16.
MONITORING AND EVALUATION

Community celebration in Iraq. © IOM 2018

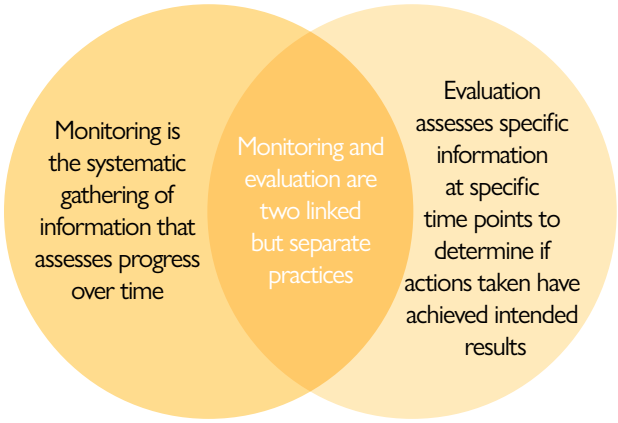
16.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

Monitoring and evaluation, currently conceptualized as monitoring, evaluation, accountability and learning (MEAL) (Sphere Project, 2015), are integral to any community-based MHPSS programme in emergencies. A community-based and participatory MEAL process brings programme managers, staff, community leaders and programme participants and clients together to ensure effective programme performance. It strengthens the ability of MHPSS programme managers to reflect thoughtfully on their work, to be sure that it is completed as intended, and to be clear as to whether and how it met expectations to improve MHPSS in affected communities. This process should allow for changes in activities and programmes, and support community learning about effective interventions for MHPSS, during the emergency and afterwards. Such a process creates additional opportunities for community ownership and accountability to accompany institutional learning at the design and implementation levels.

The aim of this chapter is to introduce the concept of **community-based** and **participatory** monitoring and evaluation in MHPSS programming, and clarify its essential role in reviewing needs, resources, socially and culturally adequate strategies of implementation, and objectives in the rapidly changing environment of humanitarian emergencies, taking into account that communities are not **homogeneous**.

Monitoring and evaluation are distinct but interrelated processes. In *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings* (**IASC, 2007**), they were identified as an essential part of MHPSS programming in emergencies. Action Sheets 2.1 and 2.2 should be read along with chapter 3 on **Assessment and mapping** of this Manual as an introduction to this chapter.

Figure 15: Monitoring and evaluation



Source: IASC (2017).

Monitoring and evaluation is applied to the following project components:

- Project inputs: Funds, materials, equipment, staff and other resources "put in" to carry on project activities.
- Project outputs: The activities achieved or "put out" in the process of implementing a project (such as training session for staff or improved access to services or facilities) that show that operational plans are on track.
- Project outcomes: What "comes about" during the course of a project as a result of the achieved outputs.
- Project impact: A lasting change in individuals, families and communities that results as a consequence of the project.

16.1.1 What monitoring is

Monitoring is the systematic gathering of information that assesses programme progress over time (IASC, 2017). Monitoring compares intention to results (Sphere 2018). During a humanitarian emergency, even the best assessment and programme design cannot perfectly predict emergency-related changes in circumstance, the difficulties of implementation in specific places,

or any other complications in programme actualization. Community-based and participatory monitoring provides the mechanism for learning, contextualization and adapting programmes throughout the implementation (Sphere, 2018).

16.1.1.2 Why monitor MHPSS programmes

We monitor for two things; process (are we implementing correctly in the specific circumstances?) and results, (is what we are doing working?) In addition, people implementing programs will want others to witness and recognize their work, and help make corrections when needed. Programs can then be modified to be sure that they do in fact address the issues at hand, as experienced in the local context.

16.1.1.3 When to monitor MHPSS programmes

Monitoring is an ongoing process, but a good rule of thumb can be to monitor after 30 days to learn whether and how implementation is possible, and what needs to be addressed; 60 days to see if things have begun and again what issues need addressing, and then at 90 days and every additional 90 days until the program's end.

16.1.1.4 Community-based participatory monitoring

Monitoring can occur through a method called community-based participatory monitoring and evaluation, which provides the mechanisms for learning, contextualizing, and adapting programmes throughout implementation (Sphere 2018). This process can include the following activities:

- Discussions with project management and staff;
- Observing the project activities while they are happening;
- Listening to programme participants about their experience of the programme in focus group discussions;
- Engaging with community representatives in focus group discussions;
- Seeking out community representatives of groups who may not be participating to be check on inclusion and exclusion;
- Developing a monitoring "grid" complete with indicators for each project objective and and holding a meeting with beneficiaries at each point to chart progress.

