KalaCORE M&E GUIDE

Version last updated 2nd June 2015

Acronyms

BCC   Behaviour Change Communication

DfID   Department for International Development (United Kingdom)

EQA   External Quality Assurance

HF   Health facility

IRS   Indoor Residual Spraying

M&E   Monitoring & Evaluation

MoH   Ministry of Health

RDT   Rapid Diagnostic Test

SOP   Standard Operating Procedures

VfM   Value for Money

VL   Visceral Leishmaniasis

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1. Background

KalaCORE, the Consortium for Control and Elimination of Visceral Leishmaniasis (VL), is supporting national elimination efforts and coordinating with control programmes in India, Bangladesh, Nepal, Ethiopia, Sudan and South Sudan. The Consortium operates through a number of implementation and operational research projects including health worker training on appropriate diagnosis and treatment of VL, upgrading health facilities, strengthening surveillance, behaviour change communication (BCC) activities to encourage early treatment seeking and uptake of indoor residual spraying (IRS), and effective measures of vector control.

Although the number of projects and implementing partners within KalaCORE are large and diverse, we each aim to demonstrate that our activities are working the best they can towards achieving our common goal of reducing the economic and health impact of VL in South Asia and East Africa.

Robust and appropriate monitoring and evaluation (M&E) will together increase the potential for projects to contribute to achieving and demonstrating the goal of the programme. M&E provides the information needed to make evidence-based decisions for program management and improvement, policy formulation, and advocacy. It also generates good-quality data to satisfy accountability requirements and will eventually save resources that may otherwise be spent in inefficient programmes.

Robust monitoring and evaluation of individual projects within the KalaCORE Consortium has two main benefits:

1. To enable evidence-based project management and implementation that will achieve the best possible outcomes for VL endemic communities;

2. To contribute towards the monitoring and evaluation of the programme as a whole, required for accountability to our donor (DfID).

This guide is intended to support a standard approach to monitoring and evaluation across the KalaCORE projects, including the use of a minimum set of standard core indicators. A brief overview is presented of some of the key principles and definitions involved in M&E, followed by a step-by-step guide on developing an M&E Plan for your individual project within KalaCORE.

2. Monitoring and evaluation: some definitions

Monitoring and evaluation are often grouped together as 'M&E'. However, although they are related and share the common goal of ensuring a programme achieves its full potential for success, monitoring and evaluation have some important differences; for example in their purpose, the frequency of data collection and sources of information (Table 1). Essentially:

- ***Monitoring*** is the routine tracking of a programme or project's performance.

- ***Evaluation*** is the periodic assessment of the change in targeted results that can be attributed to the programme or project intervention.

Dimension	Monitoring	Evaluation
Frequency	Periodic, occurs regularly	Episodic
Function	Tracking/oversight	Assessment
Purpose	Improve efficiency, provide information for reprogramming to improve outcomes	Improve effectiveness, impact, value for money, future programming, strategy and policymaking
Focus	Inputs, outputs, processes, work plans (operational implementation)	Effectiveness, relevance, impact, cost-effectiveness (population effects)
Methods	Routine review of reports, registers, admin databases, field observations	Scientific, rigorous research design, complex and intensive
Information source	Routine surveillance systems, field observation reports, progress reports, rapid assessment, program review meetings	Same sources used for monitoring, plus population-based surveys, vital registration, special studies
Cost	Consistent, recurrent costs spread across implementation period	Episodic, often focused at the midpoint and end of the implementation period

(Adapted from the Global Fund M&E Toolkit: http://www.theglobalfund.org/en/me/)

To measure progress towards the project's aim and objectives, indicators and targets are used:

- *Indicators* provide a definition of the variable to be measured.

- *Targets* provide specific values for the variable to be measured i.e. the amount of change that is desired or expected.

- An indicator with a target will tell you by how much, where, when and with who the change is expected

Indicators can be categorised according to the level at which they are measuring achievements: moving from *input* and *process* indicators that measure the resources and activities going in to the project, through *output* indicators which measure knowledge gained or services provided, to *outcome* and *impact* indicators which measure changes in desired practice and ultimately health impact.

Input, process and output indicators tend to be measured as part of the routine monitoring of a project, providing timely evidence for decision making around implementation. Measuring outcome and impact indicators requires extra data collection above and beyond what is routinely collected; this will be periodic and measure progress towards achieving the higher level project (and programme) objectives and therefore is classified as evaluation (rather than monitoring).

