in the MEIMS during the past three month period. Other than the programmatic achievements, QRM may discuss situation and unit specific issues. The meetings are chaired by the respective unit head. The minutes of the QRM is synthesized and shared with all the participants by the respective operational unit summarising the key discussions and action plan for agreed action points with timelines and responsibilities.

10.2.2. Steering committee meetings for restricted projects

A multi-disciplinary project steering committee maybe formed by the Executive Director for the restricted projects based on donor requirements. The steering committee includes but may not be limited to programmatic, M&E and finance staff of FPA Sri Lanka and representatives of partner organisations. However, the composition of the steering committee is decided by the Executive Director with justifiable reasons and the representatives for the steering committee from each unit are nominated by the respective unit heads. A senior FPA Sri Lanka staff member is nominated as the chairperson of the steering committee by the Executive Director. The steering committee is required to meet at least once a quarter to make all the strategic decisions and some operational decisions. The minutes of the steering committee meetings are synthesized and shared with all the participants by a person appointed by the chairperson of the steering committee summarising the key discussions and action plan for agreed action points with timelines and responsibilities.

10.2.3. Annual joint review meetings

Joint reviews shall be conducted annually between January and March each year, to review performance in implementation of all FPA Sri Lanka units, projects and programmes. At all times, this shall be an undertaking between the governance, management and staff of FPA Sri Lanka and its partners in family planning and reproductive health. The donor, community, other partners including representation from the public shall be involved in the review. The representative from each operational unit, project or SDP present their achievements, challenges and lesson learned in a format developed by the M&E Unit. Annual joint review meetings are chaired by the Executive Director and coordinated by the M&E unit. The M&E Unit shall from time to time publish guidelines and templates for the review and after the meeting develop a follow up action plan on the recommendations of the review. Annual review meetings are planned to collectively discuss the organisational achievements with all the stakeholders involved.

10.3. M&E product dissemination channels

As discussed, earlier effective dissemination of M&E findings / products is important to facilitate evidence based decision making at every level of the organisation. The general principle is that, users must be able to access required information, at the time they require in the relevant and pre-agreed format. This section describes the dissemination channels of M&E products.

10.3.1. Online access to reports generated by MEIMS

The MEIMS itself serves as an important channel for distribution of M&E data among all relevant users. MEIMS facilitates the generation of various kinds of reports with aggregated and disaggregated data which can be utilised by every management level. Apart from that, MEIMS generates dash boards to identify issues that need remedial action to be takenby the senior management. Access to MEIMS auto generated reports is provided for all MEIMS users based on role based authentication. So, all the staff including the senior management has been given access to MEIMS reports that are relevant to their role in the organisation and are expected to log into the system as a part of their routine activities. It is the responsibility of the respective unit heads to create a culture where the programmatic data is utilised to the maximum by all staff members in the unit. All

the programme focal persons of the organisational thematic areas are expected to utilise the auto generated reports of the MEIMS and periodically (Ex: - quarterly) provide their feedback to operational staff.

10.3.2. Online document repository and knowledge sharing system

The electronic document management system (DMS) / document repository developed as a separate application of the MEIMS system is used to disseminate M&E products among all key stakeholders (FPA Sri Lanka staff and partners). This document repository is a system (based on computer programmes in the case of the management of digital documents) used to track, manage and store all M&E related documents. This FPA Sri Lanka document repository is an online application integrated to MEIMS with role based authentication facilities. The users can access any document as and when required at any location, only if he/she has required authority to access that particular document. Apart from accessing the documents, the document repository has developed in an interactive manner where the users can comment on the document to share his/her inputs / feedback with other MEIMS users. The ultimate objective of the document repository is that, users will read, process, and utilise evaluation findings at the time they need information, not necessarily at the time of initial information dissemination. Therefore, evaluation findings and other important documents shall be made available to all relevant users at their finger-tips with necessary role based authentications for better use of M&E findings. The document repository keeps a log of all the history, with the date and time of previous downloads, etc to measure estimated use of the resource.

It is important to note that although this module falls under the Subject of Monitoring and Evaluation (as part of MEIMS), this initiative will cover a broad area of knowledge exchange among all MEIMS users which consist of FPA Sri Lanka staff, management and its' partners. Not only the M&E staff, all the MEIMS users are given limited facilities to upload reports/resources (Research papers, IEC/BCC materials / Training manuals, case studies, project progress reports etc.) that they need to share with other MEIMS users which is expected build a knowledge base within the organisation. Users are required to use the template provided as annexure 42 to share resources with other MEIMS users.

10.3.3. Report dissemination through the Information Centre

FPA Sri Lanka Information Centre(IC) is the heart of accumulation and dissemination of knowledge of the Association. The Centre may be described as a multipurpose archive consisting of a diverse collection of books, journals, magazines, E and multimedia resources. In addition, its comfortable and laid back environment provides trouble-free access to information. In keeping with one of the Association's core aims of knowledge creation and dissemination, a regular book overview will be offered to those who wish to have access to updated information.

Selected evaluation reports and resources which FPA Sri Lanka would like to provide access to the general public, accumulate and disseminate through the IC. All the resources are handed over to the Information Centre using a registry maintained by the M&E unit. The manager of the IC is responsible for protecting and providing necessary access to all FPA Sri Lanka stakeholders including the general public.

10.3.4. Training Sessions and workshops

Training sessions and workshops for FPA Sri Lanka staff and its' partners are an effective means of disseminating feedback. These substantive lessons from experience are useful in various stages of programme or project management, including evaluation. Training should focus on such areas as how to improve the quality of UNDP programmes and projects. Training should also develop skills in methodological innovations such as participatory evaluation, the selection of indicators, and use and presentation of information and knowledge in areas not traditionally captured, such as "soft" assistance.

10.3.5. Other dissemination channels

Further to the formal dissemination channels discussed earlier, other dissemination channels such as e-mail, registered post, personal handing over, etc may be used depending on the audience and the situation. A valid confirmation of receipt is required, if the document is distributed through a third party.

10.4. Management responses for evaluation recommendations

The Executive Director is the first receiver of the final evaluation reports from the evaluator / M&E unit. The final evaluation report (approved by the Executive Director) including recommendations is uploaded into the common document repository in the MEIMS. Please refer section 10.2.2 for more details on M&E product dissemination and use. Further, the final report may be disseminated among all relevant stakeholders using other distribution channels (E-mail, post, information centre, etc.) based on the requirement.

A management response to the substantive and implementation issues raised is important for all Monitoring and Evaluation recommendations. For outcome evaluations in particular, the management response should identify what recommendations are accepted or not accepted and why and how the accepted recommendations will be implemented and monitored.

Management responses will be prepared for each of the recommendations using the standard template provided as annexure 40 by the respective programme focal person in consultation with other stakeholders when necessary. A management response must contain status of agreement with the recommendation considering the practical application and ground realities and a plan of action for implementation with the responsible person / unit /organisations. Draft management responses will be circulated among the stakeholders for their comments and be finalised within one month of receiving the final evaluation report. The programme focal person may convene a meeting with relevant stakeholders/partners to discuss and agree on a management response when necessary. The finalised management response (with the approval of the respective unit head) should be uploaded into the FPA Sri Lanka central document repository in MEIMS within one month of receiving the final report of an evaluation**.**

10.5. Management action taken on findings

Once agreed upon in the management response document (Annexure 40), the recommendations of an evaluation becomes management actions which need to be implemented according to an action plan and closely monitored by the next immediate management level/supervisors. The respective unit heads are responsible for allocation of resources (human/financial), implementation and monitoring of management actions under the overall supervision of the

Executive Director. The respective programme focal person prepares an 'action taken' report as per the standard template provided as annexure 41 in pre agreed intervals (Eg:- after six months of implementation / after one year of implementation). Draft 'action taken' reports will be shared with all relevant stakeholders and finalised before the dead line agreed in the management response. The finalised action taken report with the approval of the unit head will be submitted to the Executive Director with a copy to the M&E Unit. The Executive Director in consultation with the unit head and the M&E Unit will take the final decision on the progress of the management action and may take further actions where necessary.

10.6. Use of M&E data for external communications

All evaluation reports and findings are considered as internal organisational documents which may be shared with limited external stakeholders. (Ex: - Project partners)The Executive Director has to approve all products/outputs of M&E done by FPA Sri Lanka on the projects/ programmes implemented before it is disseminated to external stakeholders (FPA Sri Lanka M&E policy, 2013). Considering the primary focus of Monitoring and Evaluation which is to improve evidence based management decisions, most of the M&E products are developed in technical language and contents which may not be understood by many external parties. (Ex: - General public). So, it is the duty of the non M&E technical experts (Ex: - communication experts, Advocacy experts, Branding and promotional experts) to develop the messages as per the target audience and the objective of the initiative using M&E data and findings. The M&E Unit shall provide necessary data and information in pre-agreed format to develop such external communication messages.

References

11. References

01) FPA Sri Lanka(2014), Core indicator reference guide

02) FPA Sri Lanka(2013), FPA Sri Lanka Monitoring and Evaluation Policy and Policy implementation Guideline.

03) FPA Sri Lanka(2014), Service Statistic Manual; Service Definitions and Glossary of Terms.

04) FPA Sri Lanka(2010), FPA Sri Lanka Monitoring and Evaluation Strategic Plan 2010 – 2015.

05) FPA Sri Lanka Organisational Web Site – www.FPA Sri Lankasrilanka.org

06) IPPF (2013), Branch Performance Tool user manual

07) IPPF (2014),Programmatic Guidance to Member Associations on Associated Clinics

08) IPPF (2009), Putting the IPPF Monitoring and Evaluation Policy into practice: A Handbook on collecting, analysing and utilising data for improved performance, International Planned Parenthood Federation (IPPF), 4 Newhams Row, London SE1 3UZ, United Kingdom. Available at : http://www.ippf.org/sites/default/files/ippfmonitoringevaluationhandbook.pdf

09) International Federation of Red Cross and Red Crescent Societies(2011), Project/ programme monitoring and evaluation (M&E) guide

10) International Planned Parenthood Federation(2010), IPPF Framework for Comprehensive Sexuality Education (CSE)

11) International Planned Parenthood Federation – Western Hemisphere Region (2010), Handbook for advocacy planning

12) United Nations Development Programme (2002), Handbook for monitoring and evaluation for results.

13) UNICEF (Not available), Guide for Programme Monitoring and Evaluation; Making a difference

14) Centre for Global Development (2013). US Spending in Haiti: The Need for Greater Transparency and Accountability

15) The Health Communication Capacity Collaborative HC3 (2014) Utilising ICT in demand generation for reproductive, maternal, newborn and child health: Three case studies and recommendations for future programming. Baltimore: Johns Hopkins Bloomberg School of Public Health Center for Communication Programmes.

16) United Nations Population Fund (2002) Communication and Behavior change tools, entertainment education

17) MEASURE Evaluation (2008). Data quality audit tool, guideline for implementation

18) UNAIDS (No year), 12 component Monitoring and Evaluation system strengthening tool

19) Pathfinder international (No year), Monitoring and Evaluation and Management Information systems.

20) Bernice Taylor & Associates (2009), Why hire an external evaluator?

Annexes

Annexes

Annexure 01 :- Glossary of Terms in M&E

Baseline information

Information consisting of facts and figures collected at the initial stages of the programme or project, it provides the basis for measuring the effect of an intervention.

Benchmark

A reference point or standard against which performance and achievements can be compared. A benchmark might refer to what has been achieved in the past.

Beneficiaries

The individuals, groups or organisations that directly or indirectly benefit from the development intervention.

Effect

Intended or unintended change resulting directly or indirectly from a development intervention.

Effectiveness

A measure of the extent to which a programme or project attains its objectives at the goal or purpose level- i.e. the extent to which a development objective has attained its objectives efficiently.

Efficiency

A measure of how economically inputs are converted into outputs

Evaluation

A systematic examination of a planned, ongoing or completed project / programme. Evaluation aims to answer specific management questions and judge the overall value of an intervention and provide lessons for future actions, planning and decision making.

Feedback

Dissemination of evaluation findings to all stakeholders for learning and sharing of information.

Impact assessment

The process of assessing the impact of a programme/project on a targeted or untargeted group.

Indicator

Quantitative or qualitative factor or variable that provides a simple and reliable basis for assessing achievement, change or performance. A unit of information measured over time that can show changes in a specific condition. A given goal or objective can have multiple indicators.

Input

The financial, human, material resources necessary to produce the intended outputs of a project/ programme.

Joint Evaluation

An evaluation in which different institutions or partners are involved.

Logical Framework Approach

An analytical, presentational and management tool that involves problem analysis, stakeholder analysis, developing a hierarchy of objectives and selecting a preferred implementation strategy.

Mid-Term Evaluation

An evaluation performed in the middle of the period of project/ programme implementation

Monitoring

The systematic and continuous collecting and using information for corrective measures during the implementation of the programme, it helps to provide information during evaluation.

Monitoring and Evaluation (M&E)

A process whose purpose is to measure and assess performance in the overall implementation of a programme/project.

M&E framework

An overview of the M&E system developed during the design phase of project/programme and included in the appraisal of the project

M&E plan

An overall framework of performance and learning questions, information gathering requirements, reflection and review of events with stakeholders, resources and activities required to implement a functional M&E system.

M&E System

The set of planning, information gathering and synthesis, reflection a d reporting processes, along with necessary supporting conditions and capacities required for an effective M&E programme.

Objective

A specific statement detailing the desired accomplishments or outcomes of a programme/ project.

Outcome

The results achieved at the level 'purpose' in the objective hierarchy. The expected change at community, beneficiary or policy level.

Output

The tangible, immediate and intended results to be produced through sound management of agreed inputs.

Qualitative

Something that is not summarized in numerical form. Qualitative data normally describe people's behaviour or attitudes.

