Evaluation Guide for HIV Testing and Linkage Programs in Non-Clinical Settings

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

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Chapter 1. About the Non-Clinical HIV Testing And Linkage Program Evaluation Field Guide

The Evaluation Field Guide for HIV Testing in Non-Clinical Settings and Linkage to Health and Prevention Services (hereafter referred to as the Evaluation Guide), was developed to complement the Centers for Disease Control and Prevention's (CDC's) 2001 *Guidelines for HIV Counseling, Testing and Referral Services* as well as the soon to be released *Revised Guidelines for HIV Testing in Non-Clinical Settings and Linkage to Health Prevention Services* (expected release early 2013[1,2]). The Evaluation Guide serves as a companion resource to the *Planning and Implementing HIV Testing and Linkage Programs in Non-Clinical Settings: A Guide for Program Managers* (hereafter referred to as the Implementation Guide).[3] This Evaluation Guide provides HIV testing staff members and other HIV prevention program planners, technical assistance providers, and program evaluators with information, exercises, and tools that can be used to design and implement a monitoring and evaluation (M&E) strategy for HIV testing and linkage programs in non-clinical settings. As with any M&E effort, the information and tools offered in this guide should be tailored to fit your local needs.

The Importance of HIV Testing and Linkage in Non-Clinical Settings

More than 1.2 million people are living with HIV in the United States and approximately 48,000 new infections occur each year.[4] Seventy percent of sexually transmitted cases of HIV are attributed to persons who are unaware of their HIV-positive status, and nearly 50% of people who test positive for HIV are diagnosed with AIDS within 3 years.[5,6] These facts point to persons most at risk for contracting HIV or who may present with early infections are not being reached by health care or clinical settings.[7] In the *Revised Guidelines for HIV Testing in Non-Clinical Settings and Linkage to Health Prevention Services*, CDC presents a revised

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[1] Centers for Disease Control and Prevention. (2001). Revised guidelines for HIV counseling, testing, and referral. *Morbidity and Mortality Weekly Report*, *50*(RR19), 1–58.
[2] Centers for Disease Control and Prevention. (2013). *Revised guidelines for HIV testing in non-clinical settings and linkage to health prevention services.* Manuscript in preparation.
[3] Centers for Disease Control and Prevention. (n.d.). *Operational guide for HIV testing in non-clinical settings and linkage to health and prevention services.* Manuscript in preparation.
[4] Prejean J, Hernandez A, Ziebell R, Green T, et al. (2001) Estimated HIV Incidence in the United States 2006-2009. PloSone 6(8):e17502.doi:10.1371/journal.pone.001.
[5] Marks, G. (2006). Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. *AIDS*, *20*(10), 1447–1450.
[6] Centers for Disease Control and Prevention. (2009). Late HIV testing—34 States, 1996–2005. *Morbidity and Mortality Weekly Report*, *58*(24), 661–665.
[7] Giradi, E. (2007). Late diagnosis of HIV infection: Epidemiological features, consequences and strategies to encourage earlier testing. *Journal of Acquired Immune Deficiency Syndromes, 46,* S3–S8.

approach to HIV testing; a shift from the traditional counseling, testing and referral strategy to a targeted testing model and immediate linkage of HIV-positive persons to care.[2] It is the hope that this honed strategy for non-clinical HIV testing and linkage programs, referred to in the Evaluation Guide as non-clinical HIV testing and linkage to care (TLC), will increase the number of persons aware of their serostatus, facilitate or increase linkage of HIV-positive persons to medical care and treatment, and decrease transmission of HIV.

Non-Clinical settings, or settings that do not provide both medical diagnostic and treatment services, are a critical venue for HIV testing because they allow agencies to reach those in the community who do not access health care through a primary provider, those who may be testing for the first time, or those at highest risk who would benefit from regular testing.[8] Examples of non-clinical settings include mobile testing units, street corners, churches, CBOs, bathhouses, parks, needle-exchange programs, social service organizations, homeless shelters, and drug treatment facilities. Offering testing in these venues also allows agencies to be strategic and target their services to those most at risk in their community. By building a service network with other local providers, non-clinical testing and linkage programs can provide comprehensive services and refer community members to critical prevention and care services efficiently and effectively.[8] Often, those who are at highest risk for transmission can greatly benefit from risk reduction and structural interventions, including sexually transmitted disease (STD) screening, housing, mental health services, or intensive behavioral interventions. HIV testing in non-clinical settings also plays a key role in the early and effective linkage of HIV-positive persons to medical care and treatment. This link is critical in increasing access for those testing HIV positive, as well as those individuals who were previously diagnosed as HIV positive and are not in care, to antiretroviral and prophylaxis therapies, as well as assisting in their retention in medical care and medication adherence. These factors contribute to HIV-positive persons living a longer and healthier life.[9,10,11]

Introduction to Monitoring and Evaluating Non-Clinical HIV Testing and Linkage Programs

Major goals of HIV testing are to increase the number of individuals who know their current HIV status, provide access to services needed to live healthy lives, and bring an end to the HIV/AIDS epidemic. Non-Clinical HIV TLC programs have many benefits for individuals and communities, including reducing risk behaviors, increasing individual knowledge of HIV

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[8] Bowles, K. (2008). Implementing rapid HIV testing in outreach and community settings: Results from an advancing HIV prevention demonstration project conducted in seven U.S. cities. *Public Health Reports, 3,* 78–85.
[9] May, M. (2011). Impact of late diagnosis and treatment on life expectancy in people with HIV-1: UK Collaborative HIV Cohort (UK CHIC) Study. *BMJ*, *343,* d6016.
[10] Montaner, J. (2006). The case for expanding access to highly active antiretroviral therapy to curb the growth of the HIV epidemic. *The Lancet*, *368,* 531–536.
[11] Centers for Disease Control and Prevention. (2011). *CDC trial and another major study find PrEP can reduce risk of HIV infections among heterosexuals.* Retrieved January 12, 2012, from the NCHHSTP News Media Line: http://www.cdc.gov/nchhstp/newsroom/PrEPHeterosexuals.html

status, decreasing transmission rates, reducing coinfection, increasing access to care and treatment, and improving overall public health.[12] Non-Clinical HIV TLC programs include the following services: provision of prevention information, HIV testing, and linkage to medical, prevention, and support services.

The National HIV/AIDS Strategy, published in 2010 by the White House Office of National AIDS Policy, stressed the importance of HIV testing and reemphasized its goals by calling for a demonstrated reduction in the number of new infections, an increase in access to care for HIV-positive persons, and a decrease in HIV-related health disparities.[13] Federal and local agencies across the country are aligning their efforts to meet these goals, and they are conducting M&E activities to determine whether these goals are being accomplished. For example, agencies such as CDC, Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration, and others use M&E questions to get a better idea of what HIV prevention efforts look like in broad strokes, across programs and funding streams. Many programs generate reports after collecting and analyzing data driven by these M&E questions. These reports help each funding agency determine the impact a specific program has on its predetermined HIV testing goals, as well as determine its overall impact on the epidemic.

At the local level, you should consider M&E at each step of your non-clinical HIV TLC program, including planning, implementation, documentation, and improvement to gauge your progress toward achieving your program goals. M&E activities can help you determine if you are accomplishing your goals effectively and efficiently, identify areas for improvement, report your efforts to internal and external stakeholders, and demonstrate accountability to your funders. M&E is a process that can help your program answer these questions:

- Are we doing what we planned to do?
- Are we being effective?
- Do we need to make a change?