Note: measuring impact indicators goes beyond the requirements of individual project M&E strategies. This will be the responsibility of the KalaCORE M&E Task Team as they evaluate the impact of the programme as a whole.

An approach called *"theory of change"* is being used to inform the overall monitoring and evaluation strategy of KalaCORE (see Annexes 1 & 2 for KalaCORE theory of change diagrams) and this is also the method being advised for developing individual project M&E Plans. A theory of change is a map of a causal

pathway, illustrating how an intervention is intended to achieve its outputs, outcomes and impact within the constraints of the setting in which it is implemented.

Using the example of a project that will train health workers on appropriate diagnosis and treatment of VL: with sufficient resources (inputs), training sessions will be conducted for health workers responsible for VL case management (process/ activities), resulting in improved knowledge amongst health workers (output), this knowledge is then translated into improved diagnosis and treatment of VL patients (outcome) resulting in lower case fatality rates (impact). See Figure 1 for an overview of this theory of change with example indicators that will need to be measured to assess whether it holds true.

A)

B)

C)

3. Developing your project M&E Plan: a step-by-step guide
Step 1: Define the "theory of change" for your intervention

Using the example in Figure 1 as a guide, create a visual map of the theory of change for your intervention: what are the processes that need to happen for your project to achieve its stated objectives? In what sequence do they need to occur?

It is important to note that the example in Figure 1 has been simplified. As well as understanding the intervention itself, it is important to consider the wider setting in which it is being implemented – how could factors that might be outside your control affect your intervention's success? What assumptions do you need to make about these external factors for your intervention to be successful?

Once you have a flow diagram of your intervention's theory of change, the next step is to transfer this to a table. Use a new row for each process/stage in the theory of change and describe the assumptions that you need to make for that stage to be successful. See Table 2 for an illustration of how this would look for the intervention introduced in Figure 1.

All of this may take some time to think through and it could be useful to work with others in your team to try to capture all the processes and assumptions involved in your project.

TABLE 2: A SIMPLE THEORY OF CHANGE FOR A HEALTH WORKER TRAINING INTERVENTION

	Process	Assumptions
1	Training materials produced	- input from national programme & other stakeholders provided in timely manner
2	Training sessions conducted	- suitable trainers available - eligible health workers offered and accept training
3	Participants' knowledge of appropriate diagnosis and treatment increased in the training	- required knowledge included in the training - training conducted effectively
4	The increase in knowledge results in appropriate diagnosis	- by those that participated in the training - stock & resources available

		- patients accept diagnostic method
		- staff retained in facilities
5	The increase in knowledge results in appropriate treatment	- by those that participated in the training
		- stock & resources available
		- patients accept treatment prescribed
		- staff retained in facilities
6	The increase in appropriate diagnosis & treatment reduces the case fatality rate	- patients seek care early
		- patients adhere to the treatment regimen
		- No outbreak of other fatal disease or emergency in the area

Step 2: Identify the indicators you will need to measure

By breaking down your intervention in to the processes that need to happen and the assumptions that need to hold for it to succeed (your theory of change), it is possible to see what needs to be measured as part of your monitoring and evaluation plan. For project M&E, you should be thinking about indicators for all levels up to but not including impact. This means input, process, output, and outcome indicators. Since input indicators relate to resources (financial and human), these will tend to already be measured and reported as part of financial accounting. Therefore, the focus here is on helping you to identify the relevant process, output, and outcome indicators.

To help with comparison between the projects within KalaCORE, interventions have been categorised and a list of standard indicators is being developed for each of these categories:

- Clinical health worker training to improve diagnosis & treatment

- Laboratory training to improve diagnosis

- Supply of drugs & diagnostics

- Upgrading health facilities

- Strengthening surveillance

- Behaviour change communication

- Vector control

The list of standard indicators by intervention category should provide a starting point for your own M&E Plan (Table 3).

Please note, not all of the standard indicators will be appropriate for your project, depending on the detailed design of the intervention as summarised in your theory of change. Likewise, this list is not exhaustive and there are likely to be other indicators that are relevant for your project which are not included in Table 3 but can be collected in addition.