Quantitative

Something that can be measured or measurable in numbers (quantified).

SMART

Specific**, M**easurable**, A**ccurate, **R**elevant**& T**imely -performance indicators characteristics.

Target

A specified objective that indicates what is to be realised at the end of a project.

Target Group

A specific group targeted by the programme/ project

Annexure 02:- Logical Framework Approach for Project Planning (An example ; Prevention of HIV among MSM)

Project Element	Objectively Verifiable Indicators	Sources / Means of Verification	Assumptions
Goal (What is the overall broader impact to which the action will contribute?)	What are the key indicators related to goals?	What are sources of information for these indicators?	What are the external factors necessary to sustain objectives in the long term?
Ex:- Maintain the current low prevalence level of HIV among MSM in Sri Lanka	**Eg:-** **1) Percentage of men who have sex with men who are HIV infected** **2) Syphilis prevalence among MSM**	**Eg:-** **National IBBS among MSM** **National IBBS among MSM**	**Eg:-** **Availability of good quality and accessible service delivery points without discriminations for MSM**

Project Element	Objectively Verifiable Indicators	Sources / Means of Verification	Assumptions
Outcome / Purpose (The expected change at community, beneficiary or policy level) Ex:- Increased safe sax practices and health seeking behaviors of men who have sax with men (MSM) in Sri Lanka	Which indicators clearly show that the expected change has been achieved? **Eg:-** **1) Percentage of MSM who used condoms for anal intercourse at the last occasion with a non-regular male sexual partner** **2) Percentage of MSM who received an HIV test in the last 12 months and who know their results**	What are the sources of information that exist or can be collected to verify the achievement of outcome indicators? **Eg:-** **National IBBS among MSM** **National IBBS among MSM**	If all outputs have been achieved as planned, which external factors and conditions are necessary to achieve the expected outcome? **Eg:-** **MSM will be able to read and understand the IEC materials distributed by the project.** **Peer educators will be able to train and motivate their peers for correct and consistent use of condoms and regular health check-up at STI clinics**

Project Element	Objectively Verifiable Indicators	Sources / Means of Verification	Assumptions
Output (The tangible, immediate and intended results to be produced through sound management of agreed inputs. This must be strong enough to produce expected outcome)	What are the indicators to measure whether and to what extent the action achieved the expected immediate results?	What are the sources of information (Ex: - programmatic documentation) that can be used to verify the achievement?	If the project has conducted all the activities as planned, what external conditions must be met in order to obtain the expected immediate results?
Ex At least 80% of men who have sex with men accessed minimum package of basic services for HIV prevention of which 40% of MSM received voluntary testing and counselling (VCT) from government STI clinics.	**Eg:-** **1) Number of peer educators from MSM trained on BCC** **2) Number and percentage of MSM reached with minimum sexual health package for HIV prevention** **3) Number of condoms distributed among MSM** **4) Number of MSM escorted to government STI clinics for VCT**	**Eg :-** **Training attendance sheets Pre and post-test forms** **Peer educator diary Peer educator calendars** **Peer educator calendars Stock registers** **Peer educator calendars Escort slip signed by the medical officer at STI clinic**	**Eg:-** **National STI and AIDS control programme will provide required support for VCT.** **High level of commitment from voluntary peer educators to reach their peers**

Project Element	Objectively Verifiable Indicators	Sources / Means of Verification	Assumptions
Activities What are the key activities to be carried out and in what sequence in order to produce the expected output / result? Please do not include implementation steps (such as selection of peer educators) as activities.	01) **Selection and training of 500 MSM peer educators (conduct 20, five day trainings to develop skills and knowledge of participants to implement peer education programmes focusing on behavioral change communication** 02) **Develop and distribution of peer educator toolkits among 400 MSM peer educators (The tool kit will include behavioral change communication guide, dildo for condom demonstration, a bag, peer educator ID, Peer educator daily record book/dairy)** 03) **Develop and printing of three sets of IEC materials (7000 from each set) in Sinhala and Tamil languages and distribute among 6000 MSM** 04) **Implement outreach activities through 400 peer educators and 40 field supervisors** 05) **Printing of client registration forms, peer educators pocket calendars, templates for meeting minutes and clinic escort slips to closely monitor outreach activities** 06) **Conduct monthly progress review meetings (one per each district) with peer educators.**		

Annexure 03 :- Rationale for selection of the community and service delivery approach (An example; Prevention of HIV among MSM)

Rationale for selection of the community

The most common mode of transmission of HIV has consistently been found to be sexual. Key populations at higher risk from this mode of transmission are female sex workers and their clients, beach boys, men who have sex with men, and prisoners. The National HIV and AIDS Strategic Plan 2007 – 2011 looks to the likely drivers of the epidemic in the future and in its first strategy includes the following key populations at higher risk for targeted prevention: female sex workers and their clients, men who have sex with men, drug users including injecting drug users, and prisoners (The National HIV and AIDS Strategic Plan 2007 – 2011).

The estimated population of high risk men who have sex with men in the country is 7,551with the range from 6,547 to 8,554 (National size estimation of most at risk populations for HIV in Sri Lanka, 2013).While prevalence of HIV (less than 1%)and syphilis (less than 2%)is low, overall MSM show poor performance on all Global AIDS Response Progress Reporting (GARPR) indicators, including condom usage (64.3% to 34.2%), HIV testing, knowledge and reach of prevention programmes. Anal sex is high amongst MSM across all districts, alongside poor condom usage, clearly providing a pathway for the increased spread of HIV. Presence of sex with women is present, illustrating the potential for cross-spread between MARP and general populations. Many MSM have both sold and paid for sex, and the qualitative component further confirmed that identities and boundaries are sometimes blurred between MSM and sex work. These blurred sexual boundaries may be creating potential for multiple environments of risk, which are not well understood by service providers and should be taken into account for successful prevention and treatment and care programmes (Integrated biological and behavioral surveillance among key population in Sri Lanka, 2015).

Rationale for selection of service delivery approach

This project includes peer education, which is one of the community outreach service delivery models as the key service delivery approach. Peer Education is an approach to health promotion, in which community members are supported to promote health-enhancing change among their peers. Peer education is the process of teaching or sharing of health information, values and behavior in educating others who may share similar social backgrounds or life experiences. Rather than health professionals educating members of the public, the idea behind peer education is that ordinary lay people are in the best position to encourage healthy behavior to each other. Peer education has become very popular in the broad field of HIV prevention. It is a mainstay of HIV prevention in many developing countries, among groups including young people, sex workers, men who have unprotected sex with men, or people who use intravenous drugs. Peer education is the most suitable and effective approaches to reach hidden populations like MSM. Peer educators will escort their peers to the nearby static clinic lead by a professional service provider for further services based on individual needs.

Annexure 04:- An example for development of beneficiary and service provider Selection criteria – HIV prevention among MSM

Selection criteria for MSM

- Definition - Men who have had sex with another men in the past six months as a matter of preference or practice, regardless of their sexual identity or sexual orientation, and irrespective of whether they also have sex with women or not.
- Should be a *male* who engages in sex (receptive or insertive) regularly or irregularly with male/s
- Should be operating in the particular District taken into consideration for the particular project
- Transgender people are also considered as MSM.
- No age limit; but sexually active. However this project strongly recommends not selecting children less than 18 years of old.
- Willing to receive information and services from their peers.

Peer Educators:

- Should be a *male* who engages in sex regularly or irregularly with male/s (Should fulfill all above criteria)
- Should complete at least 4 days out of 5 days of the peer educator training programme
- Should be operating in the particular District taken into consideration for the particular project
- Should have good interpersonal and leadership skills
- Should be literate and be able to understand complex instructions
- Should possess skills required to acquire knowledge and to train peers with limited literacy capabilities.
- Should be able to find a minimum of 15 peers in the operating area
- Willing to work voluntary for this project
- It is encouraged to recruit people with a national identity card and personal bank account
- Previous work experience in a similar project is an added advantage.

Annexure 05:- Template for selection of geographical locations (Districts and MOH areas or PHM areas) for implementation of new projects or expansion of existing projects (please use latest available data). [9]

Name of the Project : - ……

Director/s responsible : - …….. Date: - ……

Justification of Selection of geographical area

Geographical area (District, MOH area or PHM area)	Achievements of the current program (if available)	Quantitative evidences / Indicators[8]					Selected or Not	Justification for selection or not
		Indicator-1	Indicator-2	Indicator-	Indicator-	Indicator-n		

Remarks:- …… ……

……

……

Prepared by:-

Name :- ……..

Designation :- ……..

Signature :- ……..

Date :- ……..

Approved by:-

Name :- ……..

Designation :- ……..

Signature :- ……..

Date :- ……..

8 An indicator guide with source of information is presented in the bellow table.

9 This table will provide only a guidance on secondary information but not an all-inclusive list of indicators.

Geographical level	Focus	Indicator	Source
1) District / RDHS area Selection	Maternal and child health	Maternal Mortality Ratio	Annual Report - Family Health Bureau
	Unmet need for family planning	Percentage of sexually active couples who are not expecting a child in the next two years and yet not practicing any family planning method.	Annual Report - Family Health Bureau
	Contraceptive prevalence	Current family planning user rate for modern methods	Annual Report - Family Health Bureau
	Contraceptive prevalence	Percentage of currently married women aged 15-49 who are currently using any modern methods of contraception	Demographic and Health Survey
	Unmet need for family planning	Pregnant mothers P5 and above registered	Annual Report - Family Health Bureau
	Exposure to family planning information	Percentage of ever-married women age 15-49 who heard or saw a family planning message on the radio or television or in a newspaper	Demographic and Health Survey
	Exposure to family planning information	Percentage of women who neither discussed family planning with a fieldworker nor at a health facility	Demographic and Health Survey
	Demographic trends	Total Fertility Rate	Demographic and Health Survey
	Access to well women Services	Percentage of 35 year age cohort subjecting to pap smear testing	Annual Report - Family Health Bureau
	Access to government family health services	Percentage of eligible families registered by PHM (Out of estimated eligible families).	Annual Report - Family Health Bureau
	Access to ANC services	Percentage of pregnant mothers registered by PHM (Out of estimated pregnancies)	Annual Report - Family Health Bureau
	Access to ANC services	Percentage of pregnant mothers reported first ante natal clinic visit (out of estimated pregnancies)	Annual Report - Family Health Bureau
	Access to ANC services	Percentage of antenatal mothers having the first home visit	Annual Report - Family Health Bureau
	Access to ANC services	Percentage of ANC clinic attendees screened for VDRL	Annual Report - Family Health Bureau
	Access to ANC services	Number of VDRL clinics available	Annual Report - Family Health Bureau

Geographical level	Focus	Indicator	Source
	Access to child health services	Percentage of infants -with at least one field visit registered for infants after 42 days.	Annual Report - Family Health Bureau
	Adolescent health	Percentage of teenage pregnant mothers registered	Annual Report - Family Health Bureau
	Adolescent health	Percentage of all women aged 15-19 who have had a live birth or who are pregnant with their first child	Demographic and Health Survey
	STI prevalence	Percentage of mothers (ANC) with reactive VDRL	Annual Report - Family Health Bureau
	STI prevalence	proportion of new STD clinic attendees who had at least one sexually transmitted infections (STI)	Annual Report - National STI and AIDS Control Programme
	HIV prevalence	Cumulative number of HIV cases reported	Annual Report - National STI and AIDS Control Programme
	HIV prevalence	Rate of HIV cases reported (Cumulative) per 100,000 population	Annual Report - National STI and AIDS Control Programme
	HIV prevalence among MARP	HIV prevalence among MARP (MSM/BB/FSW/DU and IDU)	Recent IBBS
	STI prevalence among MARP	HIV prevalence among MARP (MSM/BB/FSW/DU and IDU)	Recent IBBS
	Most at risk populations (MARP) for HIV and STI	Estimated number of MARP (MSM/BB/FSW/DU and IDU)	Recent Population size estimation
	Access to STI services	Number of functioning STI clinics available in the district	National STI and AIDS Control Programme
	Access to STI services	Number of functioning STI clinics with a consultant venereologist	National STI and AIDS Control Programme
2) MOH area / PHM area	Access to SRH services	Number of dedicated PHM	RDHS / MOH office
	Adolescent health	Percentage of teenage pregnant mothers registered	RDHS / MOH office
	Need for family planning services	Number of pregnant mothers P5 and above registered	RDHS / MOH office
	Need for family planning information and services	Number of unsafe abortion cases reported	RDHS / MOH office

Annexure 06:- Template for planning and design of advocacy projects (An example; advocate for access to safe abortion for rape, incest and fetal abnormalities)

01) **Advocacy Issue / Problem**

a) What is the advocacy issue or policy that you are focusing on? (Maximum 100 characters)

Restrictive law on abortion which leads to high incidence of unsafe abortions and its consequences (Ex: - maternal morbidity) in Sri Lanka

b) Briefly explain the above advocacy issue using examples? (Maximum 500 characters)

Abortion is legally permitted in Sri Lanka only if it is performed to save the mother's life (Penal Code 303 Sri Lanka, 1883). Even with a relatively high National Contraceptive Prevalence Rate (CPR) of 68 percent with 50 percent using modern methods, some women still resort to abortion in Sri Lanka (Senanayake, 2009). As there is a restrictive law on abortion in the country, it is difficult to determine an accurate prevalence rate for illegal and unsafe abortions. Although Sri Lanka has a very restrictive law on abortion, it is estimated that 125,000 to 175,000 induced abortions are performed annually in Sri Lanka and around 500 abortions are performed daily in the city of Colombo alone (de Silva, 1997).