Click **here** for an example of one such chart. After charting the results, the participants can evaluate for themselves whether the group is "on the right track." Are the actions they are taking really improving their sense of psychosocial well-being? Are these changes having any negative effects on their well-being? If so, can they be corrected?

16.1.1.5 Questions addressed by community-based participatory monitoring

Community-based and participatory monitoring addresses the following questions:

- Is the programme being implemented as planned after the participatory assessment?
  - o If not, what are the obstacles?
  - o How should they be addressed? Need the programme be further contextualized?
- Are all of the intended affected populations being reached?
  - o Who is being excluded? Why?
  - o How can the programme bring in additional marginalized populations?
- Have the circumstances of any given population changed significantly?
  - o What adaptations are needed to operate in these new circumstances?
- Are the needs, resources and methodology of intervention identified at assessment still relevant to the psychosocial well-being of the affected

individuals and communities?
  - Do the proposed activities still seem likely to improve their psychosocial well-being and social relations?
- What are the unintended negative consequences to date?
  - How do they affect the populations' well-being?
  - How will the programme address these?
  - Is there a functioning and transparent grievance mechanism?
- Is inter-agency coordination proceeding as planned?
  - If not, what adjustments are necessary?
- Are staff members performing according to standards, and are self-care programmes and measures available?
  - If not, what adjustments are needed?
  - Recognize and support the positive efforts of staff, participants, and community members.

With these questions answered, monitoring information can guide programme, project, or intervention revisions, verifying target criteria, and confirm that the intervention is reaching the people who need it (Warner, 2017).

16.1.2 What evaluation is

Evaluation is a systematic and objective assessment of the design, implementation and results of an ongoing or completed intervention, project, programme or policy (Sphere, 2017). Evaluation refers to the process of examining a programme at specific points in time, minimally at the beginning, then at the middle (if possible), and after completion to see if it achieved the desired results as determined in the assessment. Engaging community members and programme participants in the evaluation process ensures their inclusion in learning. In MHPSS programmes, IOM, from a technical perspective, evaluates outcomes and, when possible, impact:

- Outcome evaluations assess the effectiveness of a programme in producing change. They ask what happened to programme participants and how much of a difference the programme made for them. They are conducted at midterm and again at the end of a project of intervention.
- Impact evaluations attempt to measure if the project promoted lasting positive changes in the participants' mental health, psychosocial well-being, attitudes, behaviours and social relationships.

Box 71

Questions that IOM evaluations of MHPSS programmes try to answer

- How was the programme delivered? Which processes contributed to positive and negative effects?
- Which internal and external factors intervened to affect (positively and negatively) the impact of the project?
- Was the integration of specialized services provided by the project effective in stabilizing, treating and preventing mental, neurological and substance use disorders?
- Did the project improve and activate resilience, promote inclusion, facilitate positive human connections, and restore agency, self and community efficacy, and hopefulness to individuals, families and groups at each targeted level of the pyramid?
- Did the project enhance the protection of persons in institutions or segregated at home, in tents or in camps?
- What are the most relevant good practices, innovations and lessons learned in implementation, monitoring and evaluation of the project?
- What structural and ongoing changes have been made to the lives of the individuals, families and communities who participated in the project?

16.1.3 Understanding indicators

Indicators are the measurable information used to help, ask and answer the questions identified in the monitoring and evaluation plan. The choice of indicators informs the rest of the monitoring and evaluation plan, including methods, data analysis and reporting. Indicators can be quantitative or qualitative. Participatory indicators are those that are developed together with stakeholders, especially community members and participants, that help all of those concerned to be precise about whether the programmes are succeeding to improve mental health and psychosocial well-being in the community. Strong indicators are referred to as SMART – specific, measurable, attainable, relevant and time-bound.

- Input indicators: These measure the contributions necessary to enable the programme to be implemented (such as funding, staff, key partners and infrastructure).
- Output indicators: Many programmes use output indicators as their process indicators; that is, the production of strong outputs is the sign that the programme's activities have been implemented. Others collect measures of the activities and separate output measures of the products/ deliverables produced by those activities.
- Outcome indicators: Measure whether the programme is achieving the expected effects/ changes in the short, intermediate, and long term.
- Impact indicators: Because outcome indicators measure the changes that occur over time, indicators should be measured at least at baseline (before the programme/project begins) and at the end of the project. Long-term outcomes are often difficult to measure and attribute to a single programme.

