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Sectoral Guideline for Measuring Results in Health Programmes

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What is the point of a sectoral guideline?

This sectoral guideline is intended for regional desk officers in the BMZ Division for Health and Population Policy as well as for technical experts, programme directors and project managers at KfW and GIZ. It concerns the health sector, including social health protection, and complements the **Guidelines and Annotated Structure for Programme Proposals** for Joint Development Cooperation Proposals from 2012. It aims at making programme proposals easier to understand. Thereby results measurement in health programmes should be improved.

BMZ's revised guidelines state that, as of 2012, all programme proposals must have uniform results matrices for objectives and indicators. This should help to better align programme results measurement with international standards.

This sectoral guideline provides assistance in the form of:

- **Quality-controlled indicators (core set of sectoral indicators)** for orientation and application in programme proposals and
- **Exemplary results matrices** for typical intervention areas of health programmes.

This sectoral guideline further contains:

- **Guidelines on the use of data** for the measurement of indicators and for results-oriented monitoring;
- Links to **evidence syntheses** that provide brief summaries of the latest findings from studies and research on results of typical interventions supported by German development cooperation in the health sector.

Measuring results in the health sector

The result of a development measure is any change that occurs in consequence of such a measure and that can, at least partially, be traced back to the respective measure.

We can achieve results:

- at lead executing agencies or partner organisations,
- in the policy areas concerned,
- among the target groups in the partner country.

Consequently changes in structures, processes and behaviour patterns can be identified at the following levels:

- at national or general societal level (macro level),
- at the level of institutions (meso level),
- directly among the people concerned (micro level).

Examples of results:

Structural change in the health sector
Health legislation is being changed in order to improve the delivery of health care.

Process results
There is visible progress in the provision of health-care services.

Changes in individuals' behaviour in the target population
More use is made of condoms for family planning and HIV prevention.

The definition of results also includes negative results that were not to be expected.

Examples of unintended negative results:

- A successful programme frees up financial resources in the partner country, which then get diverted into the military budget.
- The development measure provides the population with free malaria nets for their beds. As a side-effect, local production of malaria nets ceases and people lose their jobs.

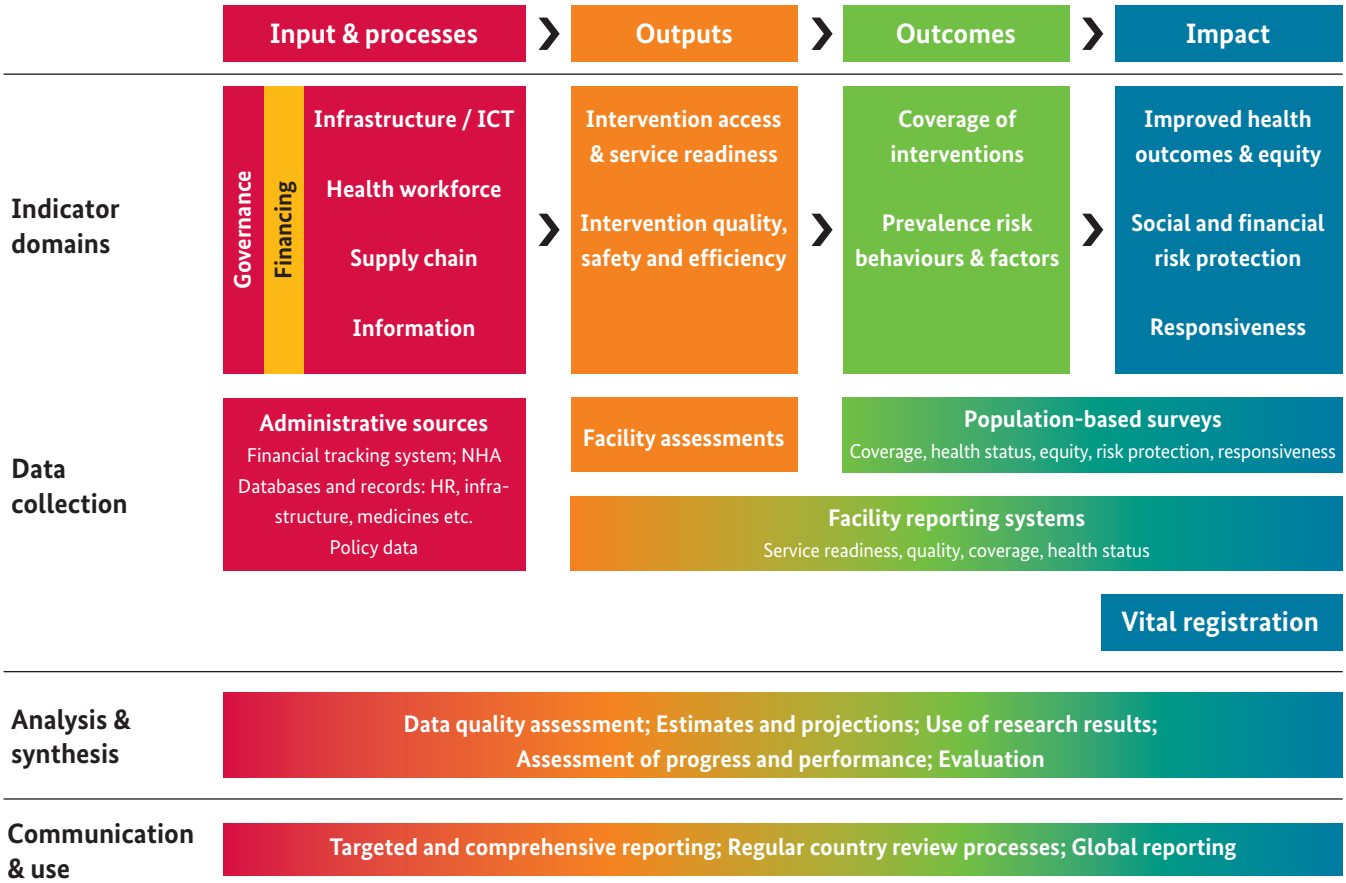
The **BMZ results matrices for programme proposals** list the various objectives in hierarchical order. The **programme objective** is usually at the **impact level**; in exceptional cases, it might be at the **outcome level**, too. **Module objectives** are always at the **outcome level**. The individual module objectives help achieve the programme objectives which are located further up the matrix hierarchy. The different results levels combined produce the **results logic**. The criteria for the various results levels are outlined in BMZ's guidelines on programme proposals.