As per the Family Health Bureau, the percentage contribution from abortion to maternal mortality was 13.5 percent, making it the second common cause of maternal death (FHB, 2010). Cause specific mortality rate for abortion is reported as 4.5 in 2010. Other consequences of abortion include, cost to the mothers (direct cost and indirect cost), cost to the health system, psychological problems, family issues, social stigmatization and emotional trauma, loss of fertility as well as post abortion complications leading to acute and chronic ill health. A recent study revealed that, the average cost (both direct and indirect) of an abortion that is incurred for obtaining and managing the associated complications amounted to LKR 46,176 which consists of 79 percent of the health system cost (LKR 36,479), direct cost of the women (LKR 4,156) and indirect cost (LKR 5,541) of the women (Talagala, 2010a). Furthermore, a few studies conducted in selected samples indicate that about 12 to 14 percent of abortion seekers in Sri Lanka experienced some form of medical complication following abortion (Perera et al., 2004).

c) Please provide maximum widely accepted scientific evidences which describe the above issue.

Quantitative

	Indicator	Year	Data source (Source for verification)	Figure
01	Estimated number of illegal abortions in Sri Lanka	1997	Silva, I. W. D. (1997) The Practice of Induced Abortion in Sri Lanka, Takemi Programme in International Health 137, Harvard School of Public Health.	125,000 to 175,000
02	Percentage contribution from abortion to maternal mortality	2010	Family Health Bureau (2010)	13.5%
03	Cause specific mortality rate for septic abortion	2010	Family Health Bureau (2010)	4.5
04	Average cost (both direct and indirect) of an abortion that is incurred for obtaining and managing the associated complications	2010	Talagala, N. (2010a) Economic perspectives of unsafe abortions in Sri Lanka. The Family Planning Association of Sri Lanka, The Family Planning Association of Sri Lanka, Colombo 07.	LKR 46,176
05	Percentage of abortion seekers experienced medical complications following an illegal abortion	2004	Perera, J., De Silva, I. W. and Gange, H. (2004) Knowledge behavior and attitude on induced abortion and family planning among Sri Lankan women seeking termination of pregnancy. Ceylon Medical Journal.	12% - 14%
06	Number of rape (and incest) cases reported	2011	Police Department statistics (Sunday times, June, 24, 2012)	1169
07	Percentage of infant deaths due to congenital abnormalities	2009	Family Health Bureau (2007/2008)	42.8% (1351/3153)

Qualitative

	Indicator	Year	Data source (Source for verification)	Description
01	Incidences of illegal abortions in Sri Lanka	2008	Senanayake, L., Willatgamuwa, S. and Jayasinghe, K. (2008) Reducing the burden of unsafe abortion in Sri Lanka. Family Planning Association of Sri Lanka, Family Planning Association of Sri Lanka, Colombo 07.	If one were to consider the lower estimate of unsafe abortions (658 per day), there must be 240,170 abortions performed in one year whereas there are only 370,424 births in one year (FHB, 2005). If these estimates are accepted, two fetuses are aborted for three babies born in Sri Lanka.
02	Medical, social and psychological, consequences of unsafe abortion	2004	Perera, J., De Silva, I. W. and Gange, H. (2004) Knowledge behavior and attitude on induced abortion and family planning among Sri Lankan women seeking termination of pregnancy. Ceylon Medical Journal.	consequences of unsafe abortion include, cost to the mothers (direct cost and indirect cost), cost to the health system, psychological problems, family issues, social stigmatization and emotional trauma, loss of fertility as well as post abortion complications leading to acute and chronic ill health.
03	Current trend in rape and incest incidences	2012	Police Department statistics (Sunday times, June, 24, 2012)	5 rape cases are reported each day and this rate has risen over the last 5 years. In 2011 alone, there were 1169 reported cases of statutory rape compared to 800 in 2005.

d) Please provide information on current policies / legislatives which are related to the above issue.

Name of the policy or legislatives	Clause / statement related to the issue	How does this policy effect overcoming the issue? (Supportive or conflicting)	Key actors / implement-ers of the policy / close	Is the policy (or clause) / legislative been implemented actively? (Yes / No)	Remarks
Section 303 of the Penal Code -1883	An abortion may only be performed to save a woman's life. A legally acceptable abortion requires two board certified Gynaecologists to confirm that carrying the pregnancy to term and/or delivering the baby will be a threat to the woman's life.	Conflicting	Police Depart-ment ?? Ministry of Health ??	Yes	Any person performing an illegal abortion is liable to be punished with imprisonment of either description for a term which may extend up to 3 years or with fine or with both.
Section 304 of the Penal Code -1883	In case of death of such women, the person performing an illegal abortion shall be punished with imprisonment up to 20 years	Conflicting	Police Depart-ment Ministry of Health ??	Yes	
	If a person comes for an illegal abortion and she is referred for that purpose to another medical officer, the person who made the refer-ral would be guilty of the offence of abetment of abortion and such person had knowingly facilitated the commission of the offence	Conflicting	Police Depart-ment Ministry of Health ??	Yes	

Name of the policy or legislatives	Clause / statement related to the issue	How does this policy effect overcoming the issue? (Supportive or conflicting)	Key actors / implement-ers of the policy / close	Is the policy (or clause) / legislative been implemented actively? (Yes / No)	Remarks
??	A medical officer need not report to the authorities when a person after an illegal abortion visits him for treatment. There is no legal obligation to furnish information with respect to the commission of the offence of abortion. A medical officer to whom a patient is re-ferred to after complications after an abortion will not be guilty of treating the patient. Even when a person comes requesting an illegal abortion, though it is clear that the person would get it done some-where else, still there is no legal duty on the part of the medical officer to report that information to the police.	Supportive	Police Depart-ment Ministry of Health ??	Yes	

e) Please provide information of key stakeholders (including decision makers) related to the above policy or advocacy issue (Stakeholder Mapping).

Stakeholder / Decision maker	Role or activities that affect the policy or policy activities	Attitude towards the issue (Strongly support, Moderately support, Strongly oppose, Moderately oppose, Unknown)	Power to make a change happen (High, Medium, Low)	Reasons for supporting or Opposing (reasons for being either progressive or controversial) / Motivating interest
All Sri Lankan women in the reproductive health sector	Face the issue.	Unknown	Low	Unknown
Family Health Bureau	Main key actor in the sector. Implement the MCH programme	Supportive	Medium	Exposed to the issue in day to day life
SLCOG	Professional body with high technical capacity	Supportive	Medium	Exposed to the issue in day to day life
Parliamentarians	Key decision maker	Oppose	High	Social, cultural values
Religious leaders	Key opposite group	Oppose	Medium	Religious teachings
University - Medical Faculties	Develop and transfer knowledge	Unknown	Medium	Unknown
Law Professionals	Provide technical inputs for development of laws	Unknown	High	Unknown
Media	Agent for social change	Unknown	Medium	Unknown
Politicians and party leaders (other)	Affect the decisions of key decision makers	Oppose	High	Social, cultural values
Ministry of women's affairs	Key actor in the process of policy development and initiation of the change	Moderately Supportive	High	Exposed to the issue in the day today life

Stakeholder / Decision maker	Role or activities that affect the policy or policy activities	Attitude towards the issue (Strongly support, Moderately support, Strongly oppose, Moderately oppose, Unknown)	Power to make a change happen (High, Medium, Low)	Reasons for supporting or Opposing (reasons for being either progressive or controversial) / Motivating interest
Police Officials	Implementation of current law	Oppose	Medium	Legal
Civil society Organ-isations working for women's rights	Future partners of the initiative	Strongly Supportive	Low	Rights based

02) **Advocacy Expected Results (AERs)**

a) What is the goal of your advocacy effort? (Goal is your vision or the broad long term impact of your efforts that you would like to see)

To reduce incidence of unsafe abortion and its' consequences by 20% in Sri Lanka by 2025

b) What is / are the advocacy expected result/s (AERs) or advocacy objective/s?(Please note that the advocacy expected results must be Specific, Measurable, Achievable, Realistic and Time bound)

Pass an amendment to the current law on abortion (Penal code 303, 1883) to legalize abortions under rape, incest and fetal abnormality conditions by 2018.

c) Please briefly describe your advocacy expected result. Explain the positive change that you would like to see as the results of your efforts.

The proposed change is to expand the law to include rape, incest and congenital abnormalities (not compatible with life) as justifiable reasons to terminate a pregnancy. This amendment will thus provide solace only to women in circumstances that are largely beyond their control. These groups of women are currently being forced to complete their pregnancies, go through labour and suffer the ensuing complications to become mothers to children conceived under violent and traumatic circumstances.

We have seen women who have got pregnant after rape or incest, who are desperately in search of a termination. While a few may even resort to suicide, the majority undergo unsafe abortions that can result in permanent physical disability, psychological trauma or even death. Some who cannot afford a termination or have no access to the service, conceal the pregnancy, deliver the baby and abandon it in desperation.

Relaxing the law on abortion for rape, incest and fetal abnormalities **DOES NOT MEAN** that **ALL** pregnant women under these circumstances will be forced to terminate their pregnancies. It will **ONLY** give these women an option, of choosing to complete the pregnancy or terminating it within a given legal period of time if they so desire. Women with religious or other moral convictions against abortion should be given the support they need to continue with their pregnancies.

d) Please describe historical efforts to achieve above advocacy expected results, if any

For the first time in the late 1970's a private bill was endorsed by a member of the Sri Lanka parliament with the intention of legalizing abortion. But it was unsuccessful due to pressures from religious groups. An amendment to liberalise the abortion law for some situations (rape, incest and fetal abnormalities) was presented to the Sri Lankan Cabinet in July, 1995. There was much debate and after being presented to the parliament again it was rejected due to pressures from religious groups (Senanayake et al., 2008).

e) What is the time frame?

Before 31st December 2020

f) Please identify maximum (up to four) milestones for your advocacy expected result.

Milestone	Description	Time Frame
Active coalition to implement and manage the change that is formed and established.	Formation of the coalition means at least 80% of members in the coalition will agree in writing to publicly speak for the advocacy expected result. Establishment of the coalition means at least 4 coalition meetings have been conducted	Before 31st of December 2016
Cabinet paper and the amendment to the law are drafted and accepted by the ministry of women affairs.	Accepted means the ministry of women's affairs agreed in principle to present the paper to the cabinet	Before 31stof December 2017
Cabinet paper is approved	N/A	Before 31stof December 2019
Amendment to the current abortion law is passed in the parliament.	N/A	Before 31stof December 2020

03) **Advocacy Targets / Audiences**

a) Please state the primary target / audience of your advocacy efforts (please note that the primary target is the institution or the person who can make the above policy decision. (Please be specific in your answer)

Primary Target	Parliamentarians
Contact Person (if applicable)	Not applicable
Designation	
Postal address	
Telephone (Office):-	
Telephone (Mobile):-	
Fax :-	
e-mail	
Level of understanding / knowledge about the issue (High, Low, unknown)	Low
Degree of support for or opposition to advocacy expected results (Support, Oppose, Neutral, unknown)	Oppose
Remarks	

b) Please identify secondary targets / audiences of your advocacy efforts (Please note that the secondary targets or audiences are the institutions or people who can influence the primary targets / audience)

Secondary Targets (General info- same as above)	How they can influence primary targets	Level of understanding / knowledge about the issue (High, Low, unknown)	Degree of support for or opposition to advocacy expected results (Strongly Support,Support, Oppose, StronglyNeutral, unknown)	What changes do we want to see in their behavior and the actions they take
Ministry of women's affairs	By getting the amendment approved by the cabinet	Low	Supportive	Agree to present the amendment to the cabinet
Party leaders and other politicians	Can make collective agreements and force parliamentarians	Low	Unknown	Speak for AER at political meetings
Religious leaders	Oppose and hinder the change. Can build opposition social groups.	Low	Strongly Oppose	Do not oppose and do not raise social problems
Media Personnel l	By changing the attitudes and opinions of the community	unknown	Unknown	Speak / write for AER
Law Professionals	Oppose and hinder the change	unknown	unknown	Speak / write for AER

Annexure 07:- Template for M&E metrics (An example from prevention of HIV among men who have sex with men)

Level	Indicator	Indicator Reference[10]	Data collection methodology	Frequency of data collection	Responsible person, unit or partner
Goal / Impact	01) Percentage of men who have sex with men who are HIV infected	Indicator HIV/IM/03 of FPA Sri Lanka CIRG[11]	IBBS report	Once in 2 years	NSACP
	02) Syphilis prevalence among MSM	Indicator HIV/IM/02 of FPA Sri Lanka CIRG	IBBS report	Once in 2 years	NSACP
Outcome / Purpose	01) Percentage of MSM who used a condom for anal intercourse at the last occasion with a non-regular male sexual partner	Indicator HIV/OC/05 of FPA Sri Lanka CIRG	IBBS report	Once in 2 years	NSACP
	02) Percentage of MSM who received an HIV test in the last 12 months and who know their results	Indicator HIV/OC/10 of FPA SRI LANKASL CIRG	IBBS report	Once in 2 years	NSACP
Output	01) Number of peer educators from MSM trained on BCC	Indicator HIV/OP/03 of FPA Sri Lanka CIRG	MEIMS[12]	Monthly	Peer educator and field Supervisor
	02) Number and percentage of MSM reached with minimum sexual health package for HIV prevention	Indicator HIV/OP/05 of FPA Sri Lanka CIRG	Peer educator calendar and MEIMS	Monthly	Peer educator and field Supervisor
	03) Number of condoms distributed among MSM	Indicator HIV/OP/08 of FPA Sri Lanka CIRG	Peer educator calendar and MEIMS	Monthly	Peer educator and field Supervisor
	04) Number of MSM escorted to a government STI clinic for VCT	Indicator HIV/OP/06 of FPA Sri Lanka CIRG	Peer educator calendar and MEIMS	Monthly	Peer educator and field Supervisor

