Best Practices in Monitoring and Evaluation: Lessons from the USAID Turkey Population Program

by

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Executive Summary

Simple, state-of-the-art monitoring and evaluation (M&E) plans enable programs to make data-based decisions regarding public health interventions and they provide funding agencies with evidence-based program outcomes. Monitoring and evaluation plans that adhere to a set of accepted best practices are easy to implement and yield data that can be used to continually improve program performance. Best practices drawn from the USAID Turkey M&E plan include linking M&E to strategic plans and workplans, focusing on efficiency and cost-effectiveness, employing a participatory approach to monitoring progress, utilizing both international and local expertise, disseminating results widely, using data from multiple sources, and facilitating the use of data for program improvement.

The USAID Turkey M&E plan utilized a variety of data sources, including national population-based surveys; administrative, service and financial statistics; self-administered assessments for NGOs and questionnaires for the government of Turkey; and Quality Surveys that include facility checklists, client exit interviews and mystery client visits.)

Significant program improvements were targeted by the USAID Turkey M&E plan and were subsequently achieved over the 1998 to 2001 period, including

- *Availability of three or more modern methods increased from 70% in Istanbul and 67% in Cukurova facilities to 94% for both regions.*
- *Distribution of information, education and communication (IEC) materials during the client's visit increased from 17 to 78% in Istanbul facilities and from 6 to 90% in Cukurova facilities.*
- *Contraceptive commodity forecasting, budgeting and procurement improved from a score of 60 to 92%.*
- *The proportion of the government's Women's Health/Family Planning Plan activities completed rose from 18 to 67%.*
- *The proportion of health facilities having a supervisory visit in the past six months rose from 48 to 82%.*

These improvements were accompanied by increases in daily family planning client volume, including new client share, and in the level of client understanding of their contraceptive methods and satisfaction with family planning care received.

The conclusions emerging from the USAID Turkey M&E experience are that

- *M&E is a program asset, not a burden.*
- *Local ownership is fundamental to increased utilization and sustainability.*
- *Leadership continuation and commitment is requisite.*

Acknowledgments

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Our special thanks go to the leadership of the Ministry of Health, General Directorate of Maternal and Child Health and Family Planning for recognizing the value of a strong monitoring and evaluation system and providing resources and support to make this system a reality.

In particular, we want to thank the small but extraordinarily capable and committed staff from the Provincial Health Directorates of the three provinces where the USAID program currently works. To name a few, we would like to thank Nalan Yetkin, Berna Eren, Goksin Pekyalcin, Sukran Sarilar, Atakan Kizilok, Hulya Tekin, Mutlucan Karaman and Buket Ozcaltepe, for their relentless work, and strong ownership of this state-of-the-art monitoring and evaluation system.

The entire staff of USAID's Cooperating Agencies in Turkey has been closely involved in the development and implementation of the Monitoring and Evaluation Plan. We would like to thank the staff of EngenderHealth International, JHPIEGO, The Futures Group International and Management Sciences for Health (MSH) for their generous contributions. Our special thanks go to Hulki Uz of MSH, whose time and effort working on the M&E Plan never ceased.

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List of Acronyms

CA	Cooperating agency
DHS	Demographic and Health Survey
FP	Family planning
GOT	Government of Turkey
IEC	Information, communication and education
KIDOG	NGO Advocacy Network for Women’s Issues
M&E	Monitoring and evaluation
ML	Minilaparoscopy
MOH	Ministry of Health
NGO	Non-governmental organization
NSV	No-scalpel vasectomy
RH	Reproductive health
SDP	Service delivery point
SSK	Turkish Social Security Organization
TDHS	Turkish Demographic and Health Survey
WH/FP	Women's health/family planning

Best Practices in Monitoring and Evaluation: Lessons from the USAID Turkey Population Program

I. Introduction: Managing for Results

Simple, state-of-the-art monitoring and evaluation (M&E) plans enable programs to make data-based decisions regarding public health interventions and they provide funding agencies with evidence-based program outcomes. Monitoring and evaluation plans that adhere to a set of accepted best practices are easy to implement and yield data that can be used to continually improve program performance. While reporting requirements are often regarded as a burden on activities in the population and health sector, routine project monitoring can be designed to meet the needs of both local project managers and funding agencies.

In order to better track progress and evaluate improvements in the quality of family planning services in Turkey, the USAID Turkey program has implemented an innovative M&E system. The M&E plan incorporates several accepted best practices in monitoring and evaluation. The plan utilizes simple data collection and analysis techniques to encourage the use of data at all levels for the continuous improvement of services. The M&E plan was designed to be a user-friendly tool for health facilities and local program managers, in order to improve prospects for sustainability.

II. Background: Family Planning in Turkey

Recent transitions in the demographic situation and donor assistance patterns in Turkey have made strategic planning even more necessary for USAID's population assistance than in the past. In the past few years, Turkey's total fertility rate – the expected lifetime births a woman would have during her childbearing years at current levels – has declined considerably, from 4.3 in 1978 to 2.6 in 1998. Contraceptive prevalence increased from 38 to 64 percent of married women aged 15 to 49. However, due to couples' reliance on less effective traditional family planning methods and limited access to quality family planning services, unplanned pregnancy and abortion remain at very high levels. In the 1998 Turkish Demographic and Health Survey (TDHS), nearly 37 percent of pregnancies in the period 1995-1998 were unwanted or mistimed and 41 percent of these pregnancies were aborted (Senlet et al., 2001).[1]

Turkey's current population (1999) of approximately 66 million people is growing at a rate of 1.5 percent per year (Population Reference Bureau, 2001).[2] Although unlikely, at this rate, the population could double in 46 years, to 130 million people by the year 2047. Turkey currently ranks as the 17th most populous country in the world.

While the Turkish family planning program has made significant contributions toward meeting the contraceptive needs of couples, the program still faces major challenges in the next decade. While overall contraceptive prevalence is high, only 37.7 percent of married women use modern

[1] Pinar Senlet, Sian Curtis, Jill Mathis, and Han Raggers, Role of Changes in Contraceptive Use in the Decline of Induced Abortion in Turkey," *Studies in Family Planning* 32(1): 41-52, 2001.
[2] Population Reference Bureau, 2001, World Population Data Sheet. Washington, DC: Population Reference Bureau.

contraceptive methods, a figure lower than that of many developing countries. An unusually high percentage of couples (26 percent, or two-fifths of all contraceptors) use traditional family planning methods, particularly the withdrawal method (Hacettepe University and Macro International, 1998).[3] The use of less effective traditional methods results in high unplanned pregnancy and abortion rates. The most commonly used modern contraceptive is the IUD, which is used by 20 percent of married couples. The 1998 DHS indicates that 62 percent of currently married women want no more children and an additional 14 percent want to wait at least two years before having another child. However, the substandard quality of family planning and reproductive health (FP/RH) services continues to be a major impediment to meeting the needs of Turkish couples.

III. The USAID Turkey Monitoring and Evaluation (M&E) Plan

Strategic Framework. USAID Turkey designed its Family Planning and Reproductive Health Program to address the issues of FP/RH service quality. The overall strategic objective of the USAID Turkey program is to increase the utilization of family planning and reproductive health services (see Appendix 1 for the Strategic Framework of the USAID Turkey Program). The Program targets two major strategies to achieve this goal: 1) the strengthened sustainability of the FP/RH program and 2) the expansion of high quality FP/RH services in the public and private sectors. In order to strengthen the sustainability of FP/RH services, USAID/Turkey focuses on achieving contraceptive self-reliance in the public health sector and on strengthening local NGOs. In order to expand the quality of FP/RH services, the program focuses on increasing the availability of post-abortion and postpartum FP services, increasing client knowledge about family planning, and improving the performance of health providers, trainers and administrators. By improving the quality of services, USAID/Turkey can help increase client satisfaction and increase the utilization of FP services, thereby improving the chances of program sustainability.

One of the most important recent achievements for USAID/Turkey was the successful implementation of activities through a joint workplan. The joint workplan served as a model for coordination among USAID Cooperating Agency (CA) projects. CAs work together to complete one comprehensive workplan, assuring USAID of coordinated implementation of activities and achievement of program goals. Turkish institutional partners, including the Ministry of Health (MOH), Social Insurance Organization (SSK), and non-governmental organizations (NGOs), participate in the preparation of the workplan as well. This improves the chances for program sustainability after the planned graduation of Turkey from USAID population assistance in 2002.

