**Monitoring and evaluation guidance note for ERU PSS component**

**Introduction**

Earthquakes, severe flooding, violence, epidemic outbreaks or other disasters can cause significant psychological and social suffering to affected populations. The past decade has seen immense development when it comes to what we understand about early psychological reactions and social impact, and what kind of immediate psychosocial support we should give to those who receive and deliver aid. A smaller percentage develops mental disorders after a disaster, but stress reactions are relatively common amongst survivors and relatives – and those who provide aid.

Early psychosocial reactions can be understood e.g. as signs of distress, fear, and helplessness – without being seen as signs that people need individual counselling or clinical treatment. Most people are likely to need support to address security and basic needs, such as health, food, shelter as well as regain a sense of self, dignity and hope. Furthermore rebuilding social structures and reconnecting with loved ones are extremely important. This means that people often need support and provision of resources to resume a balance in their lives as well as support to resume routines and normal day to day activities, rather than receive psychological treatment. Early psychosocial support interventions have shifted from a focus on talking and emotional processing to interventions known for promoting stress-resistance and resiliency following exposure to extreme stress. These kinds of PS interventions would include providing practical and social support.

Any early intervention approach should preferable be based on an accurate and current assessment of needs prior to intervention (refer to data collection tools/Tool H). If it is not possible to collect assessment and baseline data yourself there is often a lot of other secondary information that can be used as a source of information; other NGO’s may have assessment information, UN agencies, situation reports etc. Even though it is highly recommended to conduct assessments of needs, in an emergency situation it is sometimes necessary to start activities without solid assessment information. In any case the interventions themselves should be culturally sensitive, related to a local formulation of problems and ways of coping, as well as being adapted/changed to comply with needs as the information flow starts increasing. It is also important that the interventions comply with international standards and best practices such as SPHERE handbook and IASC guidelines on MHPSS. Hobfoll et al. (2007) has identified key intervention principles to guide the kind of support which should be provided in the immediate and mid-term phases of potentially traumatic events affecting many people. This means from the immediate hours a crisis event hits to several months after the event. Promoting these five key intervention principles have been identified as promoting resilience following exposure to extreme stress, and thus these will serve as our Theory of Change in this M&E package. The intervention principles are:

1. A sense of safety

2. Calming

3. A sense of self- and community efficacy

4. Connectedness

5. Hope

In the context where the ERU Psychosocial component operates, the work includes meeting basic needs of large groups of children and adults. For PS delegates this means providing community-based psychosocial support interventions aimed at reducing stress and strengthening social support for the affected population (for more information about the ERU psychosocial component and the role of the PS ERU delegate see; Health Emergency response Unit, Psychosocial Support Component, Delegate Manual. 2012). As a PS Delegate, it is important for you to know how PSS and the activities you will be responsible for works. A well thought through *simple* monitoring and evaluation system can answer the most relevant questions without being difficult to implement. Facing the chaotic reality of an emergency this document seek to provide the PS delegate with some practical guidance and tools that are feasible in an emergency and easily applicable and are linked to best practice and research. The documents aims to meet the reality of the field and at the same time provide accountability to stakeholders and beneficiaries. In the field there is often not capacity and resources to set up a comprehensive M&E system within the first month of the intervention, however in this period of time there is still reporting requirements. Therefore this document has been developed to support PS delegates in basic and necessary planning, monitoring and evaluation in the midst of an emergency. The M&E approach have been simplified to comply with an emergency context and it offers outcomes and output indicators related to the PS interventions PS ERU delegate manual and the above mentioned Theory of Change, as well as simple tools for data collection.

**Do no harm**

All psychosocial support work should be done according to the principle of ‘do no harm’ which includes consideration of protection, prevention and physical safety. This principle cautions against the unintentional harm that may be caused to those who are supposed to benefit from any intervention. It applies to planning and implementations as well as monitoring and evalu­ation. It means, for example, that assess­ments should be carried out in a safe environment, respecting confidentiality and ensuring no stigmatization for participants.

Specific things to avoid in relation to the ‘do no harm’ principle:

* Inadequate preparation
* Insensitivity to emergency contexts and existing systems
* Creation of unrealistic expectations
* Inappropriate interventions for the context
* Imposing external preferences and action plans without consulting local and affected populations
* Scattered and uncoordinated support that does not regard the person’s or group’s well-being
* Focusing on individual needs rather than those of the community or population as a whole
* Regarding affected people as victims instead of capable and resourceful
* Encouraging dependency instead of capacity building and sustainability
* Attempting to provide support that one is not qualified to do, especially when professional help is needed.