Purpose of the Non-Clinical HIV Testing and Linkage Program Evaluation Guide

This Evaluation Guide was developed to assist you in monitoring your non-clinical HIV TLC program's goals and objectives implementation, and evaluate the effectiveness of your program. While every agency that approaches M&E of their non-clinical HIV TLC program may have different priorities or questions to address, all agencies share a commitment to engaging at-risk populations, providing HIV testing services to these populations to ensure

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[12] Branson, B. M. (2003). Point-of-care rapid tests for HIV antibodies. *Journal of Laboratory and Clinical Medicine*, *27*(7/8), 288–295.

[13] White House. (2010). *National HIV/AIDS strategy for the United States*. Retrieved January 12, 2012, from the Office of National AIDS Policy Web site: http://www.whitehouse.gov/administration/eop/onap/nhas

knowledge of serostatus, and linking clients with the services needed for care, treatment, and prevention.

This Evaluation Guide will provide examples of the M&E activities that can be leveraged to ensure program elements are delivered with fidelity and are in line with local priorities. This guide will also review the importance of M&E at the national and local levels and demonstrate how an agency moves from goal setting, to planning and monitoring the provision of service, to finally incorporating evaluation findings into non-clinical HIV TLC programs. This guide provides a number of practical exercises that are related to the six steps of CDC's Framework for Program Evaluation.[14] An inventory of the tools used can be found in Appendix C.

Audience for the Non-Clinical HIV Testing and Linkage Program Evaluation Guide

The information presented within these pages is meant for agencies implementing HIV testing and linkage programs in non-clinical settings. The concepts and activities covered in this guide can be universally adapted despite your funding source, data reporting requirements, or capacity. Each agency will have unique priorities when it comes to program planning, delivery, and improvement; this guide presents an overview of M&E, and then encourages you to take the concepts and create a customized M&E approach that is locally relevant, appropriately scaled, and useful. This guide offers M&E practices that can be incorporated into planning programs, collecting data, ensuring data quality, performing data analysis, coordinating reports development, as well as dissemination.

Organization of the Evaluation Guide

Many evaluation resources have compared the M&E process to building a house or a pyramid. The most critical step is building a strong foundation. Likewise, this guide is organized to present foundational concepts first and follow them with practical examples, tools, and exercises. After presenting some overview of M&E, HIV testing and linkage, and gauging your agency's capacity for M&E activities, the guide uses the structure of CDC's Framework for Program Evaluation to discuss the six steps of comprehensive M&E. This framework, presented as a cyclical process, contains six steps for program evaluation:

1. Engaging stakeholders
2. Describing the program
3. Focusing the evaluation
4. Gathering credible evidence

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[14] Centers for Disease Control and Prevention. (n.d.). *A framework for program evaluation.* Retrieved January 12, 2012, from the Centers for Disease Control and Prevention Web site: http://www.cdc.gov/eval/framework/index.htm

5. Justifying conclusions
6. Ensuring use and lessons learned

While this guide is structured in a linear fashion, moving from step to step in the framework, the tools and exercises within each step can be referenced when needed. If you are just starting a non-clinical HIV TLC program, you may benefit from starting at the beginning and working your way through the Evaluation Guide in sequential order. If you are currently implementing a non-clinical HIV TLC program, you may want to consult the table of contents to find a topic that is most applicable to where you are in your non-clinical HIV TLC program implementation.

In the next chapters we will discuss the following:

- What is M&E and how it can be applied to non-clinical HIV TLC programs.
- The six steps of CDC's Framework for Program Evaluation. At each step, we will discuss the specific connections and practices that can be applied to your non-clinical HIV TLC program. We will discuss the following activities:
  - Engaging stakeholders in the M&E process
  - Using specific, measurable, achievable, realistic, and time-based (SMART) objectives and a logic model to create an M&E plan
  - Reviewing the elements of your M&E plan to further focus your evaluation questions
  - Documenting a data collection plan and determining measures of success for your agency
  - Determining quality assurance measures and data analysis roles and responsibilities
  - Using your data to reach conclusions about your program
  - Making recommendations for program improvement
  - Reporting findings and progress markers to community stakeholders
- A set of reference resources, including the guide's glossary (Appendix A) and useful links (Appendix B).
- The tools used as a part of exercises in this guide, including an overview of each tool and instructions on how to complete the tools (Appendix C).

Identifying Helpful Hints

As this guide moves through concepts and exercises that relate to evaluating non-clinical HIV TLC programs, we will pause along the way to highlight reminders or provide helpful hints. The call-out boxes below explain the types of information that will be provided.

Tip

Tips include "from the field" advice from your HIV prevention colleagues, best practices, or lessons learned that will help you perform monitoring and evaluation activities at your agency.

 **Time Saver**
Time savers are considerations or practices that can help you be more efficient and accomplish activities quicker.

 **Tools and Templates**
Tools and templates will help you construct and document critical components of your M&E plan. They can be tailored by your agency to reflect local needs and will help you determine agency capacity, prevention priorities, services for delivery, evaluation questions, objectives, and data collection plans.

 **Recommended Activity**
Recommended activities are linked to the tools and templates included in this guide and serve as reminders to document specific items to include in your M&E plan.

Also included throughout the guide are boxes which highlight examples, tips, and considerations from health department and community-based organization representatives across the United States. These field examples are provided by individuals who are implementing non-clinical HIV TLC programs and showcase practical advice for your use.

Other Resources for Non-Clinical HIV Testing and Linkage Programs

In addition to this Evaluation Guide, an Implementation Guide and Toolkit are available. The Implementation Guide provides best practices, model programs, lessons learned, and other information that is directly related to implementing your non-clinical HIV TLC program. Refer to this guide for information on program planning, implementation, and quality assurance. As mentioned earlier, the Evaluation Guide is meant to provide you with enough context and perspective so that you can devise an M&E approach that is locally relevant and useful.

What This Evaluation Guide Does Not Cover

As a provider of HIV prevention and other services, you may receive funding from one or more funders. These could include national agencies such as CDC, large foundations, State agencies like health departments, or CBOs. These agencies often allocate funds to target specific populations, investigate new technologies, or perform special studies that can gauge the effectiveness of interventions. For these reasons, agencies are often asked to report data on program activities. These reporting requirements and program priorities are important to consider as you develop an M&E work plan for your HIV testing and linkage program in a non-clinical setting; however, this guide does not reference the reporting requirements of any Federal, State, or local agency or specific funding announcement. If you have questions about your reporting requirements, please contact your funding partner.

Additionally, this guide focuses on M&E for non-clinical HIV TLC programs. For general information and resources on HIV testing in clinical settings, you may reference the following resources:

- *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings*[15]
- *Questions and Answers for Professional Partners: Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings*[16]

[15] Centers for Disease Control and Prevention. (2006). Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *Morbidity and Mortality Weekly Report, 55*(No. RR-14), 1–13.

[16] Centers for Disease Control and Prevention. (n.d.). *Questions and answers for professional partners: Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health care settings*. Retrieved on January 12, 2012, from the Centers for Disease Control and Prevention Web site: http://www.cdc.gov/hiv/topics/testing/resources/qa/qa_professional.htm

Chapter 2. Preparing to Monitor and Evaluate Your Non-Clinical HIV Testing And Linkage Program

What Is Program Monitoring and Evaluation?