Monitoring Task Force and the M&E Plan. USAID/Turkey organized several workshops for the design of the M&E plan, including the identification of data sources and the establishment of indicators. Numerous in-country partners were involved in the development of the M&E plan over a one-year period. The task force is led by USAID staff and is comprised of representatives from Turkish government agencies, universities, NGOs, pharmaceutical companies, and USAID Cooperating Agencies (CAs).

[3] Hacettepe University, Institute of Population Studies, and Macro International, Inc. Turkish Demographic and Health Survey 1998. Ankara, Turkey: Institute of Population Studies, Hacettepe University.

The USAID Program has integrated data collection for the M&E plan into a yearly program planning cycle. The standard monitoring and evaluation schedule for the program calls for annual data collection exercises to take place every June. Each September, a Monitoring Task Force meets to compare planned results with actual results, and to develop action plans for strengthening the program. The Turkey M&E cycle facilitates the feedback of data to local-level decision makers and service delivery sites where they are used for continuous program improvement. By incorporating the collection and review of data into the planning cycle, the program can efficiently use results from annual surveys for programmatic decision-making.

Because the CAs and local country partners plan and implement program activities together, they also share the responsibility for monitoring results. During Fiscal Year (FY) 1999, program results were tracked under the M&E plan, following a comprehensive set of quantitative indicators. The indicators helped USAID to assess program progress in a valid and meaningful way (USAID/Turkey, 1998 and 1999).

The Monitoring Task Force in Session

Use of Performance Benchmarks. The USAID M&E plan utilizes "benchmarks," which are programmatic goals to help health staff work toward the improvement of services with greater focus and efficiency. These planning figures help measure progress the program makes in improving the impact and quality of services.

The Monitoring Task Force developed performance benchmarks for the USAID Population Program using the information available on past progress, baseline values of the indicators, and the capacity of implementing organizations. The task force proposed projected annual benchmark values for each performance indicator using the following steps:

- The indicator's current status and resources expended to reach this level were assessed.
- When available, prior trends of indicators were examined to estimate future rates of change.
- Available resources, client needs and provider capacity were considered.

- Annual benchmark levels were projected from this information.
- Each benchmark value was then reviewed for reasonableness and feasibility, in terms of the required effort for the individual project and for the whole program.

Because local partners helped set benchmark values, stakeholders made stronger commitments to achieving established goals.

The M&E Cycle. All components of USAID/Turkey's program are linked to indicators for tracking purposes. Benchmarks, were established to help program and local staff work toward the improvement of services with greater focus and efficiency. These quantitative measures help track progress; for example, the program exceeded all benchmarks for indicators measured in FY 1999. Appendix 2 provides the M&E indicators associated with the program components.

IV. Data Sources

In order to diversify the measures used to track program progress, the USAID M&E plan relies on a variety of data sources, including national Demographic and Health Surveys and local-level surveys of service quality. All data are collected on an annual basis, with the exception of the DHS, which is administered every five years. The M&E Plan makes use of data from the following sources:

- National population-based surveys (DHS)
- Administrative, service and financial statistics
- Self-administered assessments for NGOs and questionnaires for the Government of Turkey (GOT)
- Quality Survey
  - Facility check-list
  - Client exit interviews
  - Anonymous client visits (Mystery clients)

National Surveys. The M&E plan utilizes population-based data from national Demographic and Health Surveys (DHS). The last DHS in Turkey was completed in 1998, and the next DHS is scheduled for 2003. The DHS provides the program with measures on a number of population-based indicators, such as contraceptive prevalence, at 5-year intervals. DHS surveys enable USAID and its partners to track overall program progress in improving high-level indicators, such as contraceptive prevalence rates. Because indicators based on DHS data are available only every 5 years, additional data sources are used to produce annual program measurements, which reflect intermediate improvements in FP/RH services.

Administrative, Service and Financial Records and Reports. Many indicators for the M&E plan rely on existing data, collected routinely through administrative, financial and service statistics. Because such data are readily available, they are easily used for program tracking purposes. The M&E plan utilizes a variety of routine reports on contraceptive commodity procurement, commodity distribution and sales, monthly reports of service utilization, financial expenditure reports, and personnel reports for the annual measurement of indicators.

Self-Administered Assessments and Questionnaires. Members of *the NGO Advocacy Network for Women*, known by its Turkish acronym "*KIDOG*," complete annual self-administered questionnaires to provide assessments on the status of NGO activities. *KIDOG* is a network of 20 NGOs dedicated to raising the status of Turkish women by advocating for progress in the areas of women's health, legal rights and education. Ratings from the NGO questionnaires are compiled as a measurement of progress in *KIDOG's* advocacy efforts. Similarly, GOT officials complete questionnaires in order to assess progress in implementing the National Strategy for Women's Health and Family Planning.

Quality Survey. The M&E Plan incorporates a set of innovative indicators to track improvements in the quality of family planning services. The quality surveys incorporate health facility checklists, client exit interviews, and anonymous client visits to produce a total of six indicators, which measure service quality. Among the six indicators drawn from the quality survey, some are actually composite indices comprised of multiple sub-indicators. By directly measuring the quality of health services, USAID and its Turkish partners can easily identify shortcomings and work to resolve them.

MSH was charged with working with Provincial MOH and SSK staff to organize and implement data collection, analysis and interpretation of results, development of feedback reports and organization of feedback meetings for personnel from all facilities visited. It also prepared reports in English and Turkish summarizing the detailed results of each Quality Survey.

Sharing information on monitoring results

The first baseline Quality Survey was conducted in Istanbul Province in October 1998, with subsequent rounds in 2000 and 2001. A 1999 baseline Quality Survey in Kocaeli province was not repeated due to a major earthquake that devastated the area. Two provinces, Adana and Icel, in Cukurova region were added, with Quality Survey baseline and follow-up rounds conducted in 1999 and 2001. These four provinces were selected because they are the areas where USAID focuses its assistance. The Quality Surveys cover a representative sample of facilities in four

provinces with a total population of 13.5 million, representing over 20% of the national population (Turkish State Institute of Statistics, 1998).[4] Health facilities from both the public and private sectors are included in the quality surveys. The Quality Surveys are comprised of the following three components:

- **Health Facility Check-list:** The check-list is administered in target health facilities to inventory the existence of key family planning program inputs. These inputs include the presence of trained personnel, contraceptive commodities, medical equipment, IEC materials and management resources.

- **Client Exit Interviews:** Three types of clients are interviewed upon completion of their facility visit: family planning, post-abortion, and postpartum clients. Survey questionnaires ask clients about a variety of issues regarding the quality of care received during their visit. Trained field staff interview clients in the same facilities selected for the facility checklists.

- **Anonymous Client Visits:** Because some family planning clinics serve small catchment areas and see relatively few family planning clients, it is not feasible to post survey staff to conduct client exit interviews. Thus, it is critical to survey facilities with low client volume to minimize survey selection bias. As a part of the Quality Survey, Mystery Clients visit low-volume health facilities to assess the quality of family planning services and report on their experiences to a trained survey interviewer. To ensure validity of data collected, mystery clients also visit some high volume facilities.

Statistical biases may arise from each of these data sources, especially when using self-reported data and routinely collected data from service records. However, errors in M&E plan data are believed to be minimal and all collected data have proven useful.

V. Overview of Indicators

The data sources described in the previous section yield a total of 14 indicators, which are incorporated in the M&E plan. All indicators are integrally tied to results established in the USAID Program's Strategic Plan. See Appendix 1 for a complete list of the program's strategic results along with their corresponding performance indicators.

Some of the program's indicators are commonly found in USAID performance monitoring plans. For example, DHS-based indicators, such as the contraceptive prevalence rate and the all-method contraceptive discontinuation rate, are commonly used for tracking purposes in FP/RH programs. However, the M&E plan for Turkey incorporates several innovative indicators that were developed specifically to track improvements in the quality of and access to FP/RH services. A few of these indicators are described in further detail below.

[4] State Institute of Statistics, 1998. Statistical Yearbook of Turkey 1998. Ankara: State Institute of Statistics.

Quality Index

The Quality Index is a composite measure made up of six indicators produced by data from the quality surveys. Data for these indicator components are gathered through facility surveys, client exit interviews and anonymous client visits. One of USAID Turkey's two major program results is the expansion of quality FP/RH services. The Quality Index helps USAID track progress in achieving this result, as seen below in Table 1.