TABLE 3: MATRIX OF STANDARD INDICATORS FOR DIFFERENT TYPES OF KALACORE INTERVENTION PROJECT (NOTE: THE FOCUS HERE IS ON PROCESS, OUTPUT AND OUTCOME LEVEL INDICATORS; MEASURES OF FINANCIAL INPUT WILL BE AVAILABLE FROM PROJECT ACCOUNTS; MEASURING IMPACT INDICATORS IS BEYOND THE SCOPE OF PROJECT-LEVEL M&E)

Intervention	Process Indicators	Output Indicators	Outcome Ind
Clinical health worker training to improve diagnosis & treatment	Standard operating practices and training materials produced	Overall VL knowledge of participants increased	Proportion of given approp
	Pre-/post-test produced	Diagnosis and treatment knowledge of participants increased	Proportion of given approp
	No. of people trained		
	Proportion of participants who take the pre-post test		
	Participant satisfaction with content & relevance of training		
If cascade training planned	Proportion of eligible institutional peers trained	Institutional peers' knowledge of VL increased	
	Pre-/post-test produced for institutional peers	Institutional peers' knowledge of diagnosis & treatment of VL increased	
	Proportion of institutional peers trained who take the pre-post test		
Laboratory training to improve diagnosis	Standard operating practices and training materials produced	Diagnosis knowledge of participants increased	Proportion of given approp
	Pre-/post-test produced		
	No. of people trained		
	Proportion of participants who take the pre-/post-test		
	Participant satisfaction with content & relevance of training		
	Laboratory quality control system developed	Standard operating procedures (SOPs) for laboratory quality control system developed External quality assurance (EQA) concordance ≥ 95%	
Supervision of health workers	Supervisor training materials & supervision checklists developed	Proportion of health workers receiving supervision increased	Proportion of given approp
	No. supervisors trained		Proportion of given approp
	Ratio of supervisors to supervisees		
Improve supply of drugs & diagnostics	Stock forecasting system in place	Reduction in stock outs of VL diagnostics & drugs at treatment centres	Proportion of given approp
	Stock orders placed in timely		Proportion of

Intervention	Process Indicators	Output Indicators	Outcome Ind
	manner		given approp
	Distribution chain functional		
Upgrading health facilities	Health facility (HF) checklist & protocol developed		Proportion of 'readiness' cr
	HF checklist conducted		Proportion of basic standar
	Procurement list for medical & laboratory equipment developed	All medical & laboratory equipment procured & delivered to HFs	Proportion of basic standar
	Building works planned and company identified	Refurbishment of buildings	Proportion of cold chain
Strengthening surveillance	Regular surveillance meetings held at regional & national levels	Quality of surveillance data improved (timeliness, completeness)	Level of unde
	Web-based reporting system developed	Web-based reporting system rolled out	Outbreaks de to in timely n
	No. participants trained on updated surveillance system	Reporting rate increased	
	Routine data mapped		
	Active case detection conducted where under-reporting suspected		
Behaviour change communication (BCC)	Core messages & communication plan developed	Exposure to BCC messages (by message)	Reduced time symptoms ar patients
	No. materials produced (by type)	Exposure to BCC messages (by channel)	Reduced time symptoms ar patients
	No. materials distributed (by type)	Recall of specific BCC messages (e.g. recognition of VL symptoms, early care seeking, acceptance of IRS)	Reduced dura patients
			Increased cov
Vector control	Operational research studies conducted for VC in Sudan and Ethiopia	Effective VC methods identified	VL cases prev innovative VC

[1] *HF readiness* is defined as a health facility with i) integrated VL services[2], ii) where at least one member of medical and laboratory staff has been trained in the national standardized VL training in the last year, iii) appropriate diagnostic tests and first and second line anti-leishmania drugs are in place without stock ruptures in the last three months, iv) VL guidelines and standard operating procedures (SOPs) are present, v) wards and laboratory with basic standard in place (physical structure and equipment to provide VL services), including safe waste disposal, and vi) functional cold chain (in the HFs providing AmBisome).

[2] *Integrated VL services* means that VL is delivered as part of routine services of the health facility and not as a vertical program; VL health education, diagnosis, treatment and follow-up, recording and reporting, are provided alongside the same services for other diseases.

Step 3: Determine the methods you will use to measure the indicators

Once you have identified _what_ needs to be measured to monitor and evaluate your intervention, it is important to specify _how_ you will measure these indicators.