10 Reference to details on indicator. If the project does not use standard indicators, an indicator reference sheet must be provided as an annexure to the M&E plan. Indicator reference sheet must include indicator definition, rationale, numerator, denominator, data collection methodology, means of verification, strength and weaknesses of the indicator, references, if any

11 FPA Sri Lanka CIRG = FPA Sri Lanka Core Indicator Reference Guide, 2014

12 MEIMS = Monitoring and Evaluation Information Management System

Annexure 08:- Template for performance framework (An example for prevention of HIV among men who have sex with men)[13]

Level	Indicator	Baseline			Targets				Remarks
		Value	**Year**	**Source**	**Period 01**	**Period 02**	**Period 03**	**Period 04**	
Goal / Impact	01) Percentage of men who have sex with men who are HIV infected	1%>	2009	Sentinel sero surveillance	N/A	N/A	N/A	1%>	N/A
	02) Syphilis prevalence among MSM	3%	2009	Sentinel sero surveillance	N/A	N/A	N/A	3%	N/A
Outcome / Purpose	01) Percentage of MSM who used a condom for anal inter-course at the last occasion with a non-regular male sexual partner	64%	2007	Behavioural Surveillance Survey	N/A	N/A	N/A	85%	N/A
	02) Percentage of MSM who received an HIV test in the last 12 months and who know their results	17%	2007	Behavioural Surveillance Survey	N/A	N/A	N/A	60%	N/A
Output	01) Number of peer educators from MSM trained on BCC	112	2012	Actual results reported	250	350	400	400	Annual Cumulative
	02) Number and percentage of MSM reached with minimum sexual health package for HIV prevention	N/A	N/A	N/A	N = 2,000 D= 10,000 %=20%	N = 4,000 D= 10,000 %=40%	N = 5,000 D= 10,000 %=50%	N = 6,000 D= 10,000 %=60%	Annual Cumulative D=National Size Estimation
	03) Number of condoms distrib-uted among MSM	600,000	2012	Actual results reported	192,073	439,024	329,268	658,536	Annual Cumulative
	04) Number of MSM escorted to a government STI clinic for VCT	N/A	N/A	N/A	30% of 2000	30% of 4000	30% of 5000	30% of 6000	Annual Cumulative

13 Performance framework and M&E metrics may merge together for projects planned for small time period (Eg:- Annual or less)

Annexure 09:- Template for registration of service providers

	Service provider reference[14]	*Service provider name in Full*	*Designation (FPA Sri Lanka)*	*Past relevant experiences*[15]	*Qualification (Educational and Professional)*[16]	*Employment Status at any other organisation*[17]	*Employment status at FPA Sri Lanka*[18]	*Date of commencement*
1								
2								
3								
4								
5								
6								
7								

14 This has to be a unique identification number (UIN) for each service provider. Same code must be followed for registration of all the service providers (Ex:- BT/2012/01) 0r BT/Counsellor/01)

15 Eg:- 10 years of experience as a professional Counsellor

16 Eg:- BA (Psychology special), MA (Psychology), Post graduate diploma in counselling

17 If the service provider is not a full time employee at FPA Sri Lanka, Please provide the current designation (if any). Ex:- Full time employee as the Medical Officer of Health, Lahugala MOH area

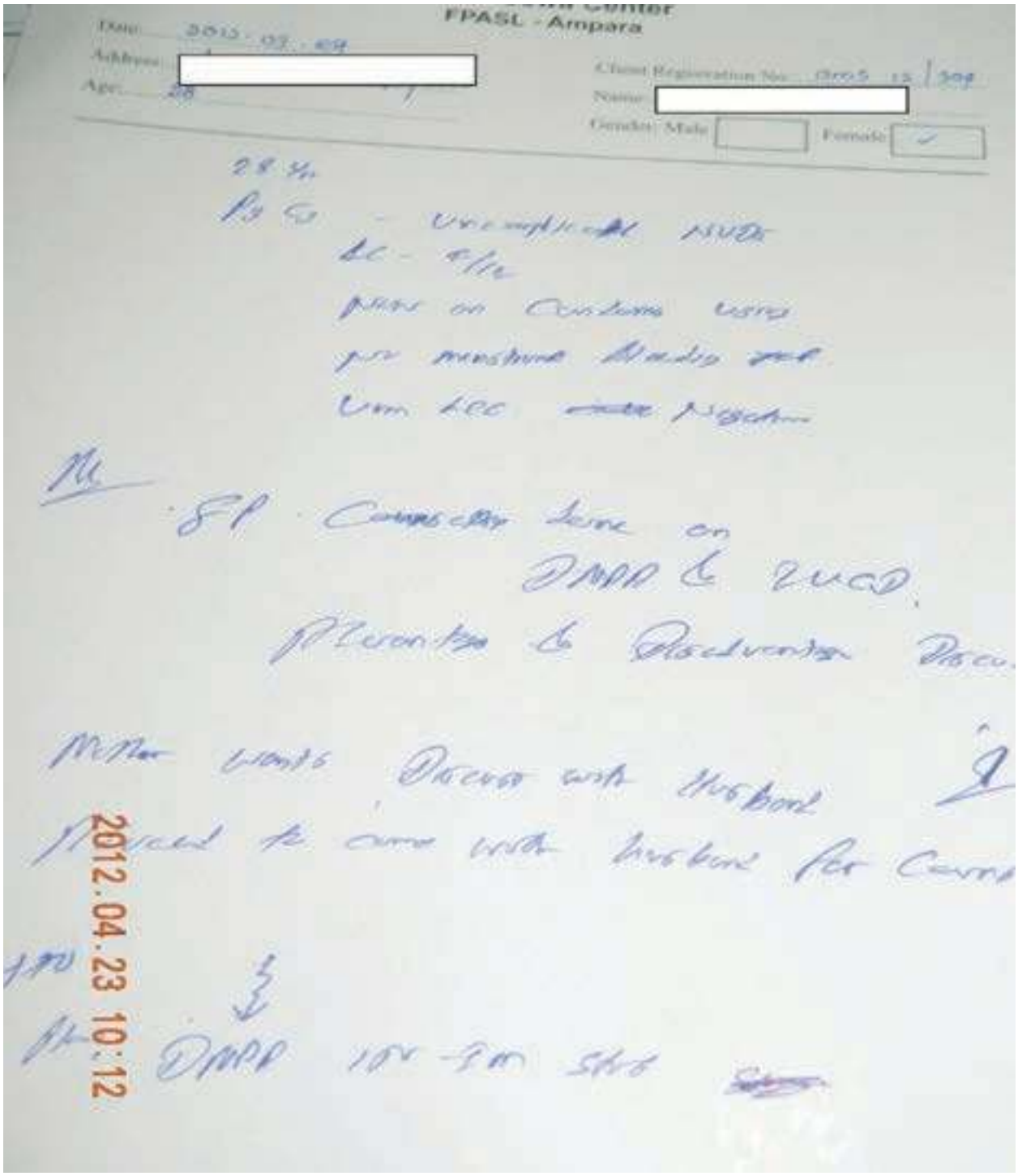
18 Eg:- Full time, Part time, Fixed term contract basis, Daily pay basis, Volunteer, etc

Annexure 10:- Template for registration of Static clinic clients

Entity unit	
District	
Client Ref Number	
Client name	
Age	
Marital status	Married ☐ Unmarried ☐
Address	
PHM area (if applicable)	
Gender	Male ☐ Female ☐
Telephone Home	
Telephone mobile	
Referred by[19]	Referred by a client ☐ Newspaper ☐ Referred by a volunteer ☐ Radio/TV programme ☐ Referred by FPA SRI LANKA staff ☐ Referred by a doctor/Organisation ☐ Happy life ☐ Demand Generation programme ☐ Leaflet ☐ Internet/Web sites ☐ Other ☐

19 Who referred the client to the SDP? Or what is the demand generation strategy. This must be identified and recorded by the receptionist after the discussion with the client. In case the client mentions two or more sources (Eg:- web site and referred / recommended by another client), the most effective source must be reported Eg:- Referred / Recommended by another client.

Annexure 11:- A sample client history form / Clinic card



Annexure 12:- Service Statistic Data Entry Format

1. ***Project name*** ***:- ……..***
2. ***Entity unit*** ***:- ……..***
3. ***Method of Service delivery*** ***:-*** ***Static clinic*** ☐
   Mobile clinic ☐
   Associated clinic ☐
   Community base distribution ☐
   Telephone hotline ☐
4. ***Specific Objective*** ***:- ……..***
5. ***Activity*** ***:- ……..***
6. ***Sub activity*** ***:- ……..***
7. ***Implementing steps*** ***:- ……..***
8. ***Client Ref Number*** ***:-*** ☐
9. ***Age*** ***:-*** ☐
10. ***Gender*** ***:-*** *Male* ☐ *Female* ☐
11. ***District*** ***:- ……***
12. ***Fee*** ***:-*** *Free* ☐
    Subsidise ☐
    Pay ☐
13. ***Service Offered*** ***:- Service Category*** ☐ ***Service offered*** ☐
14. ***Referrals*** *:- Service* ***Category*** ☐ ***Service offered*** ☐
    Name of the Organisation ☐
15. ***Items provided*** ***:- Item Category*** ☐ ***Item provided*** ☐ ***Quantity*** ☐
16. ***New User*** *:- Yes* ☐ *No* ☐
17. ***Service providers*** ***:- Entity unit*** ☐ ***Service provider name*** ☐

Annexure 13:- Template for registration of mobile service sessions

	Mobile Clinic Reference No (UIC)	*District*	*MOH area*	*PHM area*	*Venue*	*Date*		*Budget Allocation*	*Actual direct expenses*	*No of participants*		*Name/s of the Resource persons*
						From	*To*			*Male*	*Female*	
1												
2												
3												
4												
5												

Annexure 14:- Template for registration of associated clinics

	Associated Clinic Reference No (UIN)	*District*	*MOH area*	*PHM area*	*Organisation that manages the AC*	*Name and Address of the contact person*	*Telephone Number*	*e-mail address*	*Name and designation of the person who signed the AC [20]*	*MoU or agreement is valid*		*Name/s and designation/s of the service provider/s*
										From	*To*	
1												
2												
3												
4												
5												

Please make necessary arrangements to register the above associated clinic/s in FPA Sri Lanka Monitoring and Evaluation Information Management System.

…….

SDP Manager

Date : - ……..

……..

Head of the Unit

Date : - ……..

20 Please attach a copy of MoU

Annexure 15:- Template for registration of community based distributors / peer educators

Replacement or New Recruitment (Yes -Replacement, No-New Recruitment	For Replacement only			Name of the field supervisor	Name of the New Volunteer/HA	New Volunteer/ HA No	MOH area	PHM area	Qualifications and Previous Experience	Name and dates of the trainings conducted by FPA Sri Lanka	NIC Number	Mobile Number	Address
	Name of the Previous Volunteer/HA	Previous Volunteer/ HANo	Date of res-ignation of the Previous Volunteer/ HA										
No													

Please make the necessary arrangements to register above associated clinic/s in FPA Sri Lanka Monitoring and Evaluation Information Management System.

…….

SDP Manager

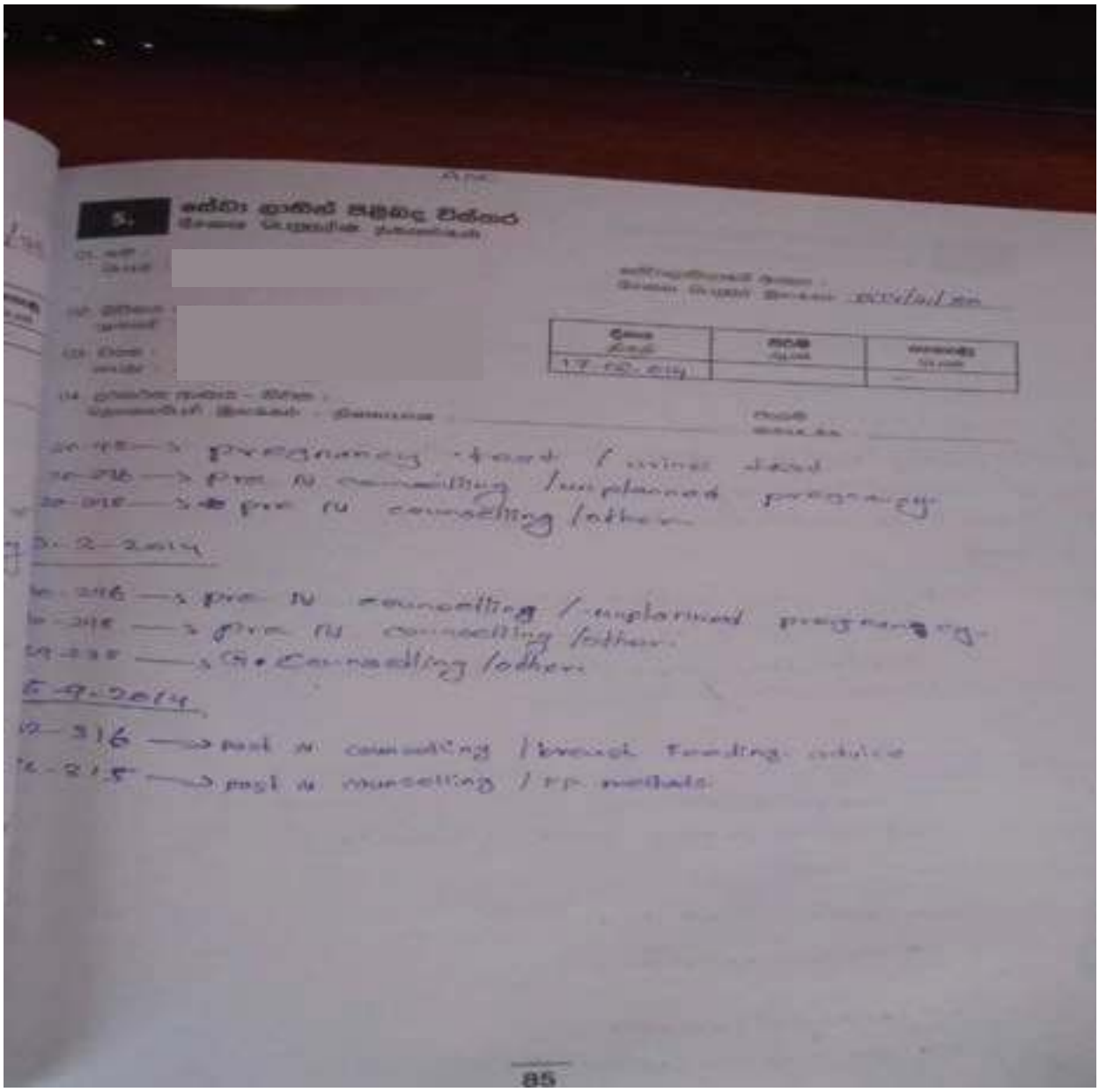
Date : - ……..