Six separate component indicators are measured in order to capture multiple dimensions of quality in family planning service delivery:

- *modern method availability*
- *availability of trained personnel*
- *perceived quality of family planning counseling*
- *adequate infection prevention measures*
- *availability of IEC materials*
- *presence of clinic signs*

Results from each of the six component indicators are combined to construct a composite index of family planning service quality. The inclusion of such an index in a monitoring and evaluation plan represents an important advancement in the measurement of FP/RH program quality. More details about the quality index can be found in Topcuoglu and Curtis (2000) and Topcuoglu and Uz (1999).[5]

Table 1. Components of Quality Index: Istanbul 1998-2001, Cukurova 1999-2001

Components	Istanbul (percent)					Cukurova (percent)		
	1998	2000		2001		1999	2001	
	Actual	Actual	Target	Actual	Target	Actual	Actual	target
Method Availability	70.5	89.3	86.0	94.2	90.2	67.2	93.8	88.9
Trained Staff	70.6	75.6	81.0	77.8	79.8	51.6	56.0	62.2
Quality of FP Counseling	70.7	74.7	75.0	79.3	78.0	67.4	89.1	75.2
Infection Prevention	24.5	55.1	43.0	82.4	65.3	29.8	77.2	61.2
IEC Materials	17.2	67.2	73.0	78.3	84.4	5.5	90.3	55.0
Visibility of Signs	18.0	40.2	90.0	55.8	53.3	2.8	42.1	54.4

[5] Ersin Topcuoglu and Sian Curtis (2000). Turkey Quick investigation of quality of family planning, post-partum and post-abortion clients. In: Tara Sullivan and Jane Bertrand (editors), Monitoring quality of care in family planning by the Quick Investigation of Quality (QIQ): Country reports. MEASURE Evaluation Technical Report Series No.5, Carolina Population Center, University of North Carolina at Chapel Hill. Ersin Topcuoglu and M Hulki Uz (1999). Family planning quality survey, Istanbul 1998. Republic of Turkey, Ministry of Health, Mother and Child Health and Family Planning General Directorate and Management Sciences for Health, Turkey Office. Ankara.

Joint Indicator for Contraceptive Self-reliance

Another innovative indicator that was created for Turkey's M&E plan is the *Joint Indicator for Contraceptive Self-reliance*. The USAID Program provides technical assistance for the Government of Turkey to improve its ability to provide contraceptive supplies and services for the public sector. The contraceptive self-reliance indicator measures the Turkey's growing ability to supply public sector facilities with contraceptives without external donor assistance.

This joint indicator consists of three component indicators to capture the key areas of contraceptive commodities and logistics:

- *Forecasting, budgeting and procurement* – an annual rating of the MOH and SSK's ability to forecast, budget and procure contraceptives
- *Storage* – the percentage of service delivery points that meet eight widely-accepted standards for contraceptive storage (such as storage away from direct sunlight and excessive heat)
- *Distribution* – The percentage of IUD service delivery points that have experienced no stockouts of IUDs in the last six months

Data for these three indicators are gathered through the Quality Survey's facility checklist and through MOH reports and records. The three indicators form a joint indicator that measures the system's ability to deliver contraceptives to clients. Figures 1a-1c below illustrate progress for these three indicators in Istanbul facilities.

What is noteworthy in Figure 1c is that the indicator captured a recent stockout problem in Istanbul province. This stockout situation is now being addressed by the MOH through its improved distribution system.

Figure 1a. Forecasting, Budgeting and Procurement Score for MOH

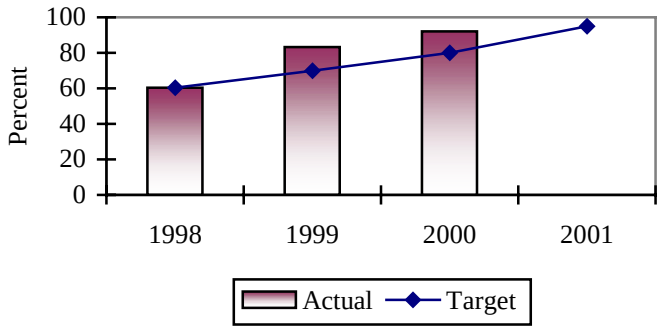


Figure 1b. Adequate Contraceptive Storage Conditions
Facilities that meet all standards (8/8) in ISTANBUL

Panel Facilities	Public Hosp. MOH (n=11)	Public Hosp. SSK (n=7)	Private Hosp. (N/A)	MCH/FP Centers (n=32)	Health Centers (n=49)	**Total (n=99)**
1998	10	5	N/A	26	41	**82**
20	9	6	N/A	28	43	**86**
2001	10	7	N/A	28	45	**90**

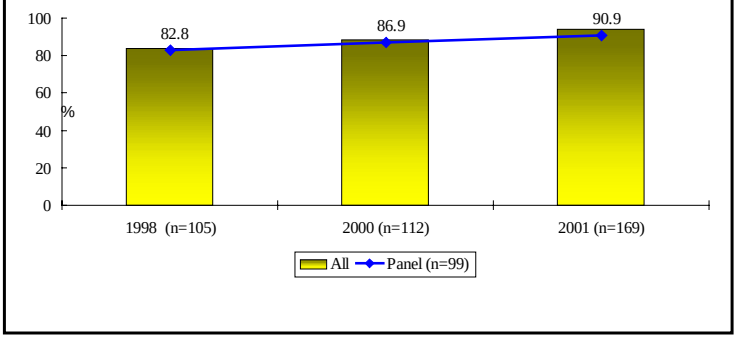


Figure 1c. Contraceptive Stock-out

Percentage of facilities that experienced stock-out in the last 6 months in ISTANBUL

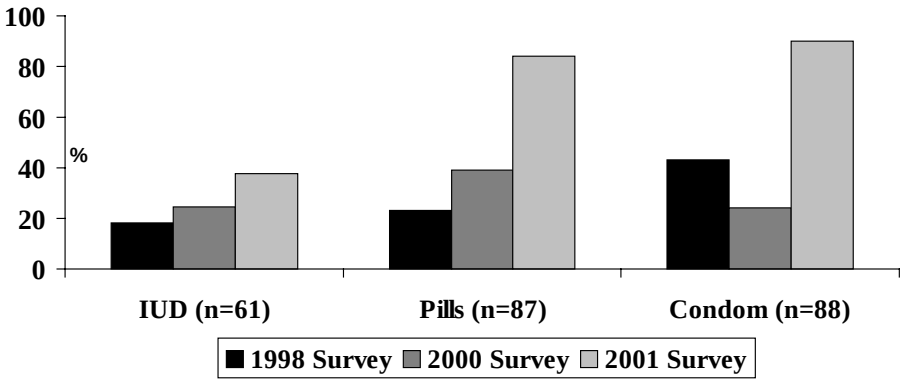
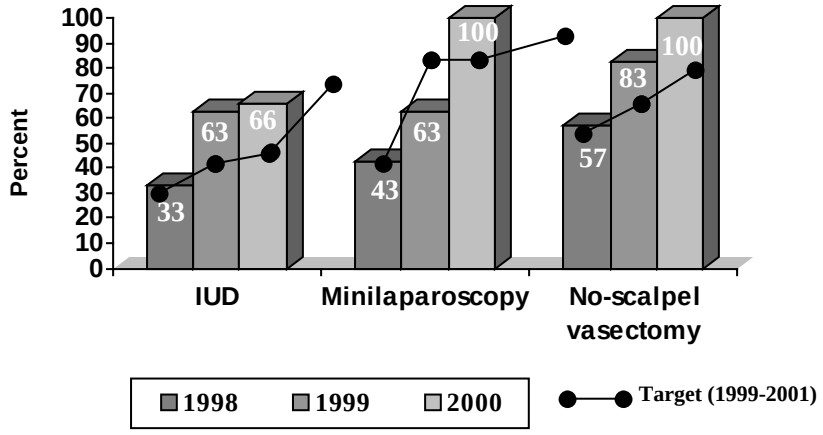


Figure 2. Percentage of Providers Who Are Performing Trained Skills: 1998-2001



Indicator for Application of Training Skills

While most programs utilize indicators to track progress in training service providers, the application of those training skills is often overlooked. The Turkey Program has identified as a priority the "improved job performance of health providers, trainers and administrators." In order to track progress in this area, the program cannot simply measure the number of individuals trained in certain skills. It must also measure the application of those skills.