Firstly you need to define the indicator operationally. Operational indicators may take a number of formats, which tend to increase in complexity as you move up the hierarchy of indicator levels:

- A simple yes/no measure of whether a particular activity has taken place – such as training materials produced

- A measure of scale – such as the number of people trained

- A summary quantitative value such as a mean or median – such as a pre-post test score

- A proportion – such as the proportion of VL patients with a confirmed diagnosis treated with the recommended first line drug. In the case of a proportion, it is also important to define the numerator and denominator that will be used to calculate the percentage. In this example, the denominator will be the total number of confirmed VL diagnoses made in a given time period (e.g. last 12 months) and the numerator will be the total number of patients with a confirmed VL diagnosis that received the recommended first line drug.

Once you have specified your operational indicators you can determine where the data will be collected from:

- Process (activity) indicators are likely to be available from routinely kept reports such as training logs or other summary activity reports.

- Output indicators may require some additional data collection method. In the example used here, that would be a multiple-choice test designed to check health worker knowledge on VL which participants take before and after the training. If the training has been successful, we would expect the median test score after training to be higher than the mean test score before the training.

- Outcome indicators will also require additional data collection.

    o This may be to validate routinely collected data. For example, the proportion of confirmed VL patients receiving appropriate treatment available from routine monthly reports could be verified by checking the VL treatment registers and/or by observations of consultations with VL patients.

    o For other outcome indicators, primary data collection may be necessary. For example, to measure improvements in community knowledge of VL following a BCC campaign, a household survey of knowledge and practice amongst endemic communities could be used. A health facility assessment using a structured checklist could measure improvements in health facility 'readiness'.

The best way to map out your data collection requirements is to create one table for the process (activity) and output indicators that you have identified and another for your outcome indicators. Take a row for each indicator and specify the operational definition and where the data required will come from to generate that operational indicator. See Table 4 and Table 5 for examples of such tables using the health worker training intervention used in earlier sections.

As these tables illustrate, the same method may be used to collect data for several indicators.

This exercise makes sure that for each of your indicators you know when, where and how you will collect the data. By detailing the operational indicator you also have the formula for calculating the indicator once you have collected the relevant data.

Process (activity)/ Output	Indicator	Operational indicator	Verification/ source of data
Production of training materials	Training materials produced	Yes / No No. of training materials produced (by type)	Training report
Development of pre-post training test	Pre-/post-test produced	Yes / No No. of questions on diagnosis No. of questions on treatment	Training report
Training conducted	No. of people trained	No. of people trained No. of treatment centres with participants attending	Training report
Participant pre-post test conducted	Proportion of participants who take the test	Numerator: No. of participants that took the test Denominator: No. of participants attending the training	Pre-/post-test records Training report
Training perceived to be well conducted	Participant satisfaction with content & relevance of training	Median score for content Median score for relevance	Post-training evaluation from participants Training report
Pre-post knowledge of participants	Overall VL knowledge of participants increased	Increase in median pre-/post-test scores	Pre-/post-test
Pre-post diagnosis & treatment knowledge of participants	Diagnosis & treatment knowledge of participants increased	Increase in median pre-post diagnosis knowledge index Increase in median pre-post treatment knowledge index	Pre-/post-test

Outcome	Indicator	Operational indicator	Verification/ source of data
Quality diagnosis practice of participants	Proportion of suspected VL patients given appropriate diagnosis	Numerator: No. suspected VL patients given appropriate diagnosis as per national guidelines Denominator: No. of suspected VL patients	Check patient records & VL and lab registers in treatment centres; Physical observation of practices; Monthly KA reports
	Diagnosis detection rate for rapid diagnostic test (RDT)	Numerator: Number of patients confirmed with VL (positive RDT result) Denominator: No. of patients tested by RDT	Check patient records & VL and lab registers in treatment centres; Physical observation of practices; Monthly KA reports
Quality treatment practice of participants	Proportion of confirmed VL patients given appropriate treatment	Numerator: No. confirmed VL patients given appropriate treatment as per national guidelines Denominator: No. of confirmed VL patients	Check patient records & VL and lab registers in treatment centres; Physical observation of practices; Monthly KA reports

4. Value for Money

Value for Money (VfM) can be summarised as making the optimal use of resources to achieve the intended impact and represents a core component of the KalaCORE programme. We will apply DfID's 3E framework for to assessing VfM – Economy, Efficiency, Effectiveness – with Equity as a cross cutting theme (Figure 2).