…….

Head of the Unit

Date : - ……..

Annexure 16:- Client wise record maintenance by CBDs / VHAs



Annexure 17:- Data requirement of the social marketing programme

17.1. Product database

Date	General Information				Unit of measure and sales Price			Unit of measure and sales Price				Remarks
	Brand ID	Product Category	Brand Name	Date of registration	Unit of measure	Date range [21]	Wholesale Price	Unit of measure	Date range [22]	Wholesale Price	Retail Price	

21 Database must be able to capture price changes over time
22 Database must be able to capture price changes over time

17.2. Marketing Officer Database

General Information				Line of command			Annual Targets				Dates		Remarks
Marketing Officer ID	Marketing officer Name	Mobile number	Email address	Year	Area Manager	Assistant director	Year	Brand	Unit of Measure	Annual Target	Date of Registrations	Date of Resignation	

17.3. Projection of the social Marketing Programme

Date From	Date to	Brand	Unit of Measure	Sale projection for the period	Income projection for the period	Remakes

17.4. Retail outlet database

General Information							Geographical information			Outlet type (Retail shop, Pharmacy, Medical Practitioner, etc.)	Date of registration	Pharmacy Registration Number	Remarks
Date	Retail outlet ID	Name of the outlet	Name of the Owner	Address	Mobile number	Email address	Area	District	GIS map				

17.5. Sales and Income data

Date: - …… **Sales outlet: - ……**

Name of the marketing officer: - ……

Sales Transaction ID	Brand / Brand ID	Unit of measure	Amount Sales	Amount Returned	Discount	Income

17.6. Stock update and item distribution report

Reporting period:-

Date From: - …….. Date to : - ……..

Brand: - …….. Unit of Measure : - ……..

Stock Update

Open stock as at <date from> (A) :- ……..

Number Received (B) :- ……..

Number issued to marketing officers (C) :- ……..

Number returned by the marketing officers (D) :- ……..

Number issued to other projects / Persons (E) :- ……..

Closing balance as at <to date> (A+B+D-(C+E)) :- ……..

Distribution

Marketing officer ID	Marketing Officer Name	Number to the MO issued during the period	Number returned by the MO during the period	Remarks
Total		**C**		

17.7. Income data from finance unit

Date from: - ……. Date to: - ……

Marketing Officer ID	Pharmacy ID	Total amount due as at <from date> (A)	Total invoice value (B)	Total actual income (C)	Amount due (A+B-C)

Annexure 18:- Template for Volunteer Health Assistant's (VHA) referral slip [23]

S:No

Client ID :- ……..

Client Age :- ……..

Client gender :- ……..

Clinic Date :- ……..

VHA ID : - ……..

Date :- ……..

S:No

Volunteer/Health Assistant's Referral slip
The Family Planning Association of Sri Lanka

Client ID :- ……..

Client Age :- ……..

Client gender :- ……..

Clinic Date :- ……..

Name of the VHA :- ……..

VHA ID :- ……..

Volunteer/Health Assistant signature :- ……

23 Left side of the slip is to be kept with the VHA and the right side of the slips has to handed over the clinic at the time of registration.

Annexure 19:- Template for reporting of programmes and events

Project :		**Date :**	
Specific Objective:		**Entity Unit :**	
Activity :		**District :**	
Sub Activity:		**Programme Event Type :**	
Impl Step :		**Location :**	
MOH Area :		**Target Group :**	
Venue :		**Income :**	
Budget Allocation (Rs) :		**Actual Expenses (Rs) :**	
Date From :		**Date To :**	

No of Participants

Male : Female :

Resource Person/s

Designation : Name :

Content / Key Message

Content / Key Message[24]

Remarks:

Do you have following Means of Verifications (MoV)?

24 Please provide a maximum of three key messages delivered by the programme

Annexure 20:- Template for reporting development of printed materials (Eg:- IEC/BCC, tools, guidelines, etc)

1. ***Project name*** ***:- ……..***
2. ***Entity unit*** ***:- ……..***
3. ***Specific Objective*** ***:- ……..***
4. ***Activity*** ***:- ……..***
5. ***Sub activity*** ***:- ……..***
6. ***Implementing steps*** ***:- ……..***

Cost for Development

Developed By :	FPA Sri Lanka staff	:	
	Out sourced	:	
	Budget Allocation (Rs)	:	
	Actual expenses (Rs)	:	

Cost for Printing :	No of copies printed	:	
	Budget Allocation (Rs)	:	
	Actual Expenses (Rs)	:	

Content / Key Message[25]:

Remarks

Do you have the following Means of Verifications (MoV)?

25 Please provide a maximum of three key messages delivered by IEC/BCC material

Annexure 21:- Template for Attendance sheet

Workshop Title : - .....

Project : - ..... Activity Number : - .....

Date/s : - From ..... To.....

Time : - .....

Venue : - .....

No	Name	Designation and organization	Mailing Address or e-mail address	Telephone number	Signatures		
					Day 01	Day 2	Day 3
01							
02							
03							

Summary

	Day 01	Day 02	Day 03	Day 04	Day 05	All days
Number of participants from the target group [26]						
Number of other participants						
Total						

26 Please mark / highlight the participants from the target group in the attendance sheet

Annexure 22 :- Sample participants' feedback form

Participants' Feedback Form

Workshop Title :- .....

Project :- ..... **Activity Number** :- .....

Venue :- .....

Date :- .....

Have you ever received training on these topics before?

- ☐ Yes, I received training on these topics more than one year ago.
- ☐ Yes, I received training on these topics less than one year ago.
- ☐ No, this is my first time receiving training on these topics.

Please rate the following statements.	**Strongly Agree**				**Strongly Disagree**
The training objectives were clear.....	5	4	3	2	1
The training objectives were met.....	5	4	3	2	1
The training objectives were relevant to my needs.....	5	4	3	2	1
I will be able to immediately apply what I have learned to my job.....	5	4	3	2	1
I was well engaged during the training.....	5	4	3	2	1
I was appropriately challenged during the training.....	5	4	3	2	1
I found the venue to be comfortable.....	5	4	3	2	1
Overall this training met my expectations.....	5	4	3	2	1
I would recommend this training to others.....	5	4	3	2	1

What was the most important thing you learned at the training and why?

Which topics did you NOT find to be of value?

If we offer this training again, what additional topics would you like to see added?

Please add any additional comments below

Annexure 23:- Template for workshop agenda

Workshop Agenda

Workshop Title : - .....

Project : - .....

Activity Number : - .....

Date/s : - From ..... To .....

Time : - .....

Venue : - .....

Date	Time from	Time To	Session title	Resource person / Facilitator

Annexure 24:- Template for distribution list

Title of the material : - .....

Project : - .....

Activity Number : - .....

Period

From Date : - .....

To Date : - .....

Number of materials purchased / Printed during the above period : - .....

Number in stock as at <From date> : - .....

Closing balance at stock as at <to date> : - .....

Distribution list

	Name of the person or organisation (Or Workshop [27])	Designation	Number of materials distributed	Date	Signature	
					Handed Over	Taken Over
01						
02						
03						

27 IEC or BCC materials distributed at the workshops must be entered as an entry and must be authorised by the workshop organiser Eg:- Distributed among participants of the “gender identity workshop”

Annexure 25:- Sample client registration form for IEC/BCC/SBCC interventions

Client Registration Form

Name of Peer Educator	
Name of Field supervisor	

1. Residence

   i Rural : ☐ ii Urban : ☐ iii Peri Urban : ☐

2. Name in Full : .....
3. Other Names : .....
4. Permanent Address : .....
5. Current adress : .....
6. Age : ☐
7. Telephone Number : .....
8. Marital Status

   Married : ☐
   Never married : ☐
   Widow : ☐
   Living together : ☐
   Divorced : ☐

9. Years of formal education : ☐
10. Occupation : .....
11. Name of hotspot : .....
12. Have you ever practiced injectable method?

    i. Yes : ☐ ii. No : ☐

13. Duration of the Risk behavior years:
14. Method of using drug :

    i. Oral : ☐
    ii. Injectable : ☐
    iii. Other : ☐

15. If you are using heroine

    i. Daily : ☐
    ii. One a week : ☐
    iii. More than once a week : ☐
    iv. Once a month : ☐

16. If you are using a drug daily, how many timesare you taking drugs per day? ☐

17. When did you use heroin last? (Days before) ☐

18. How much do you spend on heroin per week? ☐

19. have you ever been jailed regarding Drugs?

    i. Yes ☐ ii. No ☐

20. Have you ever been admitted to a rehabilitation centre?

    i. Yes ☐ ii. No ☐

21. Did you have any kind of sexual relationships (except with your spouse) during the last year

    i. Yes ☐ ii. No ☐

22. Number of people who have had sexual relationships with you during the last month

23. Did you use a condom at your last sexual encounter with a male/female?

    i. Yes ☐ ii. No ☐

24. Have you ever been subjected to a blood test through a government STI clinic?

    i. Yes ☐ ii. No ☐

25. Have you been subjected for a HIV testing during the last one year period?

    i. Yes ☐ ii. No ☐ iii. do not know ☐

26. Do you know the result of HIV testing

    i. Yes ☐ ii. No ☐

27. Have you been subjected to a STI/RTI testing during the last one year period

    i. Yes ☐ ii. No ☐ iii. do not know ☐

28. Do you know the result of STI testing

    i. Yes ☐ ii. No ☐

29. Have you ever been treated for a STI?

    i. Yes ☐ ii. No ☐

Annexure 26 :- Sample peer educator report format (PE calendar)

සේවා ලබාදීම පිළිබඳ වාර්තාව / Peer Educator calendar

DU ○ FSW ○ MSM ○ BB ○

දැනුවත් කරන්නාගේ නම:	මෙෙන්තු නිළධාරියාගේ නම:	වරමෙ:	මාසයේ මුළු එකතුව
දිස්ත්‍රික්කය :	නගරය/ ගම:	මාසය	

අනුක්‍රමික අංකය	සේවා ලාභියාගේ අංකය	සේවා ලාභියාගෙ නම:	දිනය															H	S	L	CD	C	E
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	HIV/AIDS පිළිබඳව දැනුවත් කිරීම	අනෙකුත් ලිංගික රෝග පිළිබඳව දැනුවත් කිරීම	පත්‍රිකා බෙදාදීම මඟින් දැනුවත් කිරීම	කොන්ඩම් භාවිතය පිළිබඳව ආදරණය	කොන්ඩම බෙදාදීම	ඖෂධෝපචාර ගිය
			එකතුව	එකතුව	එකතුව	එකතුව	එකතුව	එකතුව	එකතුව	එකතුව	එකතුව	එකතුව	එකතුව	එකතුව	එකතුව	එකතුව	එකතුව	එකතුව	එකතුව	එකතුව	එකතුව	එකතුව	එකතුව
1																							
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7																							
8																							
9																							
10																							
11																							
12																							
13																							
එකතුව Total																							

H	HIV/AIDS පිළිබඳව දැනුවත් කිරීම	CD	කොන්ඩම් භාවිතය පිළිබඳව ආදරණය
S	අනෙකුත් ලිංගික රෝග පිළිබඳව දැනුවත් කිරීම	C	බෙදාදුන් කොන්ඩම් ප්‍රමාණය
L	පත්‍රිකා බෙදාදීම මඟින් දැනුවත් කිරීම	E	ඖෂධෝපචාර ගිය

මෙම වාර්තාව නිවැරදි ලෙස පූරවා සෑම මාසෙම 18 වන දින හෝ ඊට පෙර මෙෙන්තු නිළධාරියා වෙත භාර දිය යුතු වේ.

Annexure 27 :- Template for pre and post-test form and tips to develop the questionnaire

Template for	Pre-/Post Test Form
Workshop Title: **Project:** **Date:**	**Activity Number :-**
Venue :	**Training Dates:**
Participant Name: - ……	**Participant ID: - ……**
Pre / Post test questions	
Reviewed by :-	
Verified by:	**Total score:**

Tips to develop pre and post-test questions

1. Pre and post-test questions must be developed by a technical expert in the subject area or by the resource person who conducts the session/workshop.
2. Post-test must ask the same questions as the pre-test for easy comparison.
3. The test must include questions on learning objectives.
4. The test must include questions to assess / measure whether the expected minimum competencies have been met.
5. All the test questions must be covered in the training programme directly or indirectly.
6. Answers for all the test questions must be straightforward.
7. Language must be easy to understand and must be available in local languages as well.
8. Better to include a mix of question types (true/false; multiple choice)
9. There must be an easy system to score the answers.
10. It is better to use internationally recognised / standard questions whenever possible.