For specific examples of how these questions can be addressed for CB MHPSS programs see 16.1.4 and the linked material in the section.

16.1.3.1 Goals and indicators supplied by the common framework

The IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings has created the *IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support Programmes in Emergency Settings* (IASC, 2017). This document presents a consensus on the goals, objectives, indicators and actions for the monitoring and evaluation of MHPSS programmes in emergencies. The full document can be found **here**. Its key elements as they relate to CB MHPSS are summarized here. The document enumerates a five-step process for conducting monitoring and evaluation on MHPSS programmes:

1. Assessments of MHPSS proceed as usual. The beginning of an MHPSS programme design is initiated to meet assessed needs (see chapter 3).
2. The organization considers its own programme outcomes and outputs as they relate to the programme design. Each organization considers how its project will contribute to the goal in the common framework.
3. During the design phase, practitioners/ implementers are encouraged to review the common framework to see how it aligns with their own proposed intervention(s).
4. The programme takes (at least) one goal impact indicator and at least one outcome indicator from the common framework. The programme also includes output indicators unique to the programme design.
5. The organization explores possible means of verification to measure impact and outcome indicators. These may be measures previously used by them or other organizations.

The common goal identified for MHPSS programmes is "to reduce suffering and improve mental health and psychosocial well-being". The framework describes two types of outcomes:

- Community-focused outcomes;
- Person-focused outcomes.

Box 72

How do monitoring and evaluation combine with accountability and learning to complete a MEAL?

Accountability to affected populations (AAP) is an integral part of the humanitarian programme cycle, which includes monitoring and evaluation, accountability and learning in its areas of concern.

AAP requires communities to be engaged in programme assessment, design, monitoring and evaluation. AAP requires that, as programmes are amended and adapted based on community feedback, there is a mechanism in place to report back to the community the changes being made and how to make use of newly adapted services. As participatory monitoring is an ongoing process, there are many opportunities to return to community members with the results of any adaptations. In low-resource settings, this information can be disseminated in focus groups, community meetings and activity groups, such as those mentioned earlier in this Manual. In higher resource and urban settings, these methods of dissemination are also useful, but they will require the addition of social media and radio communications in order to be effective.

The IASC toolkit on AAP provides detailed advice on how to implement this process and can be found **here**.

Participatory monitoring and evaluation invite reflection and learning as managers, staff, community leaders and programme participants work together to evaluate programme effectiveness. Learning conferences that include evaluation reports allow participants – who have participated in the entire process, from assessment and implementation to monitoring and evaluation – to consider next steps.

What about the evaluation was surprising? Anticipated? What experiences were pleasant but yielded few results? Such learning conferences and, to the extent that resources allow, their publication on interactive social media sites and through community organizations, ensure that there is a longer-term effect that communities can use to improve well-being going forward.

Some important questions to ask for reflective practice:

- What actions were taken during monitoring and evaluation to ensure that opportunities were created for reflection and learning?
- To what degree did participant perspectives influence these activities?
- How were issues identified in the process documented, acted upon and reflected in the evaluation?

To link these practices to AAP requirements, click **here**.

These reflect MHPSS programmatic activities at the community, group, family and individual levels.

The framework identifies five main common outcomes for any MHPSS project in an emergency, and provides a set of 49 indicators to measure impact and achievements. The Guide also encourages, along with the overall goal, to include at least one outcome and related set of indicators to monitor and evaluate each MHPSS project. For easy reference, Table 12 highlights three key indicators for each outcome, chosen among the ones that most relate to community-based MHPSS practices and the IOM approach; however, it is highly recommended to refer to the publication in its entirety for the full complement of indicators and details on implementation.

Table 12: Key indicators for community-focused and person-focused outcomes

Outcomes			
Community-focused	Emergency responses do not cause harm and are dignified, participatory, community-owned, and socially and culturally acceptable.	People are safe and protected, and human rights violations are addressed.	Family, community and social structures promote the well-being of all of their members.
Person-focused	Communities and families support people with mental health and psychosocial problems.	People with mental health and psychosocial problems use appropriate focused care.	

Source: Based on IASC (2017).

Table 13 provides a sample of key outcomes and indicators, again chosen among the ones that better serve CB MHPSS programmes and the IOM approach.