HIV testing providers strive to improve the health and condition of their communities through the implementation of targeted HIV testing programs. Program monitoring and evaluation is an approach to ensure progress is being made toward program goals. M&E is an important activity for all non-clinical HIV TLC programs and provides a way to look at the resources that go into a program (e.g., staff, budget, supplies); the activities or services that take place (e.g., testing, referrals, linkage); and the results or outcomes of program implementation (e.g., awareness of HIV status, linkage to care, reengagement in care). Further evaluation types such as impact and/or cost effectiveness will require a separate evaluation program design, as discussed later in the chapter.

Program Monitoring
The regular observation, tracking, and recording of activities taking place in a program or project. This includes the process of systematically observing and routinely gathering information on all aspects of the program. Monitoring also involves providing feedback about the progress of the program to the stakeholders and implementers; this feedback will be used in making decisions for improving program performance.

Program Evaluation
The systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and inform decisions about future programming.[1]

As you can see from these definitions, program monitoring and evaluation are distinct practices. For example, different questions addressing each practice may include the following:

- Program monitoring: Are you doing what you planned to do?
  - Activities may include recording general counts, inventories, or observations.
- Program evaluation: Is what you are doing having its intended effect?
  - Activities may include collecting specific program data and analyzing results.

[1] Centers for Disease Control and Prevention. (n.d.). *Partner Services evaluation field guide*. Retrieved January 12, 2012, from the Effective Interventions Web site: http://effectiveinterventions.org/Libraries/Partner_Services_Materials/Partner_Services_Evaluation_Field_Guide_041610.sflb.ashx

Both program monitoring and evaluation can provide information for use by individuals internal and external to an agency. Internally, this information can contribute to program management and improvements. Externally, it can be used to demonstrate accountability to funders and other community stakeholders.

Types of Program Monitoring and Evaluation

Generally speaking, you do not have to be a trained evaluator to ask M&E questions of your non-clinical HIV TLC program data, but it does help you to have a general understanding of the primary types of M&E. The first, and most fundamental, is solid **program planning**. The activities most commonly associated with planning are needs assessments and other types of community input to characterize specific health and social service needs. Your agency has most likely performed an assessment of your specific target populations' prevention needs, risks, and context, as well as the use of information and priorities from your program planning process. For more information on factors to consider during the planning of a non-clinical HIV TLC program, consult the companion Implementation Guide. Once you have a strong planning foundation, you are well on your way to building capacity to conduct other evaluation activities that rely on community context.

Formative evaluation builds on planning and includes efforts to develop a rigorous program plan. This process could entail conducting focus groups with your intended audience, pilot testing activities, and refining them on the basis of that information. The Implementation Guide discusses formative evaluation in detail.

Once implementation of your non-clinical HIV TLC program is underway, **process monitoring** is critical to your understanding of the activities and services delivered, the testers implementing the program, and the clients who are receiving the testing. Process monitoring is the routine documentation and review of program activities, populations served, or resources used in order to inform program improvement and process evaluation. Comparing actual implementation data with what you expected leads to questions about "how" and "why", or process evaluation. Process evaluation assesses planned versus actual program performance over a period of time for the purpose of program improvement and future planning.

Outcome monitoring and **outcome evaluation** address outcomes, or the results you hope to see by providing non-clinical HIV TLC. Outcomes could be related to service utilization (e.g., accessing a referral to medical care), acquisition of knowledge (e.g., of HIV status), or behavior change (e.g., repeat testing). If you only have outcome data (e.g., number of test results returned to clients) and no process data (e.g., number of sites providing testing, number of testers, number of clients tested), you would not have any way to interpret the outcomes. Solid process M&E data provide the basis for interpreting outcomes-related questions.

Outcome monitoring involves the routine documentation and review of program-associated outcomes (e.g., service delivery; individual-level knowledge, attitudes, and behaviors) in order to determine the extent to which program goals and objectives are being met. The primary difference between outcome monitoring and outcome evaluation is the rigor and design

employed. Outcome monitoring asks, "What outcomes occurred?" It does not attempt to say that the outcomes are a direct result of the service provided. Outcome evaluations, on the other hand, attempt to answer the question, "Did my agency's non-clinical HIV TLC program cause the outcome observed?" This requires more sophisticated methods and statistics and significant resources to obtain an answer that will be credible to others.

Finally, **impact evaluation** is used to determine long-term, far-reaching effects of a program or of the program plus other events that occur along with it (e.g., other HIV testing programs for the same population, attitude-changing news stories). Impact evaluations are usually special studies conducted with significant resources, and they often include the use of surveillance data.

Your agency may have questions that can be categorized as one or more of these types of evaluation. However, due to our practical focus on using M&E data for program improvement and the reality of resources available at many agencies, this Evaluation Guide focuses on examples and exercises related to process monitoring, process evaluation, outcome monitoring, and outcome evaluation.

CDC's Framework for Program Evaluation

In a time of reduced resources, it is critical to ensure that program efforts are targeted, tailored, effective, and efficient. Program M&E can provide data to help programs identify and leverage their strengths and/or focus in on areas to develop. Program managers should not question whether to evaluate their programs; instead they should ask the following questions:

- What is the best way to evaluate?
- What is being learned from the evaluation?
- How will lessons learned from evaluations be used to make programs more effective?

The CDC Framework for Program Evaluation demonstrates the cyclical nature of M&E.[2] The framework emphasizes six connected steps that together can be used as a starting point to help you develop an evaluation plan for your agency's non-clinical HIV TLC program. Understanding and implementing these six steps will help you (and your stakeholders) understand your program's context (e.g., the program's history, setting, and organization) and, most importantly, help you determine what parts need to be monitored and evaluated, on the basis of particular needs you identify.

The six steps are shown in Figure 2.1. The steps are shown in an ideal order, and earlier steps provide a foundation for later steps. However, because all the steps are related, you may initially encounter a step in a slightly different sequence. If you do find it difficult to follow the steps in linear order, work on whatever step is needed at the time. Using a cyclical M&E

[2] Centers for Disease Control and Prevention. (1999). Framework for program evaluation in public health. *Morbidity and Mortality Weekly Report*, *48*(RR-11), 1–58.

process helps to ensure that the effort you put into planning and implementing activities will have a demonstrated impact on your non-clinical HIV TLC program.

Figure 2.1. CDC's Framework for Program Evaluation

Along with these six steps, the framework describes four key principles, or standards, that should be at the forefront of any program evaluation:

- Utility—Serve the information needs of intended users.
- Feasibility—Be realistic, prudent, diplomatic, and frugal.
- Propriety—Behave legally, ethically, and with regard for the welfare of those involved and those affected.
- Accuracy—Reveal and convey accurate information.

Although we will briefly review each of the six steps in this section and discuss the benefits of M&E data to your program, the remaining bulk of this evaluation guide will walk you through each of the six steps in detail, as they relate to planning and implementing M&E for a non-clinical HIV TLC program. (Interested readers are encouraged to visit the CDC Evaluation Working Group's Web site at http://www.cdc.gov/eval/ for detailed information on this framework and other evaluation resources as suggested by CDC.)