FIGURE 2: DFID'S 3E FRAMEWORK FOR MEASURING VALUE FOR MONEY *(Adapted from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67479/DFID-approach-value-money.pdf)*

Value for money should be mainstreamed into all KalaCORE project activities. To demonstrate this will require collection of certain VfM indicators which can be integrated with your M&E Plan. Table 6 shows some examples of information that could be collected to demonstrate VfM.

	Area	Actions	Indicator	Verification/ source of data
Economy	Using existing infrastructure & systems	Project to be hosted by principle implementing partner in-country	Management costs as % of project costs	Budget; Financial reports
		Working with existing M&E systems to avoid costly duplications in data collection	Source of indicator data detailed in M&E Plan	M&E Plan
Efficiency	Efficient technical delivery of project	Collection & analysis of data on unit costs[3] of service delivery to identify key cost drivers/sources of inefficiency	Cost per unit of service delivery (e.g. cost per case of VL treated); broken down by cost type (e.g. consumables, personnel, overheads)	Financial reporting; Unit cost analysis report
		Data is used for decision making	Examples where unit cost data has been incorporated into planning process	Unit cost analysis report; Regular project reports
		Major innovations have costing component to allow cost effectiveness to be assessed	Pilots/ innovations assess cost effectiveness	M&E Plan; Operational research/ implementation protocols
Effectiveness	Reduction in economic burden of VL on population	Understanding how well project outputs are achieving the desired impact on poverty reduction	Reduction in household financial stress due to VL treatment	Baseline & final surveys
Equity	Equity in project delivery	Demonstrate that the project has desired impact in poorest/ most vulnerable communities	Stratify outcome indicators by wealth quintile (socioeconomic status) where possible	Baseline & final surveys

[3] The *unit cost* is the cost of delivering one unit of service (e.g. cost per case of VL treated), including all fixed and variable costs involved in delivering that service.

For completeness Table 6 covers the 3Es (economy, efficiency, effectiveness) and equity. For your individual project however, it is likely that it will be sufficient and appropriate to only collect and report information on economy, efficiency and (to some extent) equity. As with the measurement of impact indicators, measuring VfM effectiveness goes beyond the requirements of individual project M&E Plans. This will be the responsibility of the KalaCORE M&E Task Team as they evaluate the impact of the programme as a whole.

Technical support is available in identifying data collection needs for VfM, particularly if you believe your project could provide valuable information on cost effectiveness of a new or innovative strategy for VL control.

5. Data management & analysis

As part of your M&E Plan, you should think about how you will store, manage and analyse the data you will collect. Depending on the length and scale of your project and the frequency of planned data collection, you are likely to have large volumes of data that must be kept safe. The reasons for data security are twofold: (1) to protect the confidentiality of any data that could be traced back to an individual (e.g. patient records, survey questionnaires, or in-depth interview recordings and transcripts); (2) to enable quality and timely reporting of indicators measured against your project objectives.

Hard copies of data (such as supervision checklists, paper-based questionnaires, consent forms or audio tapes) should be kept in a secure locked filing cabinet. Wherever possible, data on the indicators identified in your M&E Plan should also be entered and stored electronically. In the case of quantitative data, this can be in a programme with which you are already familiar such as Excel or Access. For qualitative data e.g. from in-depth interviews, the transcripts or notes should be typed up in Word. Once data have been entered, records should be anonymised i.e. any personal identification information (in particular name and address) should be removed and the record assigned a unique identification number.

Any electronic file that contains identification data should be password-encrypted. Copies of electronic data files should be kept in at least two locations, for example keep a back-up copy on an external hard drive that is kept separately to the laptop or PC where the original files are located.

Routinely collected data may be entered directly in to your Excel or Access database. However, for quantitative data collected periodically using other tools such as a community-based household survey, pre-post training knowledge questionnaires, or structured patient exit interviews, we would recommend that the data entry programme EpiData is used. This is free open access software which can be used to design a data entry form that incorporates quality control checks; use of EpiData also enables double data entry, another data quality control measure to correct for human error, particularly important for the collation of large volumes of data. The software and more information is available from http://www.epidata.dk/

Training materials and support are available on the use of EpiData.