Annexure 28:- Template for event / training completion report

Training/event Completion Report Format

01) **General Information** :-

Activity Code :-

Name of the training :-

Name of the organisation :-

No of days :-

From :- YYYY/MM/DD To: - YYYY/MM/DD

Venue :-

Objectives of the programme :-

02) **Programme Agenda :-**

03) **Participants :-**

No of participants from the target group /Beneficiary

Expected :-

Participated :-

Reason for variance (if any) :-

Total Number of Participants :-

04) **Financial :-**

Total Budget allocated (Direct) :-

Total Direct cost of the programme:-

Reason for Variance (if any) :-

Average cost per beneficiary :-

05) **Resource Persons**

Name of the resource person	Designation / Organisation OR Qualification	Topics discussed	Number of hrs.	Resource Person fee

06) **Lesson Learnt :-**

Challenges (if any) :-

Best Practices (if any) :-

What will you do differently, if you have to implement this kind of training programme in the future (if any)?

07) **Evidence for success :-**

Ex: - Feedbacks from participants, other stake holders, Pre-Post test results, etc

Photo Gallery with description:-

Annexure 29 :- Sample mini KAP survey tool

Client Reg. No : | | | | | |

Mini-KAP Survey Tool for Peer Education Programme among Most at Risk Populations (MARP) for HIV

01. **Client was verified using (Please use one or more of the following information in the client registration form to verify the client)**

	Criteria	Yes	NO	Remarks (If Any)
1.1	Clients' Name			
1.2	Permanent Address			
1.3	Current Address			
1.4	Age			
1.5	NIC number			
1.6	Marital Status			
1.7	Occupation			
1.8	Years of formal education			

02. **Interaction with peer educator and field supervisor**

	Criteria	Reported		Observed	
		Yes	No	Yes	No
2.1	Client was able to mention the name of the peer educator				
2.2	Client was able to mention the name of the field supervisor				
2.3	What is the most recent date you had a meeting with the PE?				
2.4	How many times did your peer educator meet you during the last month?				
2.5	Have you ever participated at a pocket meeting with other peers, peer educator and field supervisor?				
2.6	Have you ever met the field supervisor?				

03. **Uptake of services from the peer educators (Please use following questions to verify data recorded**

03. 1. Awareness on HIV/STI

Reported			
	Yes	No	Remarks (if any)
Awareness on HIV (H)			
Awareness on STI (S)			
Awareness by IEC materials			

03.2) Condom Demonstration

	Criteria	Yes	NO	Do not know
3.1.1	Just after the HIV infection, the infected person becomes an AIDS patient			
3.1.2	Can a healthy-looking person have HIV?			
3.1.3	Can a person get HIV from mosquito bites?			
3.1.4	Can a person get HIV by sharing food with someone who is infected?			
3.1.5	Does anal sex have a higher risk than vaginal sex for HIV infection?			
3.1.6	Can a person reduce the risk of getting HIV by using a condom every time they have sex?			
3.1.7	Does the sharing of injecting equipment directly from person to person (without disinfection) have a risk of HIV transmission?			

Reported				
		Yes	**No**	**Remarks (if any)**
	Condom Demonstration (CD)			
Onsite Verification and observations		**Yes**	**No**	
3.2.1	Inspect the condom and expiry date.			
3.2.2	Tear the condom free from the edge of package and take out the condom. Ensure that the nails do not cause a tear in the condom			
3.2.3	To prevent the condom from bursting, squeeze the tip of the condom to takeout the air.			
3.2.4	While holding onto the tip, unroll the condom down the shaft of the penis all the way to the base of penis.			
3.2.5	Slide off the condom from the penis ensuring that the semen collected at the tip does not spill or leak out.			
3.2.6	Dispose-of the condom in a safe place where it cannot be handled by another person.			
3.2.7	Wash hands to ensure that there is no potentially infected semen or vaginal secretions on the hand			
3.2.8	Use a tissue or a paper to remove the condom to prevent potential contact of vaginal secretions on the hand			

03.3) IEC Materials

Reported				
	IEC materials (E)			
Onsite Verification and observations		**Yes**	**No**	
3.3.1	Have you received any IEC material or leaflet from the peer educator?			
3.3.2	Client correctly identified the IEC material received from the peer educator from a set of IEC materials.			
3.3.3	Have you ever read the above IEC material	**Yes, Completely**		
		Yes, Partially		
		No		

03.4) Condom Distribution

Onsite Verification and observations		**Reported**		**Observed**	
		yes	**No**	**Yes**	**No**
3.4.1	Have you received condoms free of charge from the peer educator?				
3.4.2	Average number of condoms that the client received from the peer educator per month.				
3.4.3	Number of condoms received from the peer educator is enough for me.				
3.4.4	If not, actual requirement per month (as an average)				
3.4.5	Did you use a condom during the last sexual encounter?				

03.5) Escorts to STD Clinics

Onsite Verification and observations		**Reported**		**Observed**	
		Yes	**No**	**Yes**	**No**
3.5.1	Did you visit a STD clinic during this year?				
3.5.2	If yes, date / month of the latest visit				
3.5.3	I went to a STD clinic with my peer educator				
3.5.4	Do you know the result				

04) **Tracking Duplication of clients**

Onsite Verification and observations		Reported		Observed	
		No	Yes	No	
4.1	Have you ever received condoms from another Peer Educator during this year?				
4.2	If, yes from whom? ……				
4.3	Have you ever received the same IEC material from another Peer Educator during this year?				
4.4	If, yes from whom? ……				

05) **Meeting Selection Criteria**

Observations		
Female Sex Workers		
5.1	Number of sexual partners during the last month?	
5.2	If the answer is "Zero" for the above question, what is the last date of a sexual encounter with a non regular partner? ……	
Men Who Have Sex with Men		
5.3	Number of male sexual partners during the last month?	
5.4	If the answer is "Zero" for the above question, what is the last date of a sexual encounter with a male sexual partner? ……	
Beach Boys		
5.5	Number of foreign sexual partners during the last month?	
5.6	If the answer is "Zero" for the above question, what is the last date of a sexual encounter with a foreign sexual partner? ……	
Drug Users		
5.7	Number of times you used drugs last week?	
5.8	If the answer is "Zero" for above question, what is the last date that you used drugs? ……	

……

Interviewer **Date: - ……**

Annexure 30:- Templates for advocacy databases

30.1. Template for advocacy audience database

a) Primary audience / Advocacy target

Please state the primary target / audience of your advocacy efforts (please note that primary target is the institution or the person who can make the above policy decision. (Please be specific in your answer)

Primary Target	
Contact Person	
Designation	
Postal address	
Telephone (Office):-	
Telephone (Mobile):-	
Fax :-	
e-mail	
Level of understanding / knowledge about the issue (High, Low, unknown)	
Degree of support for or opposition to advocacy expected results (Support, Oppose, Neutral, unknown)	
Remarks	

b) Secondary audience

Please identify secondary targets / audiences of your advocacy efforts (Please note that the secondary targets or audiences are the institutions or people who can influence the primary targets / audience)

Secondary Targets (General info- same as above)	How they can influence primary targets	Level of understanding / knowledge about the issue (High, Low, unknown)	Degree of support for or opposition to advocacy expected results (Support, Oppose, Neutral, unknown)	What changes do we want to see in their behavior and the actions they take

30.2. Template for advocacy partner database

Remarks				
e-mail address				
Telephone number (mobile)				
Telephone number (office)				
Postal Address				
Name of the contact person				
Registration Number				
Type of Registration				
Do you have a formal MoU / agreement for this partnership? (Yes/ No)				
What is the role or contribution of the partner for the advocacy effort?				
Type of the partnership (Coalition, Network, sub-contract or Other)				
Partner				

30.3. Template for mass media database

Remarks						
e-mail						
Mobile						
Telephone						
Postal address						
Contact person						
Category (newspaper, radio / TV channel, magazine, journals and periodical, other)						
Name of the mass media						

30.4. Template for participant log

Remarks			
Programmee related information (Eg:- Pre-test/ Posttest / Commitment score)[28]			
Attendance (Number of days completed)			
Participant from the target group or not			
Mobile			
NIC Number (Optional)			
Telephone No			
e-mail address			
Address			
Organisation			
Designation			
Full name			
Participant ID (System generated)			
Programme ID (System generated)			

28 Data requirement depends on the type of the programme. Please refer the programme related descriptions in this SOP for more details.

Annexure 31:- Templates for reporting progress of advocacy activities

The following fields are common and must be reported for all advocacy activities. So, it will not be presented in each and every template in order to avoid duplication.

A. Advocacy area :- <Drop down>
B. Advocacy Issue :- <Drop down>
C. Advocacy expected result :- <Drop down>
D. Milestone :- <Drop down>
E. Project :- <drop down>
E. Activity :- <drop down>
F. Sub activity :- <drop down>
G. Imp Step :- <Drop down>
H. Entity unit :- <Drop down>

Availability of Means of verification : - .....

31.1. Policy Brief

a. Date :- .....
b. Title :- .....
c. Description :- .....
d. Target audience: - → Primary audience / Secondary audience>
Please specify, If Secondary Audience/s :-.....
e. Advocacy message :-

Does the message contain,

i) Sufficient information on the issue? → Yes / No>If yes,
please provide examples / quotes from the message? .....
ii) Advocacy expected result / policy option? → Yes / No>If yes,
please provide examples / quotes from the message? .....
iii) Sufficient information to persuade the audience?→ Yes / No> If yes,
please provide examples / quotes from the message ?.....
iii) Suggested action from the audience? → Yes / No>If yes,
please provide examples / quotes from the message ?.....

f. Number Reached :-

Male :- ..... Female :- ..... Unable to categorise :- .....

Below 25 years :- ..... Above 25 years :- ..... Unable to categorise :- .....

(Note: - Male + Female + Unable to categorise = Below 25 + Above 25 + Unable to categorise)

g. This activity was conducted → Directly by FPA Sri Lanka, in collaboration with partner/s,
by a partner/s> If partners involved, please specify the partner/s :-

.....

h. Remarks :- .....

31.2. Sensitisation Programmes

A. Date :- ……..

B. Title :- ……..

C. Description :- ……..

D. Venue :- ……..

E. Target audience :- → Primary audience / Secondary audience>
Select Secondary Audience/s :- ……..

F. Number of participants from the target group :-

Male :- …….. Female :- …….. Unable to categorise :- ……..

Below 25 years :- …….. Above 25 years :- …….. Unable to categorise :- ……..
(**Note: - Male + Female + Unable to categorise = Below 25 + Above 25 + Unable to categorise**

G. Budget allocation :- ……

H. Actual Expenses :- ……

I. This activity was conducted – <Drop down → Directly by FPA Sri Lanka, in collaboration with partner/s, by a partner/s> If partners involved, please specify the partner/s :-

……..

J. Remarks :- <Text>

K. Required additional programmatic data

- ✓ Please complete the participant log as per the annexure 30.4
- ✓ Please complete the commitment score as per the annexure ……..

31.3. Press conference / Media workshops

Please use the template provided for sensitization programmes (annexure 31.2) with the following additional fields related to involvement of media personal

- ✓ Media Category :- TV / Radio / Printed Media/ Other
- ✓ Media : - ……..

Required additional programmatic data

- ✓ Please complete the participant log as per the annexure 30.4
- ✓ Please complete the commitment score as per the annexure ……..

31.4. One to one meeting or lobbying meeting

A. Date of the meeting : - .....

B. Time From : - ..... To: - .....

C. Place :- <Text>

D. Target audience → Primary audience / Secondary audience> Please specify if Secondary Audience/s :- .....

E. Key achievements of the meeting :- .....

F. This activity was conducted → Directly by FPA Sri Lanka, in collaboration with partner/s, by a partner/s>

G. Meeting handled by : - .....

H. If partners involved, please specify the partner/s :- .....

I. Remarks :- .....

Required additional programmatic data

- ✓ Please complete the participant log as per the annexure 30.4
- ✓ Please provide the perceived commitment of the participant to achieve AER?
- ✓ Perceived commitment to the advocacy expected result[29] :- <drop down→Highly supportive, Supportive, Neutral, opposive, highly opposive, Unknown>

Annexure 31.5. Focus group discussions

A. Date of the FGD :-.....

B. Time From :- ..... To :- .....

C. Place :- .....

D. Target audience→ Primary audience / Secondary audience>

Please specify, if Secondary Audience/s :- .....

E. Number of participants :- .....

F. Key achievements of the discussion :- .....

G. This activity was conducted – <Drop down → Directly by FPA Sri Lanka, in collaboration with partner/s, by a partner/s>If partners involved,

please specify the partner/s :- .....

H. Discussion Facilitator :- .....

I. Remarks : - .....

29 No commitment sheet or commitment questions for lobbying meetings. However, the person who conducted the meeting must provide the participants level of commitment as perceived during the meeting

Additional programmatic data requirement is exactly similar to one to one meeting(see annexure 31.4)

Annexure 31.6. Consultative meetings

A. Date :- ……

B. Time From :- …….. To :- ……

C. Place :- <Text>

D. Target audience→ Primary audience / Secondary audience> Please specify the Secondary Audience/s :- ……

E. Number of participants :- ……

F. Key achievements of the consultative meeting :- ……

G. This activity was conducted – <Drop down → Directly by FPA Sri Lanka, in collaboration with partner/s, by a partner/s> If partners are involved, please specify the partner/s :- ……

H. Meting Facilitator :- ……

I. Remarks :- ……

Required additional programmatic data

- ✓ Please complete the participant log as per the annexure 30.4

Annexure 31.7. One minute messages

A. Date :- ……

B. Time From :- …….. To :- ……

C. Place :- ……

D. Target audience → Primary audience / Secondary audience>

Please specify, if Secondary Audience/s :- ……

E. Key achievements :- ……

F. This activity was conducted – <Drop down → Directly by FPA Sri Lanka, in collaboration with partner/s, by a partner/s> If partners are involved, please specify the partner/s :- ……

G. Conducted by :- ……

H. Remarks :- ……

Required additional programmatic data

- ✓ Please complete the participant log as per the annexure 30.4
- ✓ Please provide the perceived commitment of the participant to achieve AER?
- ✓ Perceived commitment to the advocacy expected result :- <drop down→Highly supportive, Supportive, Neutral, opposive, highly opposive, Unknown>

Annexure 31.8. Fact sheet

A. Date :- .....

B. Title :- .....

C. Description :- .....

D. Target audience → Primary audience / Secondary audience>

Specify the Secondary Audience/s :- .....