Step 1: Engage stakeholders

- Stakeholders are the people and organizations that have a vested interest in your program, its M&E activities, and how answers to critical questions will be used. Stakeholders need to be engaged to determine data needs and priorities.

Step 2: Describe the program

- Program descriptions provide the reference point for determining what needs to monitored and evaluated and how you will use the incoming information. Descriptions should clearly link program activities to their desired effects (e.g., inputs and outputs in a logic model).

Step 3: Focus the evaluation design

- Once consensus on a program description has been reached, your next step is to describe what you need to know about the program. Because most organizations have limited resources (e.g., people, money, time), deciding the most efficient use of those resources are important. In this step, you will set priorities for your M&E activities.

Step 4: Gather credible evidence

- By this step in the evaluation process, you have worked with stakeholders to reach consensus on your program and its intended effects, determined your M&E questions, and determined the data needed to answer those questions. During this step, you will collect the data to answer those questions.

Step 5: Justify conclusions

- During Step 5, you will analyze and interpret your findings using the four standards (utility, feasibility, propriety, and accuracy). Conclusions are justified when they are tied to the data gathered and are agreed upon by stakeholders.

Step 6: Ensure use and share lessons learned

- This step of the framework discusses the central goal of M&E, which is to provide information for use in program improvement and planning. During this step, programs should design, prepare, and implement a feedback and follow-up process that ensures the findings will be used to make decisions on how activities are implemented.

Since M&E is a self-reflective process, it is important to remember that any M&E activity requires a degree of introspection and questioning of current approaches and practices. Incorporating M&E into multiple program components can result in noticeable benefits and lead to enhanced services and more effective programs. Exhibit 2.1 illustrates additional benefits of M&E data.

Exhibit 2.1. Benefits of M&E Data for Non-Clinical HIV Testing and Linkage Programs

M&E Can Be Useful for:	M&E Data Can:
Program planning	Help determine if program goals and objectives have been met; identify program areas that may need to be modified or improved to meet future goals and targets; and make informed decisions about program implementation, including the following: • Selecting strategies that best meet the needs of the target population • Expanding access to program services • Linking patients to appropriate medical and prevention services • Identifying and planning services for emerging populations
Program management	Help assess program performance; provide insight into what is working well and what is not. Provide an understanding of staffing patterns, workflow, resource allocation, and training needs. Increase morale and retention of staff members by emphasizing program achievements. Activities include the following: • Reviewing and updating policies and procedures on a regular basis • Assessing staff capacity to effectively recruit clients and to link HIV-positive clients to medical care • Identifying staff training needs • Allocating resources
Process improvement	Help ensure that program performance and quality of care are continuously monitored and improved. Process improvement focus areas include the following: • Timeliness of test result • Timeliness of linkage to care • Timeliness of referral to prevention services • Maintaining confidentiality • Maintaining client satisfaction with service delivery
Quality assurance (QA)	Help monitor staff performance; ensure that policies and procedures are in place, ensure services are delivered as intended, and standards of quality are being met. QA activities may focus on the following: • Timeliness of test result • Timeliness of linkage to care • Timeliness of referral to prevention services • Data completeness
Obtain community support	Help build credibility by highlighting successes, building community awareness, gaining support, encouraging policy development, expanding community outreach, and broadening the dissemination of prevention messages throughout the community. Can also help forge new partnerships with relevant providers, community leaders, agencies, and CBOs for referrals and linkage to care support.
Identify emerging needs	Help determine if emerging populations are accessing HIV testing in non-clinical settings and if the services respond to their particular needs and your local epidemic. Additionally, identification of trends or changes in client characteristics can help build a case for additional funding from new or existing sources.

The Importance of Fostering a Shared Understanding and Collaboration for M&E

Just as different HIV prevention programs have varied goals and priorities, the individuals participating in HIV prevention programs also bring unique perspectives and experiences that are valuable to the M&E process. By including stakeholders throughout the agency and community in communications and decisions around M&E, you encourage collaboration; broaden the knowledge base; and increase awareness and commitment toward M&E activities. While there may only be a few individuals in your agency who are officially tasked with performing M&E activities, each person working with the HIV testing and linkage program participates in and contributes to the M&E process, including quality data. In order to validate M&E findings and propose the most productive process and program improvements, there must be high levels of data quality and consistency in service provision. For these reasons, it is important to communicate and obtain buy-in regarding M&E priorities and goals with everyone, from line staff to executive leadership. Additionally, reviewed and summarized M&E data should be available to program staff and all levels of management to improve program delivery.

Building an M&E Plan

Whether you are an agency that is preparing to implement your first non-clinical HIV TLC program or a seasoned agency with many successful programs underway, documenting the major components of your M&E process is an essential step. An M&E plan, or a document that records your M&E goals, methods, procedures, and key players, should serve as a road map for the M&E activities at your agency. This plan should include elements that describe how your non-clinical HIV TLC program will be implemented, monitored, and evaluated. It will also help to ensure that you not only document your goals and objectives, but also document who will be involved and how you will measure success.

To support a comprehensive M&E process, this guide presents exercises that align with each of the six steps in CDC's Framework for Program Evaluation and presents them in a linear fashion. As you move through the guide you will encounter the following tools:

- Step 1: Engaging stakeholders
  - Tool 1: Stakeholder Identification Table
  - Tool 2: Monitoring and Evaluation Preparation Work Plan
  - Tool 3: Monitoring and Evaluation Organizational Capacity Inventory

- Step 2: Describe the program
  - Tool 4: SMART Program Objectives Worksheet
  - Tool 5: Program Components Table
  - Tool 6: Logic Model Template

- Step 3: Focus the evaluation design
  - Tool 7: Document and Prioritize M&E Questions Table
  - Tool 8: M&E Worksheet for HIV Testing and Linkage in Non-Clinical Settings

- Step 4: Gather credible evidence
  - Tool 9: Identifying Data Sources and Data Collection Methods Table
  - Tool 10: Data Collection and Entry Template

- Step 5: Justify conclusions
  - Tool 11: Data Analysis Considerations Table
  - Tool 12: Data Analysis Planning Template

- Step 6: Ensure use and lessons learned
  - Tool 13: Dissemination Planning Template

Throughout this guide, you will find exercises to help you complete your M&E plan. Each exercise presents a tool or template you can use to document critical components of your M&E plan. The exercises in this guide were developed to be completed in the order that they are presented because each builds upon the information documented in the previous exercise. However, depending on the maturity of your non-clinical HIV TLC program, you may choose to use select tools to build or improve upon aspects of your M&E activities at various points of time in your program implementation.

If you chose to complete all the tools in this guide, you will have documentation of the procedures that define your M&E activities. Many agencies may find it useful to complete the tools as a part of a team retreat or group activity. Gathering the input of multiple individuals, including agency leaders, program managers, grant writers, HIV testing and linkage staff, and community members will ensure that the M&E plan represents the priorities of your agency and your community. Consider using the completed set of tools to build the core of your agency's M&E, and add additional information as needed to meet your community and agency goals and objectives.

A complete list of tools and templates is available in Appendix D. As always, it is important to approach each exercise with an understanding of your local needs and capacity.