(Michael G. Wessells, 2009)

**Monitoring and evaluation in emergencies**

Monitoring and evaluation are two different processes that are interconnected and complementary. Monitoring is the process of routinely, regularly and continuously collecting data of all aspects of the project. This is done to keep track of whether the project’s activities are implemented as planned. Monitoring means being aware of the state of the project by receiving answers from various sources to the questions, *‘what is going on and how’?* and *‘Are we doing things right’?* Evaluation is the systematic, objective and periodic assessment of an ongoing or completed activity or programme. Evaluations describe work that tries to see if the changes that the activity/program was hoping to bring about have happened. A good monitoring system can provide valuable information about this. However, additional actions to collect further information are often required. Exactly what actions are necessary depend upon the questions to be addressed by the evaluation.

All psychosocial evaluations should seek to measure the change in the lives of individuals, families and communities that have come about during the course of the activity/programme as a result of activity/programme. This is the core task of an outcome evaluation. The monitoring and evaluation system should be developed from the outset of an activity/program in conjunction with project planning and integrated into each stage of the project cycle. Establishing monitoring and evaluation at the beginning helps to clarify the project’s objectives and monitors the project as it is rolled out to check that the project plan is implemented adequately. With a monitoring and evaluation system it is possible to know if something unexpected or fundamentally different is happening, to learn what improvements can be made and to find out if the intended change is taking place.

A monitoring and evaluation system does not have to be complex to be good. Looking at the four different levels of objective measurement as a continuum (input, output, outcome, impact); input monitoring can be called the most easily accessible, whereas impact measurements are very difficult to accomplish. Impact measurements are more time-consuming and it is more complex to observe change at impact level as the changes often cannot be attributed to the project/activity alone. As many factors contribute to defining impact developing indicators to measure impact is a complicated process. Especially in emergency situations measuring the impact is often not possible. Recommendations on measuring on the impact level are not within the limits of this document. This document will outline monitoring and evaluation system that focuses on outputs and outcomes of the ERU. Focusing on outputs and outcomes will provide the most essential knowledge to steer a project well and to learn from it.

*Indicators:* A one-size-fits-all indicator does not exist. Indicators measure the specific results and effects of the activity/program and therefore have to be developed especially for that purpose. In addition, psychosocial indicators depend highly on the social and cultural context. Psychosocial change and well-being is embedded in the community that the beneficiaries live in. Therefore, it is very important to learn and understand what psychosocial wellbeing means locally before planning psychosocial support and activities or programmes. However in an emergency context there is very little time and capacity, so predefined indicators are often a necessity, even though this is not ideal (Refer to Planning tools/indicator guide).

*Indicator reminders:* Indicators are critical to assess our progress towards objectives and should be carefully selected. The IFRC often use the acronym SMART as a reminder to keep indicators specific, measurable, realistic and time-related. Below are some other key indicators reminders:

* Be sure to use standard indicators when appropriate. There is no need to spend the time designing indicators if it has already been done by the sector (programme area) experts. Also, standardized indicators allow comparison across programmes.
* Be careful not to have too many indicators, which can strain capacity. Only measure what is necessary and sufficient to inform programme management and assessment. 1–3 indicators per objective statement are usually sufficient.
* Keep the indicator specific and precise.
* Be sure you have the capacity or resources to measure the indicator – or a secondary source. It can cost a lot of money to measure complex indicators. However, it may be possible to use a complex indicator already measured by a government ministry, international agency, etc.
* Don’t just have “counts” but also measure change. Do not over-concentrate on low-level, easy to measure indicators (activities and outputs). These are important for programme management, but it is also important to have indicators to measure higher level changes, such as in knowledge, attitudes, and behavior.

*Measuring at output level:*

Evaluations at the output level are also called process evaluations. Process evaluations focus on documenting the development and operation of a programme, how it is implemented, and whether the project has implemented what it set out to do it in accordance with its original plan. They answer questions on how many and which participants receive the intervention, whether activities are being carried out as planned and how resources are distributed. Process evaluations can be implemented relatively quickly and cost-effectively (refer to planning tools/ M&E plan template and plan of action, as well as data collection tools/Tool D).

*Measuring at the outcome level:*

Evaluating the outcomes is more challenging than monitoring the output. Measuring outcomes means that we are investigating whether the outputs accomplished by the project have had any effect on the lives of participants, their families, or their communities. All psychosocial interventions face the challenge that it is difficult to measure the psychosocial change they aim to produce. Psychosocial changes are changes in the psychological, emotional and behavioural sphere; areas of human life that are subject to highly individualised interpretation. Measuring psychosocial change is more complicated than measuring, for example, whether a fitness programme to improve upper body strength in swimmers is working (physiological measurement) or if a newly built playground is used (number of children and adults using the playground). As psychosocial change is always influenced by a multitude of factors within and without the control of the project, it is hard to know if changes can be attributed directly to the project or whether they are caused by external factors such as changes in relationships or life circumstances or the mere time that has passed since the critical event.