Once quantitative data is collated electronically, it will be possible to calculate the indicators defined in your M&E Plan. Depending on your familiarity with Excel or Access, you will be able to include formulae and graphs that automatically update when new data is added. These can then be used to inform project decision making as well as for routine report generation (for example, for donor requirements or to present results back to partners).

One way to analyse the effectiveness of your project is to assess changes in the indicator(s) over the course of the project and whether these changes have taken place in the direction and magnitude expected i.e. did the measure increase or decrease, and by how much. Another way to assess the effect of your intervention is to stratify the analysis by the level of actual implementation. For example, you could compare the quality of VL diagnosis and/or treatment amongst health workers that did receive training with those that did not; or, compare core VL knowledge amongst

community members that reported hearing any BCC messages in the last six months with those that did not.

6. Ethical considerations

Data collected routinely as part of project implementation activities and to inform the effective running of those activities (i.e. monitoring data) does not require additional ethical approval as long as the necessary government approval has already been granted for implementation.

However, plans for additional data collection above and beyond routine monitoring (which includes for example, a household survey of community knowledge and practice) will require approval from an ethics review board. Identifying which ethics review board and the procedure for submitting an application will depend on local context. For example, it may be that working with a partner from a national university means that approval can be obtained from that university's ethics committee (rather than the need to submit to the national ethics review board). Other partners involved in the evaluation activity may have their own institutional requirements for ethics approval (note: this includes the London School of Hygiene & Tropical Medicine).

If you think ethical approval is going to be needed, then start the process early to avoid unnecessary delays to activities as these applications can take a long time.

Regardless of whether formal ethical approval is required for the data collection, there are standard ethical principles that should guide all data collection taking place as part of KalaCORE M&E activities:

- The necessary health authorities and managers should be informed and their approval and support gained for the data collection activities planned.
- Where data or information is collected directly from individuals, they should be informed of the purpose for the data collection and how it will be used, and their consent given.
- Be prepared to answer questions that individuals may have about the project or the data collection.
- Individual confidentiality should be ensured.
- Data should be managed and stored securely (see section 5).

If you are interested in learning more about how to effectively protect human subjects during your work with them, a free online training is available at http://phrp.nihtraining.com/users/login.php

Annex 1: Theory of Change for VL elimination in South Asia

Annex 2: Theory of Change for VL control in East Africa

Annex 3: Template for Project M&E Plan

Background

- Brief background of the epidemiology of VL in your setting, including burden (number of cases, populations affected)

- Any relevant VL policies in place e.g. national control programme goals, with timeframe

- Overview of your project intervention with some idea of scale and time frame

Aim & Objectives of Project Monitoring & Evaluation Plan

Theory of Change

- Provide a brief description of your theory of change in the main text

- Include your theory of change flow diagram

- Include your theory of change table of processes and assumptions

Process	Assumptions
1	
2	
3	
4	
Etc.	

Methods

- Give an overview of your proposed methods of data collection in a paragraph or two of text, including:

    o How often different methods of data collection will take place

    o A description of the tools that you will use for data collection

    o An idea of scale wherever possible (e.g. number of facilities to be visited, number of interviews to be conducted etc.)

    o Any relevant definitions e.g. eligible training participants, levels of health facilities included in the project

- Data management – how will the collected data be stored and managed?

- Analysis plan – how will indicators be calculated? How will you determine the success of your project?

- Include copies of any data collection tools in an annex where appropriate

- Table of process (activity) & output indicators, with the means of calculation (operational indicator) and source of data for each indicator

Process (activity)/ Output	Indicator	Operational indicator	Verification/ source of data	Notes

- Table of outcome indicators, with the means of calculation (operational indicator) and source of data for each indicator

Outcome	Indicator	Operational indicator	Verification/ source of data	Notes

- Narrative of how Value for Money (VfM) is incorporated in your project and how you will measure it.
- This can be summarised in a Table of VfM indicators, following the DfID 3E Framework

	Area	Actions	Indicator	Verification/ source of data
Economy				
Efficiency				
Effectiveness				
Equity				

Ethical considerations

- Describe any ethical considerations which could arise from data collection and appropriate measures to be taken in relation to these
- If any of your evaluation activities will require ethics review board approval, outline the process you will need to follow – which review board (or boards) will you need to apply to? What is the approximate timeframe from submission to final approval?

Capacity building

- Include any specific requests to the M&E Task Team for capacity building relating to your M&E Plan (for example data management, value for money)