Chapter 3. Using CDC's Framework for Program Evaluation

Step 1. Engage Stakeholders

In the previous chapter we discussed the importance of collaboration when preparing to monitor and evaluate your non-clinical HIV TLC program. The first step in CDC's Framework for Program Evaluation, engage stakeholders, is another example of the importance of collaboration. Stakeholders contribute to successful M&E efforts by bringing varied perspectives to the table and offering support for M&E activities both within your agency and throughout your community. During this step, it is important to think about (1) the importance of stakeholders and their input; (2) the individuals who make up your stakeholder group; and (3) how you can engage stakeholders throughout the M&E process.

The Importance of Stakeholders

Stakeholders are the persons who have a vested interest in the success of your program and will be affected by the results of evaluation activities. Stakeholders are critical to the success of any M&E program. By identifying and engaging this group throughout the M&E process, you increase the likelihood that stakeholders will be invested and supportive of its findings. Engagement also ensures the use of evaluation results when making important programmatic decisions and determining the direction of your non-clinical HIV TLC program.

Because stakeholders can represent groups that are both internal and external to an agency, they can provide insight to help ensure the following:

- Evaluation efforts incorporate the feedback and perspective of your staff, clients, and community.
- There is regular communication between evaluation partners.
- Your evaluation design is feasible and appropriate.
- Your evaluation questions are reflective of program goals and are feasible to answer.
- Evaluation results reflect the feedback and perspective of multiple stakeholders.
- Evaluation findings are disseminated to the appropriate groups.

Identifying Stakeholders

It is important to identify, engage, and involve stakeholders early and throughout your program evaluation activities, because their buy-in will be critical in ensuring that evaluation results will be used for making decisions about the program. You will need to identify your stakeholders and their information needs and determine how you will engage them.

Stakeholders for non-clinical HIV TLC programs can be segmented into four groups:

- Staff implementing program services
- Clients served by the program
- Staff who will be the primary users of evaluation findings
- Funders or others who approve changes to the program

There are many groups that offer important perspectives for M&E activities. These groups contain both individuals within your agency (internal) and individuals outside of your agency (external). For example, representatives of the target population and/or community you serve, identified as external stakeholders, are important to involve because they can help identify ways to reach more people in your community, aid in the development of a culturally competent program, and increase your provider's effectiveness by addressing the needs of the community. There is no magic formula to determine how many stakeholders should be included. However, keep in mind that larger groups (more than nine) may take longer to reach decisions than smaller groups.

Exhibit 3.1 provides examples of potential stakeholders for your non-clinical HIV TLC program and their information needs.

Exhibit 3.1. Examples of Stakeholders for Non-Clinical HIV TLC and Their Information Needs

Internal Examples	Information Needs
• Staff or others who provide the following tasks or activities: ▪ Client recruitment ▪ HIV testing ▪ Risk reduction information ▪ Linkage to medical and prevention services ▪ Data entry ▪ Data management and analysis ▪ Quality assurance ▪ Supervision of staff ▪ Management of program	• Stakeholders may need information to do the following: ▪ Manage and improve programs by comparing program plans with information on how the program is working ▪ Inform capacity building plans and activities ▪ Make decisions about the future direction of the program ▪ Guide and enhance service delivery and performance
External Examples	**Information Needs**
• Representatives of the target population/community • Clients of your program • Other health departments or CBOs • Health and human services providers ▪ HIV medical care providers ▪ Case managers ▪ Physicians ▪ Laboratories • Community advocates and others • Funders	• Stakeholders may need information to do the following: ▪ Communicate program successes and challenges ▪ Gain additional resources ▪ Be accountable to clients, donors, and other stakeholders ▪ Identify best practices and lessons learned ▪ Report to policymakers

Exercise 1. Identifying Stakeholders

As discussed in this chapter, stakeholders are a critical part of M&E. The following tool will help you inventory the internal and external stakeholders you will involve in M&E activities. Creating a roster of stakeholders will also help to ensure that you have varied perspectives represented in your stakeholder group.

Tools and Templates: Tool 1—Stakeholder Identification Table

The following tool will help you identify internal and external stakeholders to involve in M&E activities. Remember all M&E programs are different, and you should identify the group that meets your local needs.

Instructions for Completing Tool 1. Stakeholder Identification Table

What is the purpose of this tool? This tool can help you catalogue individuals within your agency and the community you serve who can contribute to your M&E plan and who will benefit from M&E findings. You may also choose to involve the persons or groups identified in this tool in your agency's advisory board or HIV prevention planning group.

Who should complete this tool? You may choose to complete this tool for each program or for each non-clinical HIV TLC setting/venue. In each case, involve those persons who are familiar with the program, such as managers and coordinators, when identifying stakeholders.

When should this tool be completed? Complete this tool at the beginning of your M&E process, each time you revise your M&E plan, whenever there are changes, or as a means to creating and updating an advisory board. You may choose to do this yearly or more frequently if needed.

How should this tool be completed? Use the questions provided in the left column to start identifying stakeholders for the program. You may modify the table to list as many stakeholders as you think of for each question. Record the following in each of the designated cells:

- **Stakeholder's Position or Group:** Record the stakeholder group or individual stakeholder position. If you have identified an organization or a group as a stakeholder, be sure to specify one individual that can represent that group.
- **Internal or External:** Record whether this individual works within your agency or is a part of the community.
- **Information Needs:** Record the information that will benefit the stakeholder or that the stakeholder is specifically requesting.
- **Concerns or Anticipated Challenges:** Record any concerns or challenges you may have with communicating, engaging, or sharing findings with this stakeholder.
- **Stakeholder Name and Contact Information:** Record the name, e-mail address, phone number, and any other contact information that will help you maintain contact with this stakeholder.

Tool 1. Stakeholder Identification Table

Example:

Questions	Stakeholder(s) Position or Group	Internal or External?	Information Needs	Concerns or Anticipated Challenges	Stakeholder Name and Contact Information
Who is managing the program?	**Example:** Program coordinator	Internal	Information to improve HIV testing delivery, enhance data quality, inform staff training, and development plans	None	Sally Jones, sjones@emailcarrier.com (512) 555-1234

Questions	Stakeholder(s) Position or Group	Internal or External?	Information Needs	Concerns or Anticipated Challenges	Stakeholder Name and Contact Information
Who is managing the program?					
Who is collecting or analyzing data?					
Who represents the populations you serve?					

Tool 1. Stakeholder Identification Table (Continued)

Questions	Stakeholder(s) Position or Group	Internal or External?	Information Needs	Concerns or Anticipated Challenges	Stakeholder Name and Contact Information
Who represents your priority groups and/or your advisory board?					
Who can serve (is serving) as a champion for your program in the community?					
Who will use the evaluation findings? Who receives submitted data?					
Who relies on the information for make program changes?					

Engaging Stakeholders in the Monitoring and Evaluation Process

Just as stakeholders come from varied backgrounds and have different interests around program M&E, they may also participate in the M&E process in different ways. It is important to think about how and when each stakeholder will be involved in the M&E activities at your agency. While some stakeholders will only be involved intermittently, others may participate at various points and at various times throughout the M&E process. An initial stakeholder's meeting can help develop a shared vision for your program, as well as obtain buy-in. It can allow you to determine each stakeholder's

- information needs or desired outcomes,
- understanding of M&E,
- interest in M&E and its results,
- concerns around M&E and/or the HIV testing program,
- availability or willingness to participate throughout the M&E process,
- desired roles and responsibilities around M&E,
- preferred communication methods to obtain feedback and input.