To accomplish this, the M&E plan includes an indicator that measures the percentage of health providers and trainers who apply new skills to their subsequent work. Data for this indicator are gathered through telephone interviews with providers and trainers. Specifically, the indicator (Figure 2) measures the percentage of providers and trainers trained in IUD insertion, minilaparoscopy (ML) or no-scalpel vasectomy (NSV) in the last 12 months who are performing those procedures or who are training others to do so. Thus, the M&E plan tracks not only the number of providers trained in a particular skill, but also whether personnel policies and deployment practices enable those providers to serve clients with that new skill.

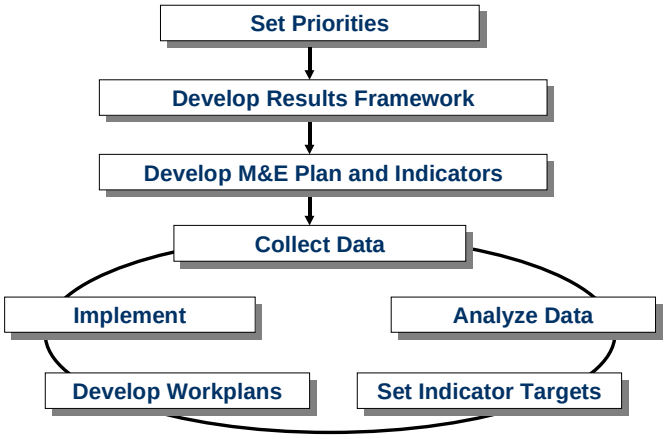
VI. Best Practices in M&E

A closer look at the components and construction of the USAID M&E plan reveals a number of state-of-the-art monitoring and evaluation principles. USAID, its CAs, and Turkish partners have learned a great deal from the development and administration of the M&E plan which can be helpful for other programs monitoring family planning services. Particularly, the USAID M&E plan's success rests on the following seven "Best Practices in Monitoring and Evaluation:"

1) Link the M&E Plan to the Strategic Plan and Workplan

Turkey's M&E plan is linked to the program's strategic plan and workplan in an integral manner. While such a linkage may seem to be an obvious necessity, the M&E plan is exceptional in that

Figure 3. The M&E Cycle



all workplan activities are drawn from specific Strategic Results and are tracked by corresponding indicators. (See Appendix 1 for the complete USAID Results Framework.)

For example, USAID identified the increased availability of post-abortion family planning services as a key results area. Under the M&E plan, a set of indicators was developed specifically to track progress in the provision of post-abortion services. Activities for improving the delivery of post-abortion family planning services were then integrated into the annual joint workplan for USAID CAs.

The collection of data for the M&E plan is but one step in a standard program planning process, which contains the following six elements:

1) Set program priorities
2) Develop program framework
3) Develop M&E plan
4) Collect data
5) Set/review targets
6) Develop program action plans and workplans

While the partners establish major priorities, a program framework, and an M&E plan only once for a program period that covers several years, the last four steps of the cycle are repeated annually. Thus the annual collection of data forms a continual feedback loop which drives the revision of targets and the development of program workplans. Figure 3 illustrates the M&E cycle.

2) Emphasize Efficiency and Cost-effectiveness

Perhaps the most notable aspects of the M&E plan are its speed, modest cost and simplicity. Annual indicators drawn from quality surveys, NGO self-assessments, and service records and reports can be collected and analyzed quickly and inexpensively, since the required data collection procedures and analysis techniques are simple and can be carried out by local staff.

The Turkey program's Quality Surveys provide a clear example of the ease and efficiency of implementation. Many family planning programs have conducted monitoring and evaluation exercises to analyze the quality of services. However, these surveys can be expensive and time-consuming because they measure an entire array of program factors related to the quality of care, rather than just a few factors closely related to program interventions. For example, the Situation Analysis approach, developed by the Population Council, has been used with great success in numerous countries. Situation Analysis has benefited programs by opening up the "black box" of service delivery to uncover strengths and weaknesses in a wide array of program areas, such as commodity distribution, client-provider interaction, and infection prevention measures.

In contrast to the Situation Analysis, the Quality Surveys are results-oriented, select a limited number of program factors to track and measure, and build in feedback mechanisms. Because Quality Surveys are limited in scope, they provide a "quick and dirty" assessment of the quality of and access to family planning services. To help meet program needs, the MEASURE Evaluation project field-tested quality surveys, which allow programs to collect data for measuring service quality in a quick and easy manner.[6] Because these quality surveys are implemented by local, in-country staff and require little external technical assistance, they are fast, inexpensive and user-friendly. For example, the Quality Survey conducted in Istanbul in 1998 by the MSH Project assessed a total of 128 service delivery points and 1,481 clients, yet cost only $33,024. The final 2001 Quality Survey in Istanbul audited 194 service delivery points and 4,837 clients and cost only $40,471. The cost per facility covered in 1998 declined from $258 to $209 in 2001 and per client from $22.30 to $8.37.[7]

Because indicators resulting from the M&E plan's quality surveys can be calculated quickly, results can be easily fed back to service delivery sites. For example, data collection for the Istanbul Quality Surveys required less than three weeks to complete, and preliminary results were available after an additional four weeks. Data were fed-back to provincial health directorates and service delivery sites, where improvements could be made immediately. The reduction in time requirements and shift toward greater MOH involvement are seen in Table 2.

[6] See *Quick Investigation of Quality (QIQ): A User's Guide for Monitoring Quality of Care in Family Planning*. MEASURE Evaluation Manual Series, No. 2. MEASURE Evaluation: Carolina Population Center, University of North Carolina at Chapel Hill, February 2001.

[7] These costs include those of preparation (training, communication, equipment, stationery supplies), fieldwork (data collection, local travel and lodging), reporting and feedback/dissemination, and MSH's staff travel costs. For the three-province effort between 1998 and 2001, the total cost was $178,672, with the proportionate breakdown across the foregoing categories 14, 34, 31 and 21 percent.

Figure 4. MOH and MSH/Turkey Level of Effort on Quality Surveys in Baseline and Final Rounds

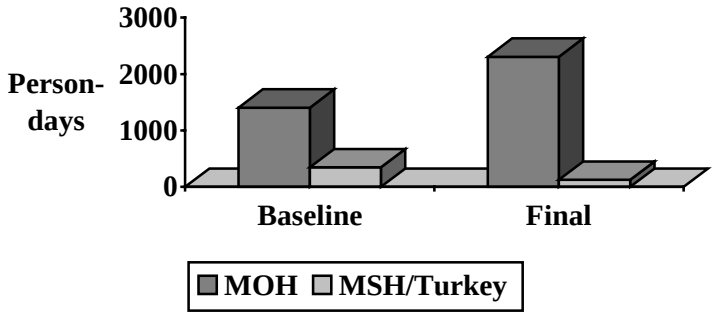


Table 2. Number of Person-Days Expended Toward Quality Surveys in Three Provinces, 1998-2001

Level of Effort/ Phases	Istanbul			Adana		Icel		
	1998	2000	2001	1999	2001	1999	2001	Total
Survey preparation	65	35	25	35	10	35	10	215
Fieldwork period	814	1426	1576	242	303	266	303	4930
Analysis & preliminary Results	55	35	30	25	15	25	15	200
Feedback & reporting	120	80	75	35	35	35	35	415
Total	1054	1576	1706	337	363	361	363	5760
MSH/Turkey	190	100	55	79	36	79	36	575
MOH	864	1476	1651	258	327	282	327	5185

The required time for survey preparation and analysis and preliminary results reporting declined in all three provinces. The time requirements for feedback and reporting at lower levels also declined in Istanbul and remained low in Adana and Icel. The fieldwork person-days increased because the observation period at each facility was raised from two to three days in rounds 2000 or later and in Istanbul the Health Directorate requested coverage of additional number of facilities in 2001.

Figure 4 shows the change in level of effort by Management Sciences for Health/Turkey, which provided external technical support on the Quality Surveys, and the MOH, which contributed the major share of person-days toward the full effort. The MOH provided 1,404 person-days during the baseline round, or 80% of the total days required, while for the follow-up round, it provided 2,305 person-days or 95% of the total effort. High involvement of local staff increases the likelihood that M&E operations will be sustained without external donor support.

Another innovative feature of the M&E plan was the use of palm top computers in data collection. In 2000, HP Jornada 820 handheld computers were used for data collection in field surveys to improve the timeliness and accuracy of the data collected. Excel databases were transferred to the computers and 10 computer literate interviewers were trained for a half-day on the use of handheld computers. Every two days these interviewers were visited on site, supplied with another handheld computer with a blank database and the computer with data was brought back to data entry site. This regular procedure helped to minimize the risk of losing data and facilitated the data entry as the data were downloaded directly into the database. It is estimated that handheld computers saved 1-1.5 days of data entry and 1,550 pages of forms during the 2000 Quality Survey in Istanbul.