The **results logic** of programmes in the health sector should be in line with the international health system model advocated by the World Health Organization (WHO) and the International Health Partnership (IHP+) (see Fig. 1). This allows programmes to show whether or not they have helped to strengthen the health system in the respective partner country.

The question as to how the programmes have contributed to changes in the given country has to be answered using the results matrices. Depending on the programme concerned, the statements can be made with varying degrees of certainty. In some cases - the intervention or evaluation design permitting - it is possible to establish a causal link. In many other cases, the contribution can be deduced on the basis of plausibility.

The way in which outputs of German development cooperation contribute to changes at the outcome level in the respective countries should be described in Sections B 3.1.4. (methodological approach) and B 3.6.2. (development effectiveness) of the programme proposal.

Figure 1: IHP+/WHO M&E Framework in the Health Sector



Tools for compiling and assessing programme proposals

The following **tools** have proven helpful when compiling and assessing programme proposals:

A) Sample results matrices

Results models are used to plan, steer and assess development measures. They can be confirmed, modified or refuted.

The structure of our programmes and the results they are intended to achieve are depicted in a simplified form using BMZ results matrices and, for technical cooperation, in graphical results chains. The examples and samples of results matrices for health and social health protection referred to in this sectoral guideline comply with BMZ's general guidelines for results matrices. Designed in keeping with the health system models advocated by WHO and IHP+, they also take account of factors outside the health sector.

The sample results matrices are intended to help you design and assess programme proposals.

[HYPERLINK TO SAMPLE RESULTS MATRICES]

Typical **programme objectives at the impact level:**

- Improve sexual and reproductive health
- Reduce deaths among children and mothers
- Reduce new HIV infections (in province x, national)

Examples of **programme objective indicators at the impact level:**

- Fertility rates among young women (aged between 15-24)
- Maternal mortality rates per 100,000 live birth
- Infant mortality rates per 100,000 live birth
- HIV cases by age groups
- HIV cases in 15-24 years olds

Typical **module objectives at the outcome level:**

- The poorer section of the population in a province increasingly uses high-quality reproductive health services
- Greater use is made of modern family planning methods
- The population in a province demonstrates increasingly preventive behaviour with respect to HIV
- The diagnosis and treatment of tuberculosis infections has been improved in a programme region