Table 13: Key outcomes and indicators

Outcomes	
1. Emergency responses do not cause harm and are dignified, participatory, community-owned and socially and culturally acceptable.	• **O1.1:** Percentage of affected people who report that emergency responses (a) fit with local values, (b) are appropriate and (c) are provided respectfully. • **O1.3:** Percentage of target communities where local people have been enabled to design, organize and implement emergency responses themselves. • **O1.4:** Percentage of staff trained and following guidance (for example, the IASC Guidelines) on how to avoid harm.
2. People are safe, protected, and human rights violations are addressed.	• **O2.1:** Number of reported human rights violations. • **O2.2:** Percentage of target communities with formal or informal mechanisms that engage in protection, monitoring and reporting of safety risks or at-risk groups (for example, children, women, people with severe mental disorders). • **O2.6:** Percentage of target group members (such as the general population or at-risk groups) who feel safe.

3. Family, community and social structures promote the well-being and development of all their members.	• **O3.2:** Extent of parenting and child development knowledge and skills among caregivers. • **O3.5:** Level of social capital, both cognitive (level of trust and reciprocity within communities) and structural (membership and participation in social networks, civil or community groups). • **O3.6:** Percentage of target communities where steps have been taken to identify, activate or strengthen local resources that support psychosocial well-being and development.
4. Communities and families support people with mental health and psychosocial problems.	• **O4.1:** Number of people with mental health and psychosocial problems who report receiving adequate support from family members. • **O4.2:** Abilities of caregivers to cope with problems (through, for example, stress management skills, conflict management skills, problem-solving skills, parenting skills, knowledge of where to seek help or information, and resources needed to access care). • **O4.4:** Perceptions, knowledge, attitudes (including stigma) and behaviours of community members, families and/or service providers towards people with mental health and psychosocial problems.
5. People with mental health and psychosocial problems use appropriate focused care.	• **O5.4:** Number of women, men, girls and boys who receive focused psychosocial and psychological care (such as psychological first aid, linking people with psychosocial problems to resources and services, case management, psychological counselling, psychotherapy or other psychological interventions). • **O5.6:** Number of people per at-risk group (for example, unaccompanied and separated children, children associated with armed groups, survivors of sexual violence) receiving focused care (case management, psychological counselling, psychotherapy or clinical management of mental disorders). • **O5.8:** Level of satisfaction of people with mental health and psychosocial problems and/or their families regarding the care they received.

Source: Based on IASC (2017).

It should be noted that a group of IASC partners and Johns Hopkins University are currently identifying recommended means of verification for each of the indicators. The resulting publication will be added to the online version of this Manual once ready. A UNICEF manual on methods of monitoring and evaluation particularly tailored to children can be found **here**.

16.1.3.2 Developing and using participatory indicators.

Many IOM MHPSS programmes, as described in this Manual, while providing a referral system for people with psychological problems, focus on the re-establishment of community protective systems, such as social cohesion and the activation of agency among groups within the population, using terms defined by the participants themselves. These activities contribute to the same overall goals as all other MHPSS programmes, but require specific indicators to represent results to be evaluated, in addition to the ones reported in the IASC Guide. In a community-based approach, it is fundamental to involve affected populations in the identification and development of the indicators used in monitoring and evaluation

16.1.4 The SEE_PET

The SEE_PET is a rapid participatory method that can be used to develop indicators of psychosocial well-being in a specific cultural context with concerned social groups. It can be used to develop indicators of MHPSS programme effectiveness, against which staff and participants can evaluate success and discard ineffective practices. Derived from the methodology of a three-country study of conflict-affected women's perceptions of psychosocial well-being (Bragin et al., 2014), it has been adapted for use with children and male adults, as well as IDP settings. The SEE_PET is used to engage community members in defining and operationalizing the components of psychosocial well-being in their own language and thinking, turning those operational definitions into SMART, contextual indicators. The method facilitates participants, community members and programme staff in the use of these indicators to monitor and evaluate the psychosocial components of emergency MHPSS programmes. It provides participants with a moment to reflect on both needs and resources in the midst of crisis, enabling them to articulate and work toward the life that they envision for themselves and their children, now and in the future. This method has subsequently been used by IOM in emergencies in different low-resource contexts, such as in South Sudan and Nigeria.

- For specific step-by-step instructions on how to use the SEE_PET, click **here**.
- To create and chart specific indicators for adults, click **here**.
- To create and chart specific indicators for children and adolescents, click **here**.
- For an illustrative IOM case study, click **here**.
- For the context and follow-up of the study, click **here**.

SEE_PET can be community-led but it is typically a process facilitated by trained experts.