Handheld computer used for field data collection

A client exit interview using the handheld PC

3) Use Data from Multiple Sources

The Turkey Program's M&E plan takes a comprehensive approach in utilizing information from multiple data sources. Data are collected through a variety of mechanisms, including DHS and quality surveys. Existing data from service statistics are also used to improve the efficiency of the M&E plan. By utilizing multiple data sources and existing data, the M&E plan is more comprehensive and efficient. The use of multiple data sources helps gauge progress at various levels of the program, from increases in contraceptive prevalence at the national level, to the improvement of infection prevention measures at local clinics.

Analyzing Quality Survey data

4) Employ a Participatory Approach

Numerous in-country partners have been involved in the development of the M&E plan and in the analysis of its indicators. USAID developed the plan by forming and facilitating the work of a Monitoring Task Force. Members of the Monitoring Task Force included representatives from the MOH, SSK, local NGOs, commercial sector organizations, such as the Eczacibasi Pharmaceutical Company, representatives from the Hacettepe University Institute for Population Studies, and USAID Cooperating Agency staff. Task force members participated in defining and measuring performance indicators and they report on indicator results for the USAID M&E plan.

In addition to involving local experts in the development of indicators, in-country staff also participated in the collection and analysis of data. Because Quality Surveys and other annual data could be collected and analyzed quickly and easily, the CA staff worked to train local MOH and other agency staff to conduct and assume responsibility for these tasks, gradually reducing the level of external assistance. For example, local physicians, nurses and midwives administered client interviews and facility surveys for the Istanbul Quality Survey. Similarly, the Hacettepe Institute of Population Studies has taken on the primary responsibility of data collection and analysis for the DHS, resulting in significant cost savings and improved utilization of data.

Because in-country staff collect much of the data for the M&E plan, they are motivated to analyze survey results more closely and make program adjustments based on those analyses. By

involving local staff in the collection and utilization of data, a greater sense of ownership is achieved. Such ownership is essential for indicator results to be utilized to the maximum extent and for future M&E exercises to be conducted without external donor support.

Participants from the major M&E meetings were pleased with the participatory nature of the M&E planning process. One participant remarked, "Excellent participation of MOH, public and private sectors; they were all involved in the process of setting [indicator performance] targets. It was very useful to see the overall program and to share and discuss the issues on the indicators with all the sectors in the field." Other participants commented on the usefulness of a participatory approach to M&E and the strengths of program strategies, which are clearly dependent on measurable objectives.[8]

5) Draw on the Best Combination of International and Local Expertise

Access to appropriate technical expertise is essential in order to ensure the validity and longevity of an M&E plan. Monitoring and evaluation structures, including indicator definitions and survey techniques, must be carefully chosen and agreed upon in order to avoid making changes from year to year.

While some of the indicators in Turkey's M&E plan have been used extensively worldwide, the more innovative indicators required additional attention in their construction and testing. To ensure the utility and validity of indicators such as those drawn from the quality surveys, indicators were adopted after careful review of state-of-the-art M&E practices and according to technical guidance from the following USAID CAs:

JHPIEGO (Johns Hopkins Program for International Training in Reproductive Health)
EngenderHealth (formerly AVSC International)
MSH (Management Sciences for Health)
The Futures Group International
MEASURE Evaluation Project

[8] "Report from the Performance Benchmarking Workshop," December 10-11, 1998, Kizilcahamam.

Drawing on international and local expertise

Turkey's M&E plan was developed while the MEASURE Evaluation Project was launching a global project under the MAQ (Maximizing Access and Quality) Initiative to develop a standard set of indicators for the measurement of family planning service quality. Turkey became one of five test countries where model quality indicators were developed. By seeking opportunities for international collaboration on M&E matters, the Turkey Program has ensured the development of indicators that track program progress in a valid and reliable manner and that can be adapted for use in various countries.

6) Disseminate the Results to a Broad Audience

An extensive dissemination plan was built into the M&E system. Dissemination of information at different levels and through different means takes place throughout the year. When the preliminary results of the quality surveys became available, they were first shared with the M&E Task Force. The input and feedback obtained from the Task Force were then incorporated into a preliminary report, which was used for rapid regional dissemination. At this stage, the results were shared and discussed in greater detail with a larger group of managers and service providers at the provincial levels for their input. A final report of quality survey results was then disseminated to a broad group of stakeholders on a national and international basis.

The indicator values gathered from all sources were shared and discussed with the Task Force at the end of every fiscal year. In this meeting, the performance targets were also determined. An annual program report incorporating the performance of the program was prepared and disseminated to all stakeholders at the end of each calendar year. Broad dissemination and discussion of results at all levels enabled an exchange of information, creative thinking, and innovative solutions to issues.

7) Facilitate the Use of Data for Program Improvement

The M&E plan is also exceptional in that it yields "living data," by setting up structures to facilitate the use of data for rapid program improvement. Because the data are simple to collect and easy to interpret, local teams have formed under their own initiative to improve program areas with inadequate quality.

In planning how to present and use the M&E results at all levels, several audiences were identified: USAID, the CAs, the central Ministry of Health, the Provincial Health Directorates, facility managers, hospital directors, and family planning clinic staff. Different dissemination approaches were used. A set of feedback reports (see Table 3) were designed for local-level managers that would enable them to

- Identify and understand results for their individual clinic
- Understand the standards set for particular indicators
- Understand how the indicator was measured
- Compare their facility with other facilities of the same type
- Compare their facility with the average scores of different facility types

- Compare their facility with the average scores for the province.

A series of meetings held to share the results also allowed participants to identify problems and propose solutions. Several working groups addressing infrastructure, quality and post-partum/post-abortion services were formed and met voluntarily to suggest improvements and expand options for the decision-making process. The CA community was also a major user of the M&E results, setting annual targets and preparing workplans accordingly.

Table 3. Sample Feedback Report for Facilities in the Quality Surveys

VISIBILITY
Permanent signs indicating the availability of FP services should be posted in each of the following three places:

1. Outside the building
2. Inside the building
3. On the door of the FP clinic

	PERMANENT SIGN		
State Hospitals	Outside the building	Inside the building	On the door of the FP clinic
Hospital A	-	-	-
Hospital B	-	+	-
Hospital C	+	+	+
…			
…			
Average for State Hospitals (%)			
Average for Province (%)			
Percent of the facilities that have all three signs was: 17.2%			

Rapid data feedback for program management

After the baseline quality survey data was conducted in Istanbul, the Provincial Health Directorate for Istanbul established "quality clusters" to analyze and use survey results. These quality clusters are teams comprised of local-level MOH staff who review survey results, facility by facility, to determine specific areas of shortcoming in programs and services.

One quality cluster team identified the lack of clinic signs as a significant problem that could be easily addressed by local staff. Most survey clinics in Istanbul did not have any signs available to direct clients to the location of services. The quality cluster decided what type of signs were needed to direct clients to services and requested assistance from the MSH project in developing and testing the signs. Quality cluster members are now implementing the use of the signs in all Istanbul health facilities. Quality cluster teams can address other service delivery issues quickly and easily by reviewing quality survey results.

8) Promote Sustainability

Because local in-country staff designed and implemented the USAID M&E plan with limited external technical assistance, the plan can be replicated in additional provinces by local partners. Also, after the phase-out of USAID assistance, M&E activities can be conducted by local partners with little external donor assistance. While USAID currently coordinates the M&E plan, responsibilities for selected M&E activities are being transferred over to the MOH, so that M&E exercises can be continued after USAID phase-out.

MSH also organized two workshops for MOH's provincial managers and SSK's headquarter and clinic managers on designing, conducting and analyzing Quality Surveys. The managers were trained in monitoring and evaluating the family planning services provided and in the development of indicators and standards, as well as survey design and implementation. These efforts help institutionalize evaluation expertise among local partners in Turkey.

VII. Challenges

- *Need for local talent.* The implementation of an M&E plan requires high-caliber local expertise that is not always available in countries. This is especially true for local data collection and analysis, such as that required for a Quality Survey. If local staff with a basic understanding of M&E techniques are not available, a country program will have to rely on more international assistance, thus compromising local ownership, participation, data utilization, and sustainability. Because such expertise was available in Turkey, a locally driven M&E plan could be built in a relatively short period of time with limited outside assistance. Countries without access to high caliber local experts must spend more time and effort in training local staff in survey design and analysis.