Examples of **module objective indicators at the outcome level:**

- Share (%) of births supervised by skilled health personnel
- Usage of modern contraceptives (15-49 years, in per cent)
- Participation in antenatal care (1 visit, 4 visits)
- Use of condoms at last high risk sex (15-49 years, in per cent)
- Case detection rates for all forms of tuberculosis (in per cent)

Examples of **programme outputs:**

- Better quality of obstetric facilities
- Improved access to contraceptives
- Well-established workplace health promotion programmes, with a strong HIV component
- Improved knowledge and changes in attitudes among specific population groups with regard to HIV and AIDS and sexuality

Examples of **indicators at output level:**

- Availability of a national (accredited) institution for quality assurance in health
- Efficiency of contraceptives supply
- Existence of an HIV workplace programme or an HIV workplace strategy, proportion of staff reached with respective programme / strategy

Examples of **programme activities:**

- Set up of quality assurance systems
- Advice public-private partnerships in the field of obstetrics / neo-natal care
- Procurement of contraceptives
- Establish and advise on voucher and other demand-side financing systems in the field of reproductive health
- Set up / improve the health management system (HMIS) for maternal and newborn care
- Support of media campaigns
- Support of training measures (for example training of midwives)
- Organisation of 'join-in-circuits'

B) Quality-controlled indicators (core set of sectoral indicators)

Indicators describe **how the occurrence of a planned change can be observed or measured.** As such, they allow us to make statements about the achievement of objectives. Indicators are required when the objective itself cannot be measured directly.

We should preferably use standardised and quality controlled indicators in our programmes. The sectoral indicators provided here complies with the WHO and IHP+ reference framework and covers the key areas of health dealt with in German development cooperation:

Main areas of core sectoral indicators:

- Health systems strengthening / sector-wide approaches (SWAps)
- Health financing
- Training of and support for health personnel
- Construction, operation and management of hospitals
- Disease control and preventive health care
- Sexual and reproductive health and rights
- HIV and other sexually transmitted diseases

Core sectoral indicators help you choose the appropriate parame-ters for your programme. They allow you to summarise the results of various programmes and make it easier to compare them.

Other country-specific indicators can certainly be used if this is justified.

We provide the core set of sectoral indicators as an excel tool. Through using the filter functions, indicators can be selected in line with the M+E analysis level (impact, outcome, output, input) or with thematic areas. The annex of this sectoral guideline contains an overview of all indicators as well as information on critical determinants of health.

Access to individual indicator data sheets with definitions

[HYPERLINK TO CORE SECTORAL INDICATORS]

Access to core sectoral indicators via the Excel tool

[HYPERLINK TO EXCEL TOOL]

Standard indicators reproductive health and family planning

The BMZ has introduced the following two standard indicators in bilateral projects and programmes on reproductive health and family planning, with the aim of facilitating reporting on project progress and, in turn, improving their effectiveness: **(i) utilization rate of modern contraceptives (core indicator B16); (ii) share of births supervised by skilled health personnel (core indicator B12)** These indicators cover the three goals of the BMZ initative Rights-based Family Planning and Maternal Health (knowledge/acceptance; family planning; safe childbirth).

See also Sectoral Guideline Sexual and Reproductive Health and Rights (March, 2012) and figures in Annex.

To illustrate how many women and men are reached through German “Muskoka”-relevant development measures, projects and programmes should collect the necessary data in their results-oriented monitoring system (absolute numbers and population shares, disaggregated by e.g. age, sex, ethnic group). The results matrix of development measures in the area of sexual and reproductive health should include at least one of the here proposed standard indicators on the M+E level of the module objective. Exemptions should be justified accordingly.

C) Further tools for improving results measurement

Guidelines on the use of data

Results measurement is about using data to set target values and to make reliable statements about the extent of achievement of objectives. Here, it is important to ensure both the quality and the validity of data. A distinction is made between **primary data** – i.e. data you have collected yourself as part of a study or survey – and **secondary data** that third parties have collected for a different purpose.

Criteria on the use of data

- **Validity:** The method and data provide suitable information for the question at hand;
- **Reliability through replicability:** Repeated surveys deliver the same results;
- **Objectivity:** The result is not dependent on the person conducting the assessment.