Furthermore, the change itself can be hard to document because it is subjective. The subjective nature of psychosocial change stems from the fact that the change is mental and personal or interpersonal. To gain information about psychosocial change it is necessary to ask questions about how people feel, behave and think, and how this has changed. What individuals feel and how relations between people and groups have changed must be considered. Because it is a challenging task to measure psychosocial change it is important to stay close to best practice and research done in the field e.g. SHERE handbook and IASC guidelines to MHPSS in emergencies, which is also why this document as well as the outputs and outcomes are closely related to Hobfolls principles. We know that if interventions are implemented according to Hobfolls principles positive change will be achieved even though it is challenging to measure it.

All tools and indicators should be adapted to suit local context and situation. It is likely that wording in the indicators need to be changed and new indicators need to be developed to ensure they are relevant and aligned with intervention. Furthermore it is important to include different target groups and vulnerable groups both in interventions and in the M&E system; elderly, people with disabilities, people with mental health disorders, children, and minority groups etc. and adapt the tools accordingly. This M&E package should be seen as starting point and for inspiration and support.

This package includes:

1. An ME guidance note (this document)
2. Planning tools: 1) An indicator guide with examples of outcome and outcome indicators, output and output indicators as well as means of verification 2) Template for Logframe (based on the CBHFA PMER toolkit) 3) Template for Plan of Action (PoA) (based on the CBHFA PMER toolkit), 4) Template M&E plan (based on the CBHFA PMER toolkit)
3. Examples of simple tools for data collection
   * Tool A - example of data collection tool for measuring outcome 1
   * Tool B - example of data collection tool for measuring outcome 2
   * Tool C – example of general guidelines for qualitative methodologies
   * Tool D – example of monitoring visit report template
   * Tool E – example of attendance sheet
   * Tool F – example of training report template
   * Tool G – example of training pre and post test
   * Tool H – example of guidelines for needs assessment
   * Tool I – quality standards for safe spaces
   * Tool J – referral templates
   * Tool K – supervision tools

**How to use the templates:**

Adapted from CBHFA PMER toolkit: http://www.ifrc.org/Global/Publications/Health/CBHFA%20PMER%20toolkit.pdf

***The logframe template (refer to planning tools/logframe template):***

***What:***The logframe template matrix consists of a table with three rows and four columns (activities planned separately in a plan of action template), in which the key aspects of a project/programme are summarized. It sets out a logical sequence of cause-effect relationships based on the results chain/objectives hierarchy.

***Why:*** The logframe is used not only for project/programme design, but also as the basis for implementation, monitoring and evaluation. It is a living document, which should be consulted and altered throughout the interventions life cycle.

***Who:*** Project team with partners.

***When:*** At the project design stage and to be reviewed periodically.

***The indicator guide (Refer to planning tools/indicator guide):***

***What:*** The indicator guide contains examples of output and outcomes as well as indicators at outcome and output level. The topics are aligned with the ERU PS component; however other indicators might be relevant depending on the interventions. The indicator guide can be used as inspiration for developing your logframe.

***Why:*** To have a ready reference and to standardize indicators across various ERU PS interventions.

***Who:*** It is critical that the indicators are selected with the participation of those who will be using them.

***When:*** At the beginning of project implementation

***M&E Plan template (refer to planning tools/M&E plan template):***

***What:*** An M&E plan is a matrix that expands a projects logframe to detail key M&E requirements for each indicator and assumption.

***Why:*** M&E planning is a critical part of project management. It encourages coordination within the M&E system, and therefore the project itself. An M6E system has a variety of interrelated activities, and its planning can ensure that these activities are complementary and mutually supportive, conducted in a timely manner, and that the resources are adequately allocated and efficiently used for M&E.

***Who:*** It is critical that the M&E plan is developed with the participation of those who will be using it. Completing the matrix requires detailed knowledge of the project and the context provided by the local project team and partners.

***When:*** M&E planning should begin during or immediately after the project design stage

***Plan of Action template (refer to planning tools/plan of action template):***

***What:*** A plan of action (also called a “work plan”) is a document analysing and graphically presenting project and programme activities.

***Why:*** It helps identify their logical sequence, expected duration and any dependencies that exists between activities, and provides a basis for allocating management responsibilities. A plan of action helps to consider and determine:

* What will happen
* When, and for how long it will happen
* In which order activities have to be carried out (dependencies)

***Who:*** Project team

***When:*** At the beginning of project implementation and to be reviewed periodically

These templates and tools are draft versions that need to be adapted /enriched based on the specific context of an emergency intervention and on the findings from the assessments. They can be used as a reference by the PS delegate or other PS staff when planning PSS activities in emergency settings. It is important to note that the indicators listed are by no means exclusive but are meant as inspiration. The detailed information on the timeframe, the resources, the cost of activities, and the assumptions have to be defined or finalized when the specific needs, local resources and costs as well as risks are known.

**References:**

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CBHFA PMER toolkit: http://www.ifrc.org/Global/Publications/Health/CBHFA%20PMER%20toolkit.pdf

Further details on logframe development and terminology can be obtained in the IFRC *Project/Programme Planning (PPP) Guidance manual,* 2010, available online at: http://www.ifrc.org/mande or on FedNet.