- *Decentralized structures*. One of the features that facilitated the efficiency of the Turkey M&E plan was the decentralized structure and operations of the health care organizations. Although the systems of MOH and SSK were designed for heavy involvement by central authorities, in time, these systems have delegated considerable authority and autonomy to the provincial levels. The implementation of the M&E plan required active involvement of the field level managers and service providers. Hence, it could be more difficult to implement a similar plan with heavily centralized organizations than was the case in Turkey. Centralized decision-making requirements would slow down the implementation of the plan. In addition, it might also diminish the ownership and utilization of data by the field staff.

- *Extensive start-up time required for developing the M&E plan*. While the M&E plan is quite easy to implement and maintain once in place, preliminary development of such a plan is a time-consuming process. Development of the Turkey M&E plan, including the indicators and benchmarks required approximately a year's worth of work and involved over 40 individuals representing various organizations. Such extensive time was necessary because all elements of the plan must undergo regular modification and testing before they are finalized. Many revisions were made in indicator definitions, in the wording of survey questions, and in the scoring of indicators before the M&E plan was ready for implementation.

- *Aspects of sustainability.* The most important challenges for an M&E plan developed with external assistance are ensuring long-term sustainability and institutionalization. The Turkey M&E plan has been receiving financial and technical support from USAID. Over the years, the amount of assistance has decreased as financial and technical responsibilities gradually shifted from USAID to the local partner organizations. In particular, technical assistance needs decreased substantially as the local staff gained more experience over the years. A system that is technically and financially sustainable requires continued implementation of the plan without any external support. Although it is difficult to assess the likelihood of sustaining the plan once the donor agency withdraws, there are certain positive indications. First, there is a well-trained cadre of local staff technically capable of maintaining the plan. Secondly, the financial resources required to sustain the system are modest, which increases the potential for long-term sustainability. A third factor, the likelihood of continuation of senior-level support, is more difficult to assess and constitutes a major question for donor-assisted programs.

VIII. Conclusions

Significant improvements in family planning programs and services have been identified by the M&E plan. In terms of progress towards planned results, trends in illustrative indicators (shown in Appendix 1) evidence the targeted changes in FP/RH service quality and program sustainability.[9] To complement these results, an impact analysis also was carried out using Quality Survey data. Data from the1998-2001 period were used to examine the relationship between service improvements in the panel of 157 facilities and outcomes, such as family planning client volume and measures of client knowledge and satisfaction. With eight key standards of service improvement targeted by the program and a maximum value of 8 points, the average quality score for facilities in the three provinces increased from 3.34 to 6.18 over the period. The estimated impact of improving the quality score by 2.84 points on average was to

- Increase the daily number of family planning clients by nearly 124,000, and new clients by nearly 62,400, across the sampled facilities in the three provinces
- Increase the proportion of clients knowledgeable about their contraceptive method, currently 17%, by 5 percentage points
- Increase the proportion of clients satisfied with the quality of family planning counseling or method received, currently 76%, by 4 percentage points
- Increase the proportion of clients receiving IEC materials during their visit, currently 31%, by 11 percentage points.

Thus, in addition to substantial increases in client volume and satisfaction with counseling quality, the service improvements identified by the M&E Task Force can be credited for much of the gain in client knowledge and the full extent of IEC material distribution to clients. In addition as USAID phased out its funding for contraceptives, from $1.8 million in 1995 to $0.4 million in 1998 and nil in 1999, MOH financing has increased from $1.6 million in 1998 to $3 million in 2001. The financing plan jointly developed by USAID and the Government of Turkey has allowed a gradual shift in responsibility to the latter.

In sum, the conclusions that emerge from the recent experience are

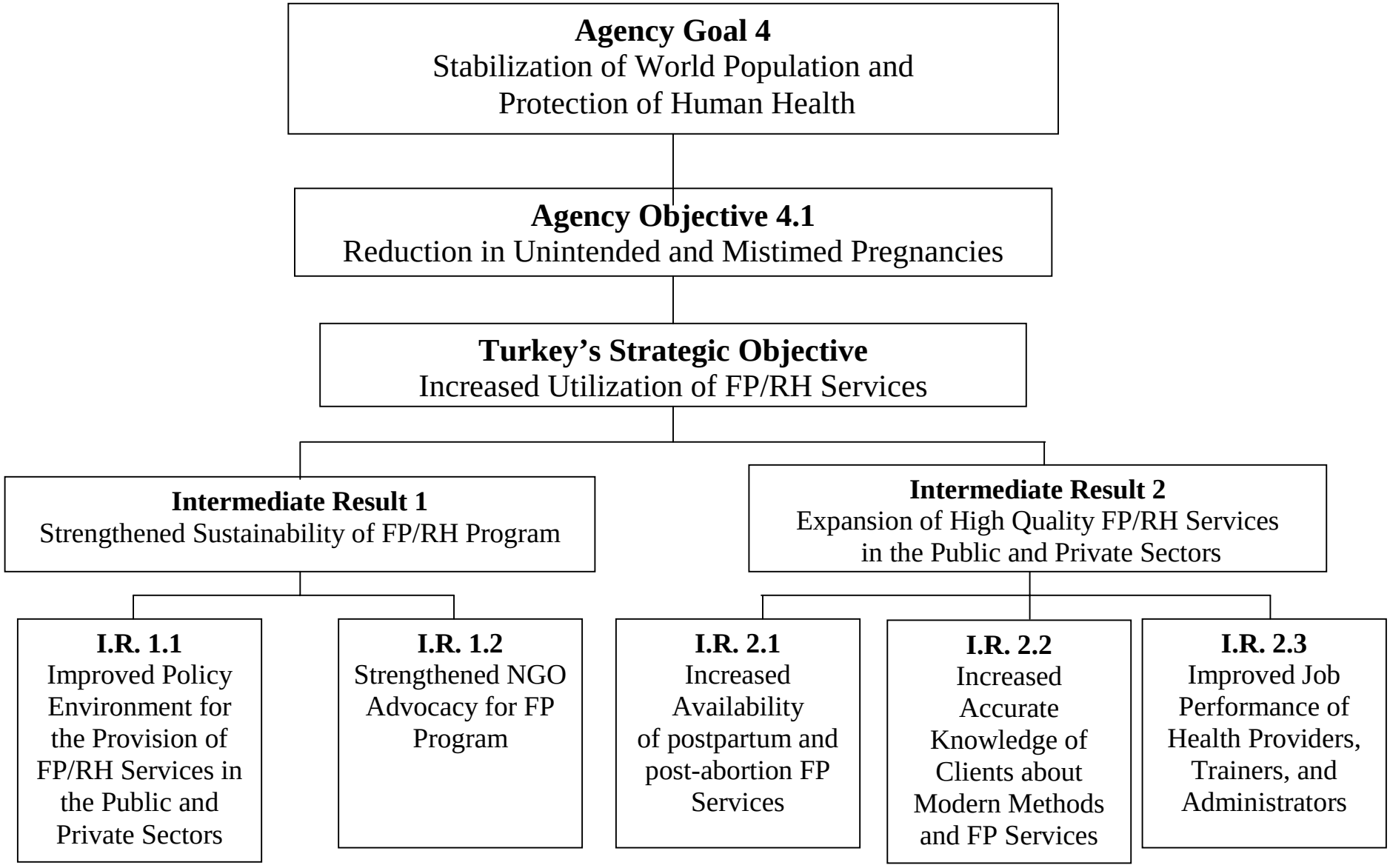
- *M&E is a program asset, not a burden*. A comprehensive and well-designed M&E plan is a key asset of any program. For some managers and staff, the extensive start-up efforts needed for the plan's development may be regarded as a burden. Additionally, a plan, even one that is well designed, can be a waste of time and resources if it is not utilized for program improvement. However, when a plan is used to improve a program at all levels, it is a key investment for the success of programs.

- *Local ownership is fundamental to increased utilization and sustainability.* Embracement and ownership of the plan by the managers and staff who will be using it are essential for maximum productivity. The best way to ensure the ownership of the system by local organizations is their active involvement at all stages—design, data collection, and analysis. Ownership is important for the results to be utilized to the maximum extent and for future M&E exercises to be conducted without external support.

[9] See also "USAID's Family Planning and Reproductive Health Assistance: Turkey, Annual Report 2000" for further detail.