It is advisable to first check whether secondary data that already exist can be used to benchmark an indicator. This is mostly the case with indicators at the impact level. Often representative population surveys are on hand, such as Demographic and Health Surveys (DHS). However, surveys of this kind are only conducted every five years and data are not always on hand for all programme regions and all key target groups (disaggregated data).

You should only collect your **own primary data** if no other suitable data are on hand. This is often the case with indicators at the **output level.**

Secondary data sources in the health sector:

- Official statistics (civil registration, e.g. register of births and deaths) or population estimates;
- Representative population-based surveys, national studies and surveys, such as Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS);
- Data obtained via the Monitoring and Evaluation (M&E) platform; an initiative for monitoring national health strategies that promotes the uniform definition of standards and minimal data records for health information systems, with the district as the central point of reference. Using these data, it is possible to record the progress of health programmes (progress and performance reviews) and to conduct annual Health Sector Reviews and other reviews;
- Country-specific Health Management Information Systems (HMIS), such as, for example, surveys on the volume of health services and the resources at their disposal (Health Facility Census or Health Facility Surveys). The Health Metrics Network has surveyed the quality of information systems and data in a number of partner countries;
- Service and administrative records of health-service providers (such as statistics concerning the utilization of services, data on sickness or settlement of costs etc. and epidemiological sentinel site surveillance; surveys among selected population groups);
- Poverty-related studies and applied research reports (Operations Research Reports) as well as reports by large-scale UN organisations

In rare cases, it may be necessary to add further information to quantitative data. This can be done by using qualitative methods that can either shed light on the findings arrived at using purely quantitative methods or that raise new questions, which can in turn be explained in quantitative terms.

Guidelines on the use of data and data collection:

[HYPERLINK TO GUIDELINES ON DATA]

Evidence syntheses

In future, descriptions of the results to be achieved should try more to explain why certain results are to be expected as a consequence of the proposed intervention. Apart from describing the conditions on site in the partner country and the core problems, reference should be made to studies and evaluation reports. These so-called evidence syntheses are tailored to development cooperation measures in the health sector and provide an overview of the knowledge available on key health interventions and approaches. New programmes that implement these approaches can refer back to evidence syntheses. They are also a useful reference in policy advice and in discussions with partners and political decision-makers.

Evidence syntheses currently available:

[HYPERLINK TO EVIDENCE SYNTHESES]