Time Saver

Create a communication plan that details how and when you will involve stakeholders in the course of M&E to save time and retain their involvement throughout the process.

It is important to remember that internal staff members are valuable stakeholders and they have different levels of experience, expertise, and understanding of M&E. Internal stakeholders are likely to be involved in activities throughout the M&E process. Depending on your agency's capacity, you may have individuals who have multiple responsibilities. The following are types of roles that are important to have represented on your M&E team for HIV testing and linkage in non-clinical settings:

- **HIV testing and linkage** staff who conduct HIV testing and linkage activities, collect information about the services provided to clients, and document important referrals and linkage to medical care.
- **Data entry** staff who collect data from HIV testing staff and enter these data in a database.
- **Supervisors** who provide supervision to line staff to ensure program fidelity, quality assurance, and program improvement.
- **Program managers** who assist in the implementation of the evaluation plan and use data for program planning, improvement, and reporting.

To build support for M&E activities, you may have to address concerns around the perceived impacts of M&E activities from staff. These may include increased workloads or weaknesses in

evaluation knowledge or skills. Regular communication with internal stakeholders can help you alleviate these concerns.

In some cases, agency staff may not have the capacity to perform or lead M&E activities. To address this, agencies may check with a local university or other community partner to obtain an M&E consultant. Often agencies can obtain evaluation expertise at low or no-cost through agreements with local universities or other organizations that can provide volunteer graduate students or evaluation professionals. Consultants can provide valuable skills and support for your M&E activities. To increase success, consultants should be aware of the goals and objectives of your M&E activities, the input received from stakeholders, and any existing evaluation plan.

Tip

There are many resources available for agencies to increase capacity for M&E activities at little or no cost. Information and links to these resources are available in Appendix B of this guide.

Jacob Dougherty of Diverse and Resilient, Inc. describes the centralized M&E approach his agency uses for M&E activities and contrasts it with a diffused approach used by other agencies in the field example to follow.

Based on different levels of capacity, staff resources, and need, there are many different models for monitoring and evaluating programs at community-based organizations. In many cases, however, the different M&E methods can be broken down into two broad categories: a centralized M&E model and a diffused M&E model.

In the centralized model, such as the one we have at Diverse and Resilient, most M&E activities are performed by a designated staff member or a team at the agency. Program staff members still do most of the data collection; but after collection is complete, any data collected are submitted to the designated data staff who then do data entry, reporting, and any other M&E activities. This allows M&E activities to be done in a consistent manner and usually results in more efficient data entry and reporting and ideally greater quality management. However, many CBOs do not have the resources to dedicate a full-time staff person to data and M&E activities.

Other agencies use the diffuse model to perform M&E activities. In this model, program staff members perform data collection, entry, and most other M&E activities for their own programs. Staff who manage a program know their programs best, so giving them responsibility for M&E activities makes sense. However, this could also result in inconsistent reporting among different programs and may require greater attention to quality management.

Jacob Dougherty
Data Manager
Diverse and Resilient, Inc.
Milwaukee, WI

Exercise 2. Building an M&E Team and Planning for M&E

As discussed in this chapter, M&E benefits from the involvement and perspectives of many people and organizations. The following tool will help you prepare for M&E activities in your agency. Completing the preparation activities will help you develop a realistic evaluation plan and ensure that there are outlined timelines and mechanisms for M&E activities.

Tools and Templates: Tool 2—M&E Preparation Work Plan

The work plan template that follows will help you design a plan to prepare your agency for M&E. It will help you identify responsible staff, timeline for completion, and potential challenges for each activity.

An agency can benefit from monitoring and evaluation, even when an M&E plan is not fully fleshed out. Just start. By using an iterative M&E process, as components of an M&E plan are completed, they can be incorporated later.

Benjamin Tsoi
Director of HIV Testing
Bureau of HIV/AIDS Prevention and Control
New York City Department of Health and Mental Hygiene

Instructions for Completing Tool 2. Monitoring and Evaluation Preparation Work Plan

What is the purpose of this tool? This tool can help you document individuals within your agency who will complete M&E activities, create a timeline for those activities, as well as predict challenges and determine strategies to address those challenges.

Who should complete this tool? Consider completing this inventory as a group activity at your agency so that you can immediately identify responsible parties and clarify roles and responsibilities for M&E activities. You may choose to involve the executive director, program managers or coordinators, grant writers, HIV testing and linkage staff, and others as necessary.

When should this tool be completed? Complete this tool in the beginning of your M&E process after you have completed Tool 1 in this toolkit. Revisit it each time you review your M&E plan or if there are significant staff changes. This may be yearly or more frequently if necessary.

How should this tool be completed? To complete this work plan, begin by indicating a person(s) to be responsible for each activity. You may choose to identify a staff role instead of a particular individual. Next, set a realistic timeline by which the task should be complete. In the third column, list any challenges that may delay the completion of the activity. Finally, consider strategies that will address any challenges you document.

Example:

Activity	Responsible Person(s)	Timeline	Challenges	Strategies to Address Identified Challenges
Contact internal stakeholders, program staff, and senior leaders who will participate in M&E activities.	Program manager	Within 4 weeks.	Many of the agency's senior leaders are out of the office over the next month, and it may be difficult to solidify commitments from this group.	The program manager will use multiple methods of communication to reach out to internal stakeholders, and will provide both digital and print-based options for documenting commitment to participate in M&E activities.

Tool 2. Monitoring and Evaluation Preparation Work Plan

Activity	Responsible Person(s)	Timeline	Challenges	Strategies to Address Identified Challenges
Developing a Shared Understanding *				
Contact internal stakeholders, program staff, and senior leaders who will participate in M&E activities.				
Contact external stakeholders such as clients, providers, and community members who will participate in M&E activities.				
Share the purpose and goals of M&E with program staff and senior leaders.				
Obtain input and feedback from program staff and senior leaders regarding M&E activities.				
Share the purpose and goals of M&E with external stakeholders.				
Obtain input and feedback from external stakeholders regarding M&E activities.				

*Reference the list of stakeholders you identified in Tool 1 when completing this section.

Tool 2. Monitoring and Evaluation Preparation Work Plan (continued)

Activity	Responsible Person(s)	Timeline	Challenges	Strategies to Address Identified Challenges
Staffing an M&E Team				
Identify an M&E coordinator or M&E team lead.				
Identify individuals for the following M&E activities:				
Engaging internal and external stakeholders				
Constructing an M&E plan including documenting practices and completing the M&E toolkit				
Data collection				
Data entry and management				
Data analysis				
Data quality assurance				
Documentation and distribution of findings				
Communicate M&E team roles and responsibilities with program staff and senior leaders.				
Orient and train program staff for their role and responsibilities.				
Orient and train program staff to use data collection tools accurately.				
Orient and train program staff to collect, enter, and manage data accurately.				