- *Leadership continuation and commitment is requisite.* Designing and developing a thorough M&E plan requires a lengthy development and implementation process, which pays off in the long term. The impact of a sound M&E plan on continuous performance improvement is better understood when the plan is implemented over a number of years. In Turkey, continued support of the plan by the leadership at both USAID and Turkish organizations has helped sustain and institutionalize the efforts.

APPENDIX 1
Results Framework for USAID Population Assistance Program in Turkey



APPENDIX 2
USAID Turkey Program Indicators

		1998 Actual	1999 Target	1999 Actual	2000 Target	2000 Actual	2001 Target	2001 Actual
1 MODERN CONTRACEPTIVE PREVALENCE RATE (CPR)		37.7					**2003 Target**	
The proportion of currently married women of reproductive age who are using a modern contraceptive method at a particular point in time.CPR = U / P X 100 U = the number of married women using a contraceptive method at a given point in time P = the number of married women of reproductive age							41.0	
2 ALL-MODERN METHOD DISCONTINUATION RATE (DCR)		25.9					**2003 Target**	
The percentage of adopters in a given time period who discontinue use of modern methods of contraception within 12 months. Calculated using life table methods.							22.9	
3 COUPLE-YEARS OF PROTECTION (CYP)								
The estimated protection provided by family planning services during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period.	**Public Sector Total**	**1,729,539**	**1,780,000**	**1,700,000**	**1,700,000**			
	Pill	111,808						
	Injectable	N/A						
	Condom	188,653						
	IUD	1,373,040						
	ML	47,663						
	NSV	8,375						
	Private Sector Total	**1,096,479**	**1,097,000**	**1,300,000**	**1,207,000**			
	Pill	260,732						
	Injectable	6,189						
	Condom	543,508						
	IUD	280,000						
	ML	6,050						
	NSV	0						
	Grand Total	**2,826,018**	**2,877,000**	**3,000,000**	**2,907,000**			

		1998 Actual	1999 Target	1999 Actual	2000 Target	2000 Actual	2001 Target	2001 Actual
4 JOINT INDICATOR FOR CONTRACEPTIVE SELF-RELIANCE								
A. Forecasting, budgeting, procurement								
A score was given to each of the three aspects: forecasting, budgeting, and procurement at the central level. The scores for each aspect may range from 0 (low) to 16 (high). The sum of the scores across the three categories may range from 0 to 48. The percentage score reflects the total score divided by the total possible maximum score and then multiplied by 100.	MOH	60,4 (29)	70,8 (34)	83,3 (40)	81,3 (39)	92,0 (44)	96,0 (46)	
	SSK	37,5 (18)	45,8 (22)	50,0 (24)	60,4 (29)	73,0 (35)	75,0 (36)	
B. Storage (for MOH & SSK) Only for Istanbul								
Percentage of SDPs that meet acceptable standards. Acceptable standards are defined as meeting all of the following 8 criteria: a. Contraceptives are accessible. b. Room/store is clean. c. Contraceptives are stored to prevent water damage. d. Room/store is adequately ventilated. e. Room/store is properly illuminated. f. Contraceptives are stored away from direct sunlight. g. Room/store is cool enough. h. Contraceptives are stored without direct contact with walls/floor.	MOH Hospitals (n=12)	91.7			85.7	83.3	85.7	
	MCH/FP Centers (n=32)	81.3			85.7	87.5	85.7	
	Health Centers (n=49)	83.7			85.7	87.8	85.7	
	SSK Hospitals (n=7)	71.4			85.7	85.7	85.7	
	Average (n=100)	**83.0**			**85.7**	**87.0**	**85.7**	
C. IUD Distribution (for MOH and SSK) Only for Istanbul (no stockouts)								
Percentage of SDPs that have experienced no stock-outs of IUDs during the last 6 months.	MOH Hospitals (n=10)	70.0			85.7	70.0	89.0	
	MCH/FP Centers (n=29)	96.6			96.6	89.7	89.0	
	Health Centers (n=18)	83.3			90.0	72.2	89.0	
	SSK Hospitals (n=7)	28.6			57.1	14.3	89.0	
	Average (n=64)	**81.2**				**73.4**	**89.0**	

		1998 Actual	1999 Target	1999 Actual	2000 Target	2000 Actual	2001 Target	2001 Actual
5 RELATIVE CHANGE IN MOH'S DISTRIBUTION OF CONTRACEPTIVE COMMODITIES ACCORDING TO ADOPTED TARGETING STRATEGY								
Percentage of contraceptive commodities distributed to targeted populations in a given year relative to baseline year by method. Figures are not available because targeting strategy is not yet final.								
6 PERCENTAGE OF SELECTED WH/FP STRATEGIC PLAN ACTIVITIES COMPLETED		17.9	46.4	50.0	64.3	67.1	82.1	
Percent of selected national WH/FP strategies that are completed. (Only the strategies and activities that are integral to USAID's program will be tracked.) Out of 106 activities listed in 49 national strategies, 28 of them were identified.								
7 AVERAGE SCORES FOR KIDOG RELATED RESULTS		2.9	3.2	3.7	3.6	3.1	4.0	
Averages across NGO assessments of annual efforts on results related to KIDOG advocacy for women network. Scores were assigned from 0 (low) to 5 (high).								
8 QUALITY INDEX								
Six indicators have been defined as determinants of quality outcomes. The total score for each category of facilities represents the sum of the scores for each of the six quality indicators. Separate scores for each category of facilities are listed for each of the indicators.	**Average**	**2.93**			**4.48**	**3.84**	**4.2**	
	MOH Hospitals	2.70			4.45	3.68		
	MCH/FP Centers	3.80			5.00	4.98		
	Health Centers	1.74			3.30	3.40		
	SSK Hospitals	3.45			4.87	4.32		
	Private Hospitals	2.98			4.80	2.83		
	Method Availability							
Facilities distribute or prescribe 3 or more modern FP methods.	MOH Hospitals (n=14)	78.6			85.0	85.7		
	MCH/FP Centers (n=32)	93.8			100.0	100.0		
	Health Centers (n=49)	38.8			45.0	77.6		
	SSK Hospitals (n=7)	85.7			100.0	100.0		
	Private Hospitals (n=20)	100.0			100.0	100.0		
	Average (n=122)	**70.5**				**89.3**	**90.2**	

		1998 Actual	1999 Target	1999 Actual	2000 Target	2000 Actual	2001 Target	2001 Actual
	Availability of Trained Staff							
Facilities have at least 2 staff assigned and 1 present at the time of the visit.	MOH Hospitals (n=12)	75.0			85.0	100.0		
	MCH/FP Centers (n=32)	93.8			95.0	100.0		
	Health Centers (n=48)	43.8			45.0	50.0		
	SSK Hospitals (n=7)	85.7			86.0	100.0		
	Private Hospitals (n=20)	90.0			95.0	75.0		
	Average (n=119)	**70.6**				**75.6**	**79.8**	
	Perceived Quality of FP Counseling							
Proportion of clients who report that they	MOH Hospitals	69.1			70.0	77.4		
1. were seated	MCH/FP Centers	71.0			75.0	78.7		
2. had sufficient time with the provider	Health Centers	66.9			70.0	66.0		
3. clearly understood the information that was provided	SSK Hospitals	73.3			75.0	74.8		
	Private Hospitals	78.4			85.0	37.5		
	Average	**70.7**				**74.7**	**78.0**	
	Adequate Infection Prevention Measures							
Facilities providing IUDs must meet all of the following 4 standards. All other facilities must meet standards 1 – 3.	MOH Hospitals (n=12)	33.3			40.0	33.3		
	MCH/FP Centers (n=32)	40.6			60.0	68.8		
	Health Centers (n=27)	18.5			30.0	48.1		
1. Plastic bucket must be available for chlorine solution.	SSK Hospitals (n=7)	14.3			56.0	85.7		
	Private Hospitals (n=20)	5.0			30.0	45.0		
2. Unused IUD kits should be kept sterile.	**Average (n=98)**	**24.5**				**55.1**	**65.3**	
3. Medical waste must be kept in leak-proof containers with lid.								
4. Appropriate containers must be available for sharp objects.								
	Availability of IEC Materials							
Extent to which facilities have appropriate IEC materials available during the day of the survey.	MOH Hospitals (n=14)	14.3			75.0	28.6		
	MCH/FP Centers (n=32)	37.5			80.0	87.5		
1. National FP guidelines (at least 1 full set including two volumes)	Health Centers (n=49)	4.1			50.0	59.2		
2. FP flip-book (at least 1copy)	SSK Hospitals (n=7)	42.9			80.0	14.3		
3. All Methods brochure or Method-specific brochures (at least two copies)	Private Hospitals (n=20)	5.0			80.0	25.0		
	Average (n=122)	**16.4**				**54.9**	**84.4**	