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Annex

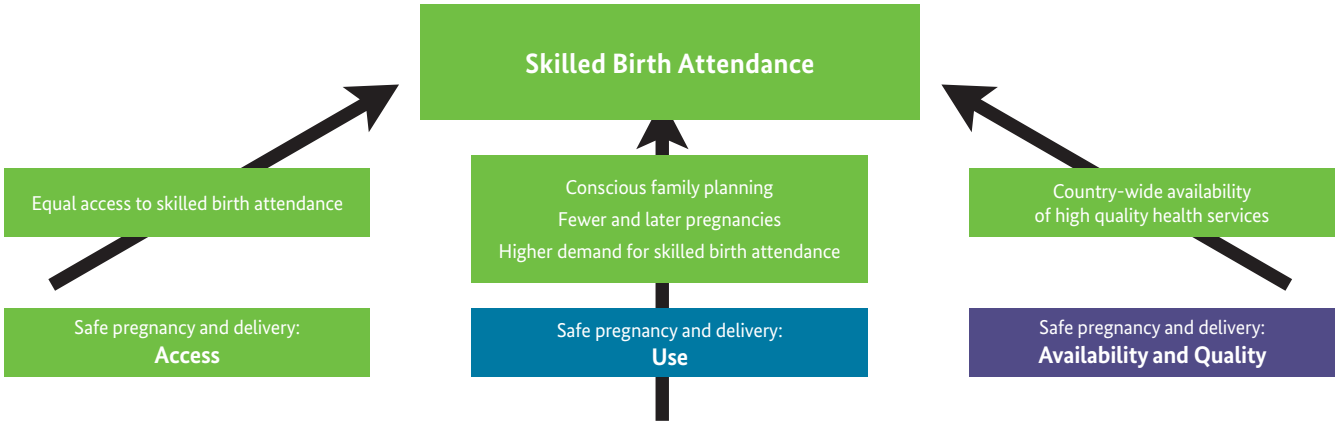
Core set of sectoral indicators

Number	M+E level Health system	Indicator name
A01	Impact	Under-five mortality rate (probability of dying by age 5 per 1000 live births)
A02	Impact	Neonatal mortality rate (death rate in the first 28 days after birth per 1000 live births)
A03	Impact	Children aged < 5 years underweight (%)
A04	Impact	Children aged < 5 years stunted (%)
A05	Impact	Polio incidence (per 100 000 children < 5 years)
A06	Impact	Maternal mortality ratio (per 100 000 live births)
A07	Impact	HIV prevalence among adults aged 15-49 years (%)
A07a	Impact	HIV prevalence among adults according to age groups (%)
A08	Impact	STI prevalence in population sub-groups (%)
A09	Impact	Estimated deaths due to tuberculosis, excluding HIV (per 100 000)
A10	Impact	Estimated incidence of tuberculosis (per 100 000 population)
A11	Impact	Adolescent fertility rate (per 100 women, 15-19 years old)
A12	Impact	Total fertility rate (per women)
B01	Outcome	Neonates protected at birth against neonatal tetanus (PAB) (%)
B02	Outcome	Diphteria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)
B03	Outcome	Measles (MCV) immunization coverage among 1-year-olds (%)
B04	Outcome	Hepatitis B (HepB3) immunization coverage among 1-year-olds (%)
B05	Outcome	Polio 3 doses in 1-year-old-children (12-23 months)
B06	Outcome	Percentage of children (aged 6-59 months), who received vitamine A supplementation
B07	Outcome	Children aged <5 years with diarrhea treated with oral rehydration salts (ORS) and continuously nourished(%)
B08	Outcome	Children (0-59 months) with ARI symptoms (presumed pneumonia) receiving antibiotic treatment
B09	Outcome	Children aged <5 years sleeping under insecticide-treated nets
B10	Outcome	Children aged <5 years with fever who received treatment with any antimalarial
B11	Outcome	Antenatal care coverage (at least 1 visit) (%)
B11a	Outcome	Antenatal care coverage (at least 4 visits) (%)
B12	**Outcome**	**Birth attended by skilled health personnel (%)**
B13	Outcome	Birth by caesarean section (%)
B14	Outcome	Ratio of women and newborns receiving post-natal care (%)

B14a	Outcome	Ratio of women receiving post-natal care (%)
B15	Outcome	Exclusive breastfeeding under 6 months (%)
B16	**Outcome**	**Contraceptive prevalence among woman aged 15-49 years (%)**
B17	Outcome	Unmet need for family planning among woman aged 15-49 years (%)
B18	Outcome	Prevalence of condom use by adults (15-49 years) in high risk sex (%)
B18a	Outcome	Prevalence of condom use at last high risk sex in youth (15-24 years) (%)
B18b	Outcome	Prevalence of condom use in sex workers (%)
B19	Outcome	Antiretroviral therapy coverage among people with advance HIV infection (%)
B20	Outcome	Antiretroviral therapy coverage among HIV-infected pregnant women for PMTCT (%)
B21	Outcome	Case detection rate for all forms of tuberculosis (%)
B21a	Outcome	Treatment success for new smear-positive cases (%)
B22	Outcome	Notified cases of tuberculosis
B23	Outcome	Population coverage with any prepayment system of health protection
B24	Outcome	Out-of-pocket expenditure as a percentage of private expenditure on health
B31	Outcome	Ratio of current school attendance of orphans to non-orphans
B32	Outcome	Percentage of people suffering impoverishment each year by out-of-pocket health payments (specification of particularly affected groups)
B33	Outcome	Percentage of households suffering financial catastrophe each year(specification of particularly affected groups)
C01	Output	Number of service delivery points offering family planning services per 10,000 women in the reproductive age group
C02	Output	Couple years of protection (CYP)
C03	Output	Ratio of availability of condoms at potential selling an delivery points
C04	Output	Efficiency of provision of contraceptives
C05	Output	Number of people reached directly by HIV prevention measures
C05a	Output	Most at risk population (MARP) reached directly by HIV prevention measures
C06	Output	Number of companies with HIV workplace policy
C07	Output	Percentage of (most-at-risk) populations who received an HIV test in the last 12 months and who know their results
C08	Output	Number of insecticide-treated bednets (ITN) distributed
C09	Output	People with access to a basic package of health, nutrition or population services
C13	Output	Ratio of health workers recruited to health facilities compared to numbers outlined in recruitment plan (%)
C14	Output	Number of health workers graduating from health professional educational institutions
C15	Output	Ratio of vacancies for selected staff categories on health facilities
C15a	Output	Proportion of health facilities which are staffed with personnel according to staffing norms