Tool 2. Monitoring and Evaluation Preparation Work Plan (continued)

Activity	Responsible Person(s)	Timeline	Challenges	Strategies to Address Identified Challenges
Staffing an M&E Team				
Orient and train program staff on data collection practices.				
Orient and train program staff on data reporting requirements.				
Obtain input/feedback from program staff on the importance and processes for data QA.				
Provide training and technical assistance on data collection, entry, management, and application (when applicable).				
Obtaining or Creating Materials				
Inventory M&E training materials, reference, or guidance documents and save in a central location for ongoing access.				
Obtain supplies for the M&E team.				
Obtain technology for the M&E team (i.e., computers, software, data collection and management system, data analysis tools).				
Make adaptations or develop data collection tools, when applicable.				
Perform the document review process on all materials before distribution.				
Obtain technology (i.e., data collection software or devices), when applicable.				

Tool 2. Monitoring and Evaluation Preparation Work Plan (continued)

Activity	Responsible Person(s)	Timeline	Challenges	Strategies to Address Identified Challenges
Establish Structure and Operations				
Plan and document regular communication methods (i.e., e-mail, meetings) between program staff and M&E team.				
Plan and document regular communication methods (i.e., e-mail, meetings) between the M&E team and external stakeholders.				
Plan and document ways to incorporate data and M&E findings in the agency's decision-making process.				

Exercise 3. Documenting Existing Agency Resources for M&E

M&E requires many different types of resources and participants. The following activity will help you in creating an inventory of your existing assets for conducting M&E on the basis of the plan you drafted in Tool 2.

Tools and Templates: Tool 3—Monitoring and Evaluation Organizational Capacity Checklist
The checklist that follows can help you assess your agency's current capacity to conduct M&E activities. It will help you identify the resources that are available to you now, may be available in the future, or areas where you need additional assistance.

Neena Smith-Bankhead of AID Atlanta, Inc. discusses in the text box below how her agency benefits from volunteers in bolstering their capacity to implement, monitor, and evaluate their HIV prevention programs.

Many times when a CBO is large, there is an assumption made that the agency has either a lot of additional resources, or already has all of the expertise needed to provide the services required to effectively implement, evaluate, and manage programs. As this may be the case in some situations, in others it may not. Large CBOs sometimes have many of the same challenges with finding the capacity to provide certain services as smaller agencies; the need may just be on a larger scale. A benefit that larger agencies may have is that by having a greater presence in the community, there may have additional opportunities to attract those who bring their expertise into the agency.

Much of our expertise comes from engaging the community in the challenges that we face, and allowing them to come in and provide support, their expertise and knowledge, and experience within our agency; most of which is provided for FREE. Having a large volunteer program has been the most helpful in allowing us to have the capacity to meet our goals, including staffing large HIV testing events, analyzing program data, managing program data, and assessing the needs of our target populations, among other agency needs. Bigger agencies have to work as hard as smaller agencies to find the capacity to provide the services necessary to maintain program activities.

Neena Smith-Bankhead
Director, Department of Education and Volunteer Services
AID Atlanta, Inc.
Atlanta, GA

Instructions for Completing Tool 3. Monitoring and Evaluation Organizational Capacity Inventory

What is the purpose of this tool? This tool will help you inventory the M&E-related resources you have available immediately, those that will be available in the future, and any gaps that may need to be filled for your non-clinical HIV TLC program.

Who should complete this tool? Within an agency, you may have different contacts for program, budget, technical, and training questions. For this reason, consider completing this inventory as a group activity. You may choose to involve the executive director, program manager or coordinator, grant writers, HIV testing and linkage staff, and others as necessary.

When should this tool be completed? Complete this tool at the beginning of your M&E process or each time you revise your M&E plan. You may choose to do this yearly or more frequently if needed.

How should this tool be completed? To complete this checklist, indicate by checking the appropriate box whether the resource is available now, whether it will be available in the future, or if you need additional support from internal or external partners to obtain that resource. For example, do you have immediately available staff, will staff be available in the near future, or do you need to request additional staff from the agency or a community partner? Record any anticipated challenges to obtaining or implementing each resource in the far right box.

Example:

Resource	Available Now	Will be Available in the Future	Need Additional Support	Anticipated Challenges
Available staff with technical knowledge (i.e., agency staff, contractors or consultants, volunteers)	☐	☒	☐	Among our agency staff, no one has both the time and expertise to conduct thorough monitoring and evaluation of our HIV testing in non-clinical settings, but we will be reaching out to a local University to partner with a graduate student who has the time and expertise to dedicate to these tasks. This partner is expected to join the team next semester.

Tool 3: Monitoring and Evaluation Organizational Capacity Inventory

Resource	Available Now	Will be Available in the Future	Need Additional Support	Anticipated Challenges
Available staff with technical knowledge (i.e., agency staff, contractors or consultants, volunteers)	☐	☐	☐	
Funding	☐	☐	☐	
Materials (i.e., office supplies and equipment)	☐	☐	☐	
Technology (i.e., computers, analysis software, data management system, geographic information system)	☐	☐	☐	
Reference Tools (i.e., M&E and data collection training materials, evaluation guides, programmatic guidelines)	☐	☐	☐	
Data collection requirements	☐	☐	☐	
Existing data resources (i.e., surveillance, M&E, and others as appropriate)	☐	☐	☐	
Available trainings (i.e., data collection, data entry, HIV testing)	☐	☐	☐	

Step 2. Describe the Program

The second step in CDC's Framework for Program Evaluation, describing the program, is an essential part of your M&E plan. M&E plans document the strategies and specific activities that you will implement to achieve your program's goals and objectives. It will also help you maximize your program's impact toward local and national HIV/AIDS prevention efforts. Once identified, key internal and external stakeholders should be involved in developing a comprehensive program description of the components and intended outcomes. This thorough description will help ensure that program staff, evaluators, and other stakeholders understand what the program entails and how it seeks to achieve its goals and objectives.

In this section we will discuss identifying and articulating your non-clinical HIV TLC program goals, objectives, and activities for M&E planning. One way to do this is through the development of a logic model. We will walk you through how to develop a logic model, as well as provide a tool to assist you in crafting your M&E questions and measures from your described program objectives. If you already have well-established program goals and objectives and a thorough program description, you can use Step 2 to review these descriptions with your stakeholders. If you do not have a well-articulated program description, the tools in Step 2 will help you to develop one while engaging your stakeholders in the process.

Writing a Program Description

Key stakeholders should thoroughly understand your non-clinical HIV TLC program elements, how the program was originally planned, and how the program is being implemented. A comprehensive program description includes the following components:

- **Problem statement:** The problem your program was designed to solve.
- **Goal:** A broad statement about what the program expects to achieve.
- **Objectives:** Specific, measurable statements that describe how the program will achieve its goal.
- **Activities:** The key programs/events you will implement to achieve your goal and objectives (e.g., train staff on HIV testing procedures).
- **Inputs:** The resources you have available to implement the activities (e.g., HIV testing kits, funding).
- **Outputs:** The direct products of your program activities (e.g., printed educational material to encourage HIV testing).
- **Outcomes**: The intended changes you seek to achieve through your program activities (e.g., increase in the number of people being tested for HIV).
- **Impacts:** The long-term results of one or more programs over time (e.g., changes in HIV infection rates, morbidity, and mortality).
- **Logic model:** A tool that visually depicts how the different parts of the program will work together to achieve the purpose of the program.