Box 73

Developing participatory indicators supporting referral for treatment of mental, neurological and substance use disorders

In some settings, IOM will be called upon to identify people with mental, neurological and substance use disorders, who require specific referral and follow-up care. In some low-resource settings, community members may not have ever had a proper system of locally available mental health care. In those instances, recent studies show that community members are aware of symptoms they associate with mental illness, neurological disorders and response to substance abuse. Such communities often have ways of identifying and differentiating people whose behaviours represent the results of grief and exposure to violence from those with ongoing issues requiring psychiatric care (Ventevogel et al., 2013).

Organizing focus group discussions supplemented by meetings with key informants – such as health-care providers, traditional healers, community leaders and psychiatric personnel who may be available – can produce positive identifications of people requiring specialized referral.

In this case, rather than asking questions regarding psychosocial well-being, focus group discussion questions might ask about persons with behavioural and emotional problems and the optimal way to care for them (Ventevogel et al., 2013). For case examples and a careful description of how to develop and analyse the results of such focus groups, see the referenced article **here**.

16.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

Nine steps to start the monitoring and evaluation process are listed below. It is important to note that each emergency is unique and that the steps may be omitted or modified based on circumstances.

1. Sites and locations: Focus on three different sites (such as camp, transit centres and host community), or three different locations in the same area (such as camp sections, nearby villages and neighbourhoods).
2. Mapping: Carry on at least three different participatory exercises, such as transect and well-being walks, social networks diagrams (see **INTRAC website**) for resources and free online related publications (**here**), and **community scoring cards**; and see MHPSS.net for an array of downloadable and practical tools and instructions on how to use **them**.
3. Affected population: Purposive sample of approximately 30 informants for each site/location, including men and women, GBV survivors, persons with disabilities, the elderly and people from marginalized groups. If children are to be included in the programme, there should be separate groups for children and adolescents.
4. Stakeholders and gatekeepers: Identification of four key informants for each site/location – teachers, health-care workers, local and religious leaders, and camp managers – to be interviewed.
5. Indicators: Identification of at least two SMART, qualitative and quantitative indicators for each activity, output and outcome.
6. Tools: Selection of at least three tools – such as activity monitoring forms, participant satisfaction questionnaires and focus group discussions – for each indicator.
7. Timing: According to the operational plans but as regularly as possible, including weekly activity monitoring data, monthly participant satisfaction questionnaires and quarterly focus groups.
8. Staff: Identification of dedicated staff with appropriate language and cultural competence to be trained in data collection and data management, including field team leaders, data entry assistants, IT managers and project officers.
9. Data management: Identification of available platforms to store information (such as spreadsheets, online databases and Word documents) and reporting forms to graphically share data (such as monthly and quarterly).

16.3. CHALLENGES AND CONSIDERATIONS

Challenges include the following:

- Special care must be taken to ensure that all community subgroups are represented in the monitoring and evaluation process. This requires a specific effort to prevent obstacles to participation such as language, education, cultural norms, accessibility, social and gender discrimination, power struggles, political interests and open conflicts.
- Cultural acceptance of methodologies and tools of community-based monitoring and evaluation

might not be taken seriously by stakeholders and affected populations themselves in emergency contexts. It is important to make them part of a larger effort to engage communities.

- Subjective changes and self-perceptions of well-being are also determined by external concurrent factors, such as conflict dynamics, displacement stages, cultural interpretations of illness, social conditions and political narratives that might rapidly change in a typical emergency scenario. This all needs to be considered when analysing the results of monitoring and evaluation.
- Community-based activities – such as public gatherings, awareness campaigns, religious celebrations, sport tournaments, skill training and livelihood promotion – require a set of specific indicators and tools to measure the actual impact on psychosocial well-being of affected populations. These are signalled, when relevant, in the relevant chapters.
- Positive and lasting impact in MHPSS might require more time than the usual short operational frame of an emergency intervention. Therefore, indicators and evaluation tools should be accurate enough to measure trends and attitudes instead of consolidated achievements and lasting changes.
- Budgets often fail to allocate sufficient resources for dedicated and qualified human resources to attend to MEAL. When resources lack, they should be included in the job descriptions and related competencies of core staff. These activities will therefore not represent added burdens, but rather a part of regular duties.

Depending on the size and characteristics of the emergency, a full participatory identification of indicators may be difficult to achieve in the very initial phase of the response. Communities and the programme can achieve this capacity later in the process. In those cases, a SEE_PET or other processes can also be initiated at a later stage, since they can still impact programme outcomes and learning.

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For other references, see the full bibliography **here**.