C30	Output	Proportion of HIV-positive clients of HIV services who receive family planning services
C31	Output	Proportion of sexual and reproductive health service clients who are offered HIV counseling and testing
C32	Output	Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV and AIDS
E05	Input	Per capita total expenditure on health
E05a	Input	Total health expenditure as a percentage of gross domestic product
E06	Input	Per capita government expenditure on health
E06a	Input	General government expenditure on health as a percentage of total expenditure on health
E07	Input	Density of physicians (per 10 000 population)
E07a	Input	Density of nursing and midwifery personnel (per 10 000 population)
E07b	Input	Density of community health workers (per 10 000 population)
E07c	Input	Density of dentistry personnel (per 10 000 population)
E07d	Input	Density of environment and public health workers (per 10 000 population)
E07e	Input	Density of pharmaceutical personnel (per 10 000 population)
F01	Determinants	Adult literacy rate (%)
F02	Determinants	Annual population growth rate (%)
F03	Determinants	Gross national income per capita (PPP int. $)
F04	Determinants	Net primary school enrolment rate (%)
F05	Determinants	Population living in urban areas (%)
F06	Determinants	Population living on <$1 (PPP int. $) a day (%)
F07	Determinants	Population median age (years)
F08	Determinants	Population proportion over 60 (%)
F09	Determinants	Population proportion under 15 (%)

Exemplary approaches and interventions that contribute to achievements of targets set by the standard indicators B16 and B12



Exemplary measures:

- Social health insurance
- User-fee removal for vulnerable and poor population groups
- Vouchers for safe pregnancy and delivery
- Sustainable health financing strategies
- Administrative efficiency and decentralisation
- Strengthening of patients rights
- Cultural acceptance

- Information and educational campaigns on sexual and reproductive health and rights
- Community-based promotion of reproductive health through volunteers
- Programmes on gender- and generation dialogue
- Advise and lobbying for women´s rights
- Establishment and promotion of support networks for victims of gender-based violence
- Establishment of effective reference systems

- Training of midwives
- Innovative solutions for staffing in under resourced areas (i.e. rotation systems, financial incentives)
- Promotion of national quality assurance systems
- Advise to the ministry of health to improve quality, efficiency and coordination in the health sector/ systematic monitoring and evaluation

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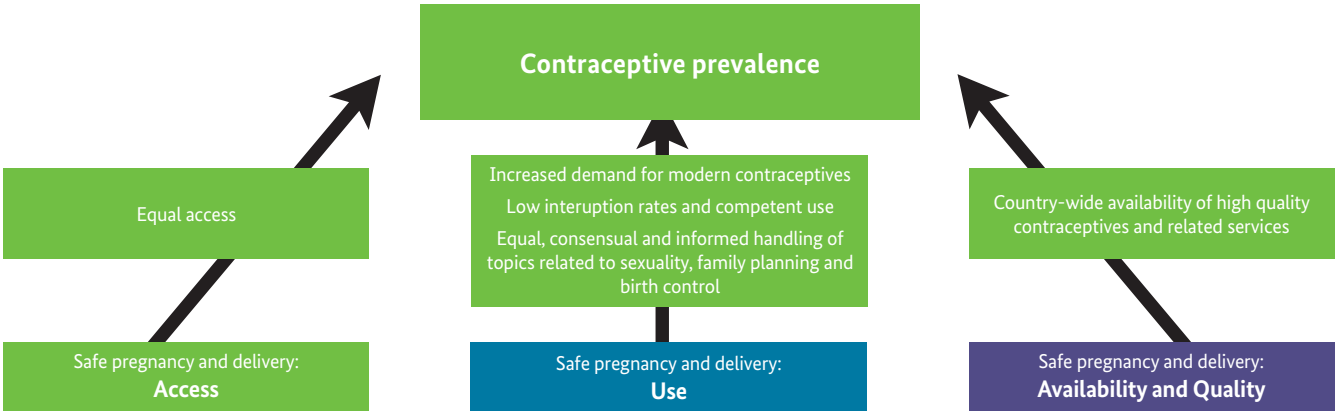

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