E. Language :- <Drop down→Sinhala/English/Tamil/Other>

F. Advocacy message:-

Does the message contain,

i) Sufficient information on the issue? → Yes / No> If yes, please provide examples / quotes from the message? .....

ii) Advocacy expected result / policy option? → Yes / No> If yes, please provide examples / quotes from the message? .....

iii) Sufficient information to persuade the audience? → Yes / No> If yes, please provide examples / quotes from the message? .....

iv) Suggested action from the audience? → Yes / No> If yes, please provide examples / quotes from the message? .....

G. Number of copies printed :- .....

H. Number of copies distributed :- .....

I. This activity was conducted → Directly by FPA Sri Lanka, in collaboration with partner/s, by a partner/s>If partners involved,
please specify the partner/s :- .....

J. Remarks :- .....

Required additional programmatic data / materials

- ✓ Please upload a soft copy of the fact sheet in the MEIMS

Annexure 31.9. Advocacy materials (Posters, leaflets, t-shirts, Booklets, etc)

Please use the template provided in annexure 31.8 to report development of advocacy materials with the following additional field

Type of advocacy material: - Posters / leaflets/ t-shirt/ Booklets/ Other

Required additional programmatic data / materials

- ✓ Please upload a soft copy of the advocacy material in the MEIMS

Annexure 31.10. Newspaper article / Press release

A. Media Category :- ……

B. Media :- ……

C. Target audience→ Primary audience / Secondary audience>

Please specify the Secondary Audience/s :- ……

D. Title of the article :- ……

E. Author :- ……

F. Date published :- ……

G. Volume :- ……

H. Page from: :- …… Page to :- ……

I. Placement and importance→front page, Editors letter, Editorial Page, as the leading article, inner page with a photo, inner page without a photo, back page, as a supplement>

J. Payments :- Free/ paid/ subsidised if Paid, amount in LKR :- ……

K. Advocacy message :-

Does the message contain?

Sufficient information on the issue?→ Yes / No> If yes, please provide examples / quotes from the message? ……

Advocacy expected result / policy option?→ Yes / No> If yes, please provide examples / quotes from the message? ……

Sufficient information to persuade the audience? → Yes / No> If yes, please provide examples / quotes from the message? ……

Suggested action from the audience? → Yes / No> If yes, please provide examples / quotes from the message? ……

L. Number of copies published :- ……

M. This activity was conducted – <Drop down → Directly by FPA Sri Lanka, in collaboration with partner/s, by a partner/s>

If partners are involved, please specify the partner/s:- ……

N. Remarks :- ……

Required additional programmatic data / materials

- ✓ Please upload a soft copy of the advocacy material in the MEIMS

Annexure 31.11. TV or Radio Programme / News

A. Media Category :- ……

B. Media :- ……

C. Target audience → Primary audience / Secondary audience>

Please specify Secondary Audience/s :- ……

D. Programme type →News / Tele-drama /advertisement/Interview/Documentary film /Short films/ News text messages / Other>

E. Title of the Programme :- ……

F. Programme Editor :- ……

G. Time duration (Mins) :- ……

H. First published date :- ……

I. Time :- From :- …… To :- ……

J. Number of times published :- ……

K. Payments (Free, paid, subsidised):- if Paid, amount in LKR :- ……

L. Advocacy message :-

Does the message contain?

1. Sufficient information on the issue→ Yes / No> If yes, please provide examples / quotes from the message? ……
2. Advocacy expected result / policy option? → Yes / No> If yes, please provide examples / quotes from the message? ……
3. Sufficient information to persuade the audience? → Yes / No> If yes, please provide examples / quotes from the message? ……
4. Suggested action from the audience? → Yes / No> If yes, please provide examples / quotes from the message? ……

M. Estimated reach :- ……

N. This activity was conducted → Directly by FPA Sri Lanka, in collaboration with partner/s, by a partner/s> If partners are involved,
please specify the partner/s :- ……

O. Remarks : - ……

Annexure 31.12. Street drama /Tele drama / Short films

A. Media Category :- ……

B. Media :- ……

C. Target audience → Primary audience / Secondary audience>
Please specify the Secondary Audience/s :- ……

D. Title of the street :- ……

E. Editor :- ……

F. Date :- ……

G. Time duration (Mins) :- ……

H. Venue :- ……

I. Advocacy message :-

Does the message contain?

1. Sufficient information on the issue? → Yes / No> If yes, please provide examples / quotes from the message? ……
2. Advocacy expected result / policy option? → Yes / No> If yes, please provide examples / quotes from the message? ……
3. Sufficient information to persuade the audience? → Yes / No> If yes, please provide examples / quotes from the message? ……
4. Suggested action from the audience? → Yes / No> If yes, please provide examples / quotes from the message? ……

J. Estimated reach :- ……

K. This activity was conducted → Directly by FPA Sri Lanka, in collaboration with partner/s, by a partner/s> If partners involved,
please specify the partner/s :- <Drop down> (Multiple options possible)

L. Remarks :- ……

Required additional programmatic data / materials

- ✓ Please upload the soft copy of the script in the MEIMS

Annexure 31.13. Advocacy campaigns

A. Target audience : - → Primary audience / Secondary audience>

Please specify Secondary Audience/s :- .....

B. Title :- .....

C. Campaign type :- .....

D. Please explain the nature of the campaign :- .....

.....

E. Advocacy message :-

Does the message contain?

1. Sufficient information on the issue? → Yes / No> If yes, please provide examples / quotes from the message? .....
2. Advocacy expected result / policy option? → Yes / No> If yes, please provide examples / quotes from the message? .....
3. Sufficient information to persuade the audience? → Yes / No> If yes, please provide examples / quotes from the message? .....
4. Suggested action from the audience? → Yes / No> If yes, please provide examples / quotes from the message? .....

F. What are the key achievements of the campaign? :- .....

G. Please explain the next step and way forward :- .....

.....

H. This activity was conducted – Directly by FPA Sri Lanka, in collaboration with partner/s, by a partner/s> If partners involved, please specify the partner/s :- .....

I. Remarks : - .....

Required additional programmatic data / materials

- ✓ Please upload the soft copies / scanned copies of available support documents in the MEIMS as means of verification of the achievements of the activity.
- ✓ Please upload the soft copies / scanned copies of advocacy materials that were used for the campaign.

Annexure 32. Template of the commitment sheet

fpa SRI LANKA enriching relationships

Commitment Sheet

Workshop Title : - ....

Project : - ....

Activity Number : - ....

Date/s : - From .... To ....

Time : - ....

Venue : - ....

Name : - ....

Designation : - ....

Organisation : - ....

Advocacy expected result: - xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxx

Pleas state your agreement / commitment to achieve the above advocacy results. If you do not like to answer any of these questions, please select the option "Can't say".

	Strongly agree (5)	**Agree (4)**	**Neutral (3)**	**Disagree (2)**	**Strongly disagree (1)**	**Can't say (0)**
01. I am happy, if the above policy change takes place in the country						
02. I would like to contribute my time to work towards the above policy change						
03. I would like to donate my own money to work towards the above policy change						
04. I would like to discuss this issue and suggested change with my friends, subordinates, and co-workers.						
05. I would like to speak in front of any audience (Public ceremony, TV or Radio programme) to advocate this policy change						
06. I would like to actively work towards the above policy change **within** the limits of my job role, duties and responsibilities.						
07. I would like to actively work towards the above policy change **even beyond** the limits of my job role, duties and responsibilities.						

Signature[30] : - .... Date:- ....

30 Based on donor requirement and the audience

Annexure 33. Standard templates to report social, political and legal changes

33.1. Newspaper articles or press release

A) Advocacy area : - .....

B) Advocacy Issue : - .....

C) Advocacy expected result : - .....

D) Milestone : - .....

E) Is this a direct output of a media workshop or press conference?→ Yes/No>

F) If yes Please specify the activity and the entity unit

   a. Project : - .....

   b. Activity : - .....

   c. Sub activity : - .....

   d. Imp Step : - .....

   e. Entity unit : - .....

G) Media Category : - .....

H) Media : - .....

I) Title of the article : - .....

J) Author : - .....

K) Date published : - .....

L) Volume : - .....

M) Page from :- ..... Page to :- .....

N) Placement and importance → front page / Editors letter / Editorial Page / as the leading article / inner page with a photo / inner page without a photo / back page / as a supplement

O) The message → Support advocacy expected result / Neutral but provide information about the advocacy issue / Oppose advocacy expected Result

P) Please quote (maximum up to three) the most important sentences of the article :- .....
.....

Q) Remarks :- .....

33.2. Radio / TV programme

A) Advocacy area : - .....

B) Advocacy Issue : - .....

C) Advocacy expected result : - .....

D) Milestone : - .....

E) Media Category : - .....

F) Media : - .....

G) Is this a direct output of a media workshop or press conference? → Yes/No>

H) If yes, please specify the activity and the entity unit

   a. Project : - .....

   b. Activity : - .....

   c. Sub activity : - .....

   d. Imp Step : - .....

   e. Entity unit : - .....

I) Programme type →News / Tele-drama /advertisement/Interview/Documentary film /Short films/News text messages / Other

J) Title of the Programme : - .....

K) Programme Editor : - .....

L) Time duration (Mins) : - .....

M) First published date : - ..... Time :- From : - ..... To : - .....

N) Number of times published : - .....

O) The message → Support advocacy expected result / Neutral but provide information about the advocacy issue / Oppose advocacy expected Result

P) Remarks : - .....

33.3. Public Speech

A. Advocacy area : - .....

B. Advocacy Issue : - .....

C. Advocacy expected result : - .....

D. Milestone : - .....

E. Is this a direct output of an advocacy effort?→ Yes/No>

If yes, Please specify the activity and the entity unit

a. Project : - .....

b. Activity : - .....

c. Sub activity : - .....

d. Imp Step (optional) : - .....

e. Entity unit : - .....

F. The speech was conducted by

a. Audience → Primary audience / Secondary audience

If secondary audience, please specify : - .....

b. Participant log

Full Name : - .....

Note: - System will show previous similar entries (name, title and organisation) of the participants entered in to the system. If the user selects a participant from a previous entry, use the same participant ID. This will allow user to track the history of each participant using one participant ID.

Title / Designation : - .....

Organisation : - .....

G. The speech was conducted at :-→ Parliament / Provincial Council / Television channel / Radio Channel / Newspaper / Public stage / Other>

H. Media Category :- .....

Media :- .....

I. The message → Support advocacy expected result / Neutral but provide information about the advocacy issue / Oppose advocacy expected Result

J. Remarks : - .....

.....

.....

33.4. Legislative and policy change

A) Advocacy area :- <Drop down>

B) Advocacy Issue:- <Drop down>

C) Advocacy expected result :- <Drop down>

D) Milestone :- <Drop down> (Optional)

E) What is the policy, programme or legislative Change? ……
……..

F) Reference number / code : - ……

G) Please explain the situation before this change : - ……
……

H) Please briefly explain the legislative change : - ……
……

I) Effective date : - ……

J) Drafted or Prepared by whom : - ……

K) Votes for : - ……

L) Votes against : - ……

M) Does this change support or oppose achievement of advocacy expected result?→ Support / Neutral / Oppose

N) If support, Please explain how it contributes to the advocacy expected result and/or milestone : - ……

O) If oppose, Please explain how it hinders the achievement of advocacy expected result : - ……
……

P) Please briefly explain the consequences of this legislative change on quality of life of the community : - ……
……

Q) Remarks : - ……
……

Annexure 34. Standard template for one to one meeting log

One to one meeting log

Project :- .....

Activity Number :- .....

Advocacy expected result :- .....

Meeting

Date :- .....

Time :- .....

Venue :- .....

Person Meet

Name :- .....

Designation :- .....

Organisation :- .....

Discussion

Discussion points :- .....

Action Points :- .....

Commitment to advocacy expected result (Highly supportive, Supportive, Neutral, opposive, highly opposive) :- .....

Advocacy Officer

Name :- .....

Designation :- .....

Signature :- .....

Annexure 35. Standard template for focus group discussion log

Focus group discussion log

Project :- .....

Activity Number :- .....

Advocacy expected result :- .....

Meeting

Date :- .....

Time :- .....

Venue :- .....

Attendees

Full name	Designation	Organisation	e-mail	Telephone	Commitment to advocacy expected result (Highly supportive, Supportive, Neutral, opposive, highly opposive)

Discussion

Discussion points :- .....

Action Points :- .....

Advocacy Officer

Name :- .....

Designation :- .....

Signature :- .....

Annexure 36. Standard template to report the progress of the strategic objectives

A. Reporting date :- .....

B. Reporting year :- .....

C. Advocacy area :- .....

D. Advocacy Issue :- .....

E. Advocacy expected result :- .....

a) Please provide the progress of the above AER → Planned

25% completed

50% Completed

75% Completed

100% Completed

Postponed the implementation

b) Please provide the justification for above answer in brief : - .....
.....
.....
.....