	1998 Actual	1999 Target	1999 Actual	2000 Target	2000 Actual	2001 Target	2001 Actual
Visibility of FP Services							
MOH Hospitals (n=14)	0.0			90.0	42.9		
MCH/FP Centers (n=32)	43.8			90.0	62.5		
Health Centers (n=49)	2.0			90.0	38.8		
SSK Hospitals (n=7)	42.9			90.0	57.1		
Private Hospitals (n=20)	20.0			90.0	0.0		
Average (n=122)	**18.0**				**40.2**	**53.3**	
9 NUMBER OF FACILITIES THAT PROVIDE FP SERVICES							
The number of facilities of each type that provide FP services. **Total**	**241**	**250**	**270**	**257**	**274**	**274**	
MOH Hospitals	14	14	14	14	14	14	
MCH/FP Centers	32	34	35	34	35	35	
Health Centers	165	165	191	165	194	194	
SSK Hospitals	7	7	7	7	8	8	
Private Hospitals	23	30	23	37	23	23	
10 POST-ABORTION FAMILY PLANNING SERVICES INDEX							
Total Score	**56.5**			**62.7**	**51.0**	**63.3**	
A. Percentage of abortion clients in selected hospitals who received pre-abortion FP counseling	73.1			80.0	56.6	70.0	
B. Percentage of abortion clients who want no more children who were informed about the availability of sterilization services.	27.8			35.0	37.5	50.0	
C. Percentage of abortion clients in selected hospitals who leave the facility with a modern method of contraception.	68.7			73.0	59.0	70.0	
11 POSTPARTUM FAMILY PLANNING SERVICES INDEX							
Total Score	**15.2**			**24.2**	**25.6**	**33.3**	
MOH Hospitals	14.4			23.3	17.8		
SSK Hospitals	17.0			32.7	35.1		
Private Hospitals	40.7			16.7	12.5		
A. Percentage of postpartum clients in selected hospitals who received FP counseling after delivery and prior to discharge	**20.7**			**29.3**	**49.3**	**60.0**	
MOH Hospitals	28.7			35.0	40.5		
SSK Hospitals	14.0			33.0	65.1		
Private Hospitals	18.1			20.0	15.0		

		1998 Actual	1999 Target	1999 Actual	2000 Target	2000 Actual	2001 Target	2001 Actual
B. Percentage of postpartum clients who want no more children who were informed about the availability of sterilization services.		**16.3**			**23.3**	**20.0**	**25.0**	
	MOH Hospitals	10.3			20.0	9.2		
	SSK Hospitals	26.5			35.0	32.9		
	Private Hospitals	8.8			15.0	7.4		
C. Percentage of postpartum clients in selected hospitals who left the facility with a modern method of contraception.		**8.7**			**20.0**	**7.4**	**15.0**	
	MOH Hospitals	4.2			15.0	3.8		
	SSK Hospitals	10.6			30.0	7.2		
	Private Hospitals	13.8			15.0	15.0		
12 PERCENTAGE OF METHOD-SPECIFIC QUESTIONS ANSWERED CORRECTLY								
Extent to which FP users understand their chosen method. For each method the accuracy of clients' knowledge is measured according to established standards.	Pill	52.5				57.8	63.0	
	Condom	56.7				67.3	73.0	
	IUD	62.8				67.0	72.0	
	Injectables	49.5				57.3	62.0	
13 PERCENTAGE OF SERVICE PROVIDERS OR TRAINERS WHO APPLY THEIR TRAINING TO THEIR SUBSEQUENT WORK								
A. Annual number of providers/trainers trained in IUD insertion/ML/NSV								
	Total	**160**	**187**	**317**	**214**	**390**	**242**	
	ML	16	26	14	36	42	42	
	NSV	5	16	6	18	50	25	
	IUD	139	145	297	160	298	175	
B. Percentage of providers/trainers trained in IUD insertion/ML/NSV who are performing IUD insertion/ML/NSV or training others								
	IUD Trainers	69.2	71.0	100.0	74.0	100.0	90.0	
	IUD inserting SPs	32.5	37.0	44.4	40.0	64.5	90.0	
	Minlap Trainees	42.9	80.0	62.5	80.0	100.0	90.0	
	NSV Trainees	57.1	65.0	83.3	75.0	100.0	90.0	
14 PERCENTAGE OF SDP'S THAT HAVE ACCESS TO UP-TO-DATE DATA								
A. Percent of SDPs visited by a supervisor in the last 6 months								
	MOH Hospitals (n=14)	21.4			71.4	35.7		
	MCH/FP Centers (n=32)	87.5			90.6	93.8		
	Health Centers (n=49)	28.6			34.7	85.7		
	SSK Hospitals (n=7)	57.1			71.4	100.0		
	Average (n=102)	**48.0**			**59.8**	**82.4**	**82.4**	

	1998 Actual	1999 Target	1999 Actual	2000 Target	2000 Actual	2001 Target	2001 Actual
B. Percentage of SDPs that have an updated FP wall-chart during the day of the visit							
MOH Hospitals (n=14)	N/A			50.0	42.9		
MCH/FP Centers (n=32)	N/A			50.0	96.9		
Health Centers (n=49)	N/A			46.9	53.1		
SSK Hospitals (n=7)	N/A			42.9	14.3		
Average (n=102)	**N/A**			**48.0**	**62.7**	**75.0**	

APPENDIX 3

List of Organization Represented on the Monitoring and Evaluation Task Force, Turkey USAID Program

Turkish Ministry of Health (MOH)
- General Directorate of maternal and Child health and Family Planning
- General Directorate of Health Training
- Department of Information Management

Turkish Social Security Organization (SSK)

NGO Advocacy Network for Women's Issues (KIDOG)

Private Physicians Network for Reproductive Health (KAPS)

Turkish Family Health and Planning Foundation (TAP)

Hacettepe University
- Department of Public Health
- Institute of Population Studies

Schering Inc.

US Agency for International Development (USAID)

EngenderHealth International (Formerly AVSC International)

Johns Hopkins University JHPIEGO (JHU/JHPIEGO)

The Futures Group International POLICY Project (POLICY Project/TFGI)

The Futures Group International Social Marketing Project (SOMARC Project/TFGI)

Johns Hopkins University Population Communication Services Project (JHU/PCS)

Management Sciences for Health (MSH)

APPENDIX 4
List of the Monitoring and Evaluation Task Force Participants, Turkey USAID Program

Ministry of Health

Rifat Kose
Ugur Aytac
Mehmet Ali Biliker
Adviye Temiz Tugay
Goksin Pekyalcin
Berna Eren
Canan Ozkan
Refika Bilgin
Dilek Ozdemir
Tevfik Cakmakli
Ibrahim Acikalin
Arzu Koseli
Suat Duranay
Zubeyde Ozanozu
Nalan Yetkin
Alev Surmen
Sukran Sarilar
Mutlucan Karaman
Buket Ozcaltepe
Oya Ogenler
Hulya Tekin

Social Security Organization

Yasar Caliskan
Dilek Sert
Gokhan Yildirimkaya
Fusun Ozdemir

KIDOG Network

Murat Firat
Nurcan Muftuoglu
Oguz Polat

Pharmaceutical Companies

Seyda Ertugrul
Bulent Azeri
Ilknur Karabeyoglu

Private Physicians

Selale Ozmen
Ercan Kose

Hacettepe University

Munevver Bertan
Aykut Toros
Nalan Sahin
Sunday Uner

USAID
Pinar Senlet
Mona Byrkit
Jill Mathis
Monica Kerrigan

MSH
Ersin Topcuoglu
Hulki Uz
Alison Ellis

EngenderHealth

John M. Pile
Cigdem Bumin
Levent Cagatay

JHU/JHPIEGO

Behire Oncuer
Tunga Tuzer
Teresa Dean

JHU/PCS

Figen Tunckanat
Rebecca Holmes
Jim Williams

TFGI/POLICY Project

Zerrin Baser
Sema Ozdilekcan
Fahrettin Tatar
Maureen Clyde

TFGI/SOMARC

Gunes Tomruk