F. Please provide the progress of the milestones of the above advocacy expected result

Milestone	Progress (Planned, 25% completed, 50% Completed, 75% Completed, 100% Completed, Postponed the implementation	Please provide the justification for above answer in brief

Annexure 37. Standard template to report the progress of research studies

1. Project :- .....
2. Activity :- .....
3. Sub activity :- .....
4. Imp Step (optional) :- .....
5. Entity unit :- .....
6. Research team :-

Name	Designation	Principle investigator or co-investigator	Qualifications	Experiences

7. Research Title :- .....
   .....
8. Overall Objective :- .....
   .....
9. Specific Objectives :- .....
   .....
10. Key findings in brief :- .....
    .....
11. Number of copies printed (if printed by FPA SRI LANKA) :- .....
    .....
12. Was this research published in a scientific forum? Yes/No

If yes, please provide the information

- ✓ Name of the Journal
- ✓ Volume
- ✓ Year
- ✓ Page/s

13. Funded by: - .....
14. Remarks: - .....

- ✓ Please upload a soft copy of the full paper / report in the MEIMS

Annexure 38. Template for supervisory field visit reports

Supervisory Field Visit Report
Family Planning Association of Sri Lanka

Section 01 – General Information

Reported by :-		
Unit :-	Reporting Date:-	Period of the trip
Name:-	From:-	
Designation:-		To:-
Places Visited *(Locations)*		
Date :-	Places Visited :-	
Report Distribution List *(Names and Designations to be provided)*		
Immediate Supervisor		
Staff of the SDP / Field office / Partner visited		
Respective staff of the pro-grammatic unit		
Respective Finance Officer		
Respective M&E Officer		
Other		
Other accompanying persons *(Names and Designations to be provided)*		
Meetings / Discussions with stakeholders		
Staff members at SDP / Field Office / Partner level *(Names and Designations to be provided)*		

Names of the Volunteers, Youth leaders etc met during the visit			
Names and designations of the government Officials met during the visit			
Other key persons met during the visit (if any) *(Names and Designations to be provided)*			
Levels Visited / Observed :-	SDP / Field Office / Partner Office ☐ Service Providers / Volunteers / peer educators at the Office ☐ Service Providers / Volunteers / peer educators at the field ☐ Government officials at their office / field ☐ Other project partners at their office / field ☐ Beneficiaries / Clients at the office ☐ Beneficiaries / Clients at the field ☐ Mobile clinics ☐ Associated clinics ☐ Demand generation programme ☐ Other (please specify) ……..		
Documents Observed :-	Stock Registers	☐ Office	☐ Partner office
	Item distribution Lists	☐ Office	☐ Partner office
	Staff personal files	☐ Office	☐ Partner office
	Staff attendance sheets	☐ Office	☐ Partner office
	Client history forms	☐ Office	☐ Partner office
	Progress meeting minutes	☐ Office	☐ Partner office
	Mobile clinic registries	☐ Office	☐ Partner office
	Health assistant record book	☐ Office	☐ Partner office
	Vehicle running charts	☐ Office	☐ Partner office
	Physical stock/Bin Cards	☐ Office	☐ Partner office
	Other documents	☐ Office	☐ Partner office
	……..	☐ Office	☐ Partner office
	……..		
	……..		

Section 02 – Observations and Recommendations

No	Observations (please provide in bullet points)	Recommendations based on the observations (If any)	Person / Organisation Responsible	Deadline

Section 03 – Follow-up of the recommendations made at previous visits

No	Observations (please provide in bullet points)	Recommendations based on the observations (If any)	Person / Organisation Responsible	Follow-up Comments

Section 04 – Any other comments: - ……

……

……

Annexure 39. Monitoring and Evaluation self-assessment tool for data management and reporting systems

	Assessment question	Assessment level			Supporting documentation required?
		M&E Unit	Aggregation Levels (if any)	Service Points	
01) M&E Structure, Functions, and Capabilities					
01	There is a documented organisational structure/chart that clearly identifies positions that have data management responsibilities at the M&E Unit.	Y			Y
02	All staff positions dedicated to M&E and data management systems are filled.	Y			
03	There is a training plan which includes staff involved in data collection and reporting at all levels in the reporting process.	Y			Y
04	All relevant staff have received training on the data management processes and tools.	Y	Y	Y	
05	A senior staff member (e.g., Senior Manager-M&E or above) is responsible for reviewing the aggregated numbers prior to the submission/ release of reports from the M&E Unit.	Y			
06	There is designated staff responsible for reviewing the quality of data (i.e., accuracy, completeness and timeliness) received from sub-reporting levels, if any (e.g., regions, districts, service points).	Y	Y		
07	There are designated staff responsible for reviewing aggregated numbers prior to submission to the next level (e.g., to districts, to regional offices, to the central M&E Unit).			Y	Y
08	The responsibility for recording the delivery of services on source documents is clearly assigned to the relevant staff.			Y	
02) Indicator Definitions and Reporting Guidelines					
09	The M&E Unit has documented and shared the definition of the indicator(s) with all relevant levels of the reporting system (e.g., regions, districts, service points).	Y			Y
10	There is a description of the services that are related to each indicator measured by the programme/project.	Y			Y
11	The M&E Unit has provided written guidelines to each sub-reporting level on what they are supposed to report on.	Y	Y	Y	Y
12	The M&E Unit has provided written guidelines to each sub-reporting level on how (e.g., in what specific format) reports are to be submitted.	Y	Y	Y	Y
13	The M&E Unit has provided written guidelines to each sub-reporting level regarding to whom the reports should be submitted.	Y	Y	Y	Y
14	The M&E Unit has provided written guidelines to each sub-reporting level on when the reports are due.	Y	Y	Y	Y
15	There is a written policy / document that states for how long source documents and reporting forms need to be retained.	Y			Y

	Assessment question	Assessment level			Supporting documentation required?
		M&E Unit	Aggregation Levels (if any)	Service Points	
03) Data-collection and Reporting Forms/Tools					
16	The M&E Unit has identified a standard source document (e.g., medical record, client intake form, register, etc.) to be used by all Service Delivery Points to record service delivery.	Y			Y
17	The M&E Unit has identified standard reporting forms/tools to be used by all reporting levels.	Y			Y
18	Clear instructions have been provided by the M&E Unit on how to complete the data collection and reporting forms/tools.	Y	Y	Y	Y
19	The source documents and reporting forms/tools specified by the M&E Unit are consistently used by all reporting levels.		Y	Y	
20	If multiple organisations are implementing activities under the programme/ project, they all use the same reporting forms and report according to the same reporting timelines.	Y	Y	Y	
21	The data collected by the M&E system has sufficient precision to measure the indicator(s) (i.e., relevant data are collected by sex, age, etc., if the indicator specifies disaggregation by these characteristics).	Y			
22	All source documents and reporting forms relevant for measuring the indicator(s) are available for auditing purposes (including dated print-outs in case of a computerised system).	Y	Y	Y	
04) Data Management Process					
23	The M&E Unit has clearly documented data aggregation, analysis and/or manipulation steps performed at each level of the reporting system.	Y			Y
24	There is a written procedure to address late, incomplete, inaccurate, and missing reports; including following-up with sub reporting levels on data quality issues.	Y	Y		Y
25	If data discrepancies have been uncovered in reports from sub reporting levels, the M&E Unit or the Intermediate Aggregation Levels (e.g., districts or regions) have documented how these inconsistencies have been resolved.	Y	Y		
26	Feedback is systematically provided to all sub-reporting levels on the quality of their reporting (i.e., accuracy, completeness, and timeliness).	Y	Y		
27	There are quality controls in place for when data from paper based forms are entered into a computer (e.g., double entry, post data entry verification, etc).	Y	Y	Y	Y
28	For automated (computerised) systems, there is a clearly documented and actively implemented database administration procedure in place. This includes backup/recovery procedures, security administration, and user administration.	Y	Y	Y	Y
29	There is a written back-up procedure for when data entry or data processing is computerised.	Y	Y	Y	
30	If yes, the latest date of back-up appropriately gives the frequency of when the computerised system is updated (e.g., backups are weekly or monthly).	Y	Y	Y	

	Assessment question	Assessment level			Supporting documentation required?
		M&E Unit	Aggregation Levels (if any)	Service Points	
31	Relevant personal data is maintained according to national or international confidentiality guidelines.	Y	Y	Y	
32	The reporting system avoids double counting people within each point of service/organisation (e.g., a person receiving the same service twice in a reporting period, a person registered as receiving the same service in two different locations, etc).	Y	Y	Y	
33	The reporting system avoids double counting people across service points/ organisations (e.g., a person registered as receiving the same service in two different service points/ organisations, etc).	Y	Y	Y	
34	The reporting system enables the identification and recording of a "drop out," a person "lost to follow-up," and a person who died.	Y	Y	Y	
35	The M&E Unit can demonstrate that regular supervisory site visits have taken place and that data quality has been reviewed.	Y			Y
5) Links with National Reporting System					
36	When available, the relevant national forms/tools are used for data-collection and reporting.	Y	Y	Y	Y
37	When applicable, data is reported through a single channel of the national information systems.	Y	Y	Y	
38	Reporting deadlines are in line with the relevant timelines of the National programme (e.g., cut-off dates for monthly reporting).	Y	Y	Y	
39	The service sites are identified using ID numbers that follow a national system.	Y	Y	Y	

Annexure 40:- Standard Template for management response and plan of action reports[31]

Management Response and Plan of action for Evaluation recommendations

A) General Information		
01	Name of the Evaluation	
02	Name of the evaluator / s	
03	Date of the final report	
04	Prepared by :- (Name of the programme focal person)	
05	Approved by :- (Name of the unit head)	
06	Finalised date of management actions	

B) Management Response and Plan of Action for evaluation recommendations

Recommendation 01			
Reference number for recommendation appeared in the evaluation report :-			
Status of agreement with the recommendation	01) Accepted ☐ 02) Accepted with minor changes ☐ 03) Accepted with major changes ☐ 04) Rejected ☐	**If your answer is 2, 3 or 4; Please provide a justification:-**	
	Management Action	**Deadline**	**Responsible person / SDP / Unit / Organisation**
Management action 1.1			
Management action 1.2			
Management action 1.3			

31 Adopted from UNDP standard template of management response for evaluations

Recommendation 02			
Reference number for recommendation appeared in the evaluation report :-			
Status of agreement with the recommendation	01) Accepted 02) Accepted with minor changes 03) Accepted with major changes 04) Rejected	**If your answer is 2, 3 or 4; Please provide a justification: -** …… …… …… …… …… ……	
	Management Action	**Deadline**	**Responsible person / SDP / Unit / Organisation**
Management action 2.1			
Management action 2.2			
Management action 2.3			

Recommendation 03			
Reference number for recommendation appeared in the evaluation report :-			
Status of agreement with the recommendation	01) Accepted 02) Accepted with minor changes 03) Accepted with major changes 04) Rejected	**If your answer is 2, 3 or 4; Please provide a justification: -** …… …… …… …… …… ……	
	Management Action	**Deadline**	**Responsible person / SDP / Unit / Organisation**
Management action 3.1			
Management action 3.2			
Management action 3.3			

C) Action taken reports		
Action taken report	**Due date**	**Person responsible**
Action taken report 01		
Action taken report 02		
Action taken report 03		

Annexure 41:- Standard Template for action taken report

Action Taken Report - Progress of Management Actions

A) General Information		
01	Name of the Evaluation	
02	Name of the evaluator / s	
03	Date of the final report	
04	Date of the management response:-	
05	Prepared by :- (programme focal person)	
06	Approved by :- (unit head)	
07	Submitted to :- Copied to :-	Executive Director (FPA Sri Lanka) Monitoring and Evaluation Unit
08	Date	

B) Progress of management action and way forward

Recommendation 01				
Reference number for recommendation appeared in the evaluation report :-				
Management Action	**Deadline**	**Responsible person / SDP / Unit / Organ-isation**	**Status (Planned /25% completed /50% completed /75% Completed / Completed / Post paned)**	**Progress made and way forward**
Management action 1.1				
Management action 1.2				
Management action 1.3				

Recommendation 02				
Reference number for recommendation appeared in the evaluation report :-				
Management Action	**Deadline**	**Responsible person / SDP / Unit / Organ-isation**	**Status (Planned /25% completed /50% completed /75% Completed / Completed Post paned)**	**Progress made and way forward**
Management action 2.1				
Management action 2.2				
Management action 2.3				

Recommendation 03				
Reference number for recommendation appeared in the evaluation report :-				
Management Action	**Deadline**	**Responsible person / SDP / Unit / Organ-isation**	**Status (Planned /25% completed /50% completed /75% Completed / completed /Post paned)**	**Progress made and way forward**
Management action 3.1				
Management action 3.2				
Management action 3.3				

C) General Comments : - ……
……
……
……
……

Annexure 42:- Template for uploading resources to FPA Sri Lanka document repository to share knowledge with other MEIMS users

Date and time	:- <use system date and time>
Title	:- <Text> (Maximum 200 characters including space)
Synopsis	:- <Text>(Maximum 2000 characters including space)
Report type	:- <Drop down> (Compulsory; Only one report type is possible; show only allocated report types for upload)
Entity Unit	:- <Drop down> (Optional; Multiple entity units are possible; show only allocated entity units for upload)
Project	:- <Drop down> (Optional; Multiple projects are possible; show only allocated projects)
Activity	:- <Drop down> (Optional; Only one activity is possible)
Sub activity	:- <Drop down> (Optional; Only one sub activity is possible)
Imp Step	:- <Drop down> (Optional; Only one imp step is possible)
District	:- (Optional; Only one district is possible)
Uploaded by information)	:- <First name><Last Name> (Compulsory; use system user
Upload File	:- < Brows from my computer> (Compulsory)
Status	:- <Active / In-active>
Functions required	:- Save and Edit (Edit – only by the person who uploaded the file)

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