Program Goal and Objectives

A *goal* is a broad statement about the long-term expectation of what should happen as a result of the program. It should state in general terms how to solve the problem that has been identified and often refers to reductions to the spread of HIV-infection and related deaths and improvements to clients' quality of life. An example of a goal for a non-clinical HIV TLC program might be to increase the proportion of high-risk African American men who have sex with men (MSM) who receive an HIV test every 6 months. It is helpful to engage your stakeholders in creating and/or reviewing your goals since, as discussed earlier, stakeholders may have different priorities. For example, funders may be interested in increasing testing or using a particular kind of technology; board members and/or program managers may be interested in effective linkage to care; line staff may be interested in ensuring client satisfaction. These various priorities are important to consider when drafting the overall program goals.

Your program *objectives* are specific steps outlining how the program's stated goal will be met. Whether you have existing program objectives or are developing them now, they should be SMART—an acronym for the characteristics of a good objective. Those that meet the SMART criteria leave no room for confusion or misunderstandings about the program and make it easier to measure program performance. SMART stands for the following:

- **S**pecific: The objective clearly specifies what you want to accomplish.
- **M**easurable: The objective is stated in a way that can measure if the objective is being met.
- **A**chievable: The objective can be attained with a reasonable amount of effort and application.
- **R**ealistic: The objective can be attained, given available resources, timeframes and experience.
- **T**ime-based: The objective specifies when it will be achieved.

Examples of non-SMART and SMART objectives are included in Exhibit 3.2.

Exhibit 3.2. Examples of Non-SMART and SMART Objectives

Non-SMART Objectives	SMART Objectives
The program will test most-at-risk populations for HIV.	By the end of Fiscal Year 2014, 500 African American men who have sex with men in the highest prevalent neighborhoods will be tested for HIV.
The program will return HIV test results to clients.	By the end of Fiscal Year 2014, 90% of clients will have knowledge of their serostatus through receipt of their test result.
The program will link HIV-positive clients to medical care.	By the end of Fiscal Year 2014, 85% of HIV-positive clients will attend their first medical appointment within 45 days of a positive result.

Your agency may also choose to craft SMART objectives that take into consideration where your agency is starting from with specific activities (e.g., a baseline) and where you would like

to go within the timeframe of the objective (e.g., a target). Stating your objectives in this way will provide a roadmap for your program to follow. We discuss considerations for establishing baselines and developing targets in Step 3.

In the example provided below, Jon Stockton of the Washington State Department of Health discusses the steps they use in his jurisdiction to assist contract agencies in drafting SMART objectives and aligning the objectives with measures of success.

Washington State's Department of Health has created a Planning, Implementing, and Evaluating Interventions guide for contractors to use when submitting prevention plans. The guide includes how to write SMART objectives for adequately evaluating interventions. Below contains the text from the guide on SMART objectives:

To adequately evaluate your intervention, the desired outcome objectives must be written in evaluable terms. Using a completed logic model, an agency will find writing outcome objectives a relatively simple process. Outcome objective should be written in the "SMART" framework.

- ***S**pecific: Does the objective clearly specify what will be accomplished and by how much?*
- ***M**easurable: Is the objective measurable?*
- ***A**ppropriate: Does the objective make sense in terms of what the intervention is trying to accomplish?*
- ***R**ealistic: Is the objective achievable given available resources and experience?*
- ***T**ime-based: Does the objective specify when it will be achieved?*

What are the steps in writing a SMART objective?

- *Write down a verb that corresponds to the best practice activity you want to do.*
- *Write down exactly what it is you will measure (e.g., time, number of sessions).*
- *Write down the target (or specific) populations you want to work with (e.g., white MSM ages 18 to 24.)*
- *Write down the baseline information. This information comes from existing data (surveillance).*
- *Write down what best practice activities your program has selected to do as an intervention.*
- *Write down the timeframe that you want to accomplish this objective.*

The following table uses the logic model written for the injecting drug user (IDU) population and provides: measurable outcome, measures of success, and where this information can be obtained.

Logic Model Outcome	SMART Outcome	Measures of Success	Data Source
Condom use will increase among IDUs with main and casual sex partner(s).	*By December 31, 2013, increase from 10% to 40% the number of clients who use condoms with main and casual sex partner(s).*	*The number of clients, among all clients served, who self-report using condoms with all sexual partners will increase.*	*Questionnaire, survey, and post-intervention individual assessment.*
Norms and attitudes among the IDU community will change to support safer infection sex practices.	*By December 31, 2013, increase from 30% to 60% the number of IDUs who practice safer sex injection activities.*	*The number of clients, among all clients served, changing from risky to safer sex and injecting practices will increase.*	*Survey, questionnaire, and client interviews.*
Referral confirmed linkage will increase.	*By December 31, 2013, increase from 15% to 40% the number of clients who attend the first appointment to any referred service.*	*The number of clients, among all clients referred, who follow through with referral appointments will increase.*	*Client journals and client-based tracking system.*

Jon Stockton
HIV Counseling and Testing Coordinator
Washington State Department of Health

Exercise 4. Developing SMART Program Objectives

The following tool is to help you develop or review your program objectives and determine if they are SMART.

Tools and Templates: Tool 4—SMART Program Objectives Worksheet

When you are reviewing your program and developing a comprehensive program description, you can use this tool to help you and your stakeholders ensure your program objectives are SMART.

Instructions for Completing Tool 4: SMART Program Objectives Worksheet

What is the purpose of this tool? This tool can be used to document each of your non-clinical HIV TLC program objectives and identify whether they related to process or outcome M&E and if they are SMART. If you already have specified program objectives (e.g., stated your program plan or other program document), you may use this worksheet to determine if the objectives are SMART. If you have not prepared program objectives, you may use this worksheet to draft them.

Who should complete this tool? Non-Clinical HIV TLC program staff, such as managers and coordinators, may choose to complete this tool on their own and then share with interested parties, including grant writers, funders, and HIV testing and linkage staff.

When should this tool be completed? This tool may be completed at the beginning of each program year and revisited, as necessary, to add or edit program objectives.

How should this tool be completed? To complete the tool, begin by recording any existing program objectives in the second column and indicate whether they are process or outcome items. Next, check the boxes in the third column to determine if each objective meets the SMART criteria. If any of the criteria are not met, use the third column to revise your objective to make it specific, measurable, achievable, realistic, and time-based.

Example:

Program Objective (If Existing)	Process or Outcome?	SMART?	Revised Objective
HIV test results will be returned to clients.	**Process:** ☐ **Outcome:** ☒	**S**pecific: ☐ Yes ☒ No **M**easurable: ☒ Yes ☐ No **A**chievable: ☒ Yes ☐ No **R**ealistic: ☐ Yes ☒ No **T**ime-based: ☐ Yes ☒ No	By the end of Fiscal Year 2014, 90% of clients will have knowledge of their serostatus through receipt of their test result.

Tool 4. SMART Program Objectives Worksheet

Program Objective (If Existing)	Process or Outcome Objective?	SMART?	Revised Objective
	Process: ☐ **Outcome:** ☐	**S**pecific: ☐ Yes ☐ No **M**easurable: ☐ Yes ☐ No **A**chievable: ☐ Yes ☐ No **R**ealistic: ☐ Yes ☐ No **T**ime-based: ☐ Yes ☐ No	
	Process: ☐ **Outcome:** ☐	**S**pecific: ☐ Yes ☐ No **M**easurable: ☐ Yes ☐ No **A**chievable: ☐ Yes ☐ No **R**ealistic: ☐ Yes ☐ No **T**ime-based: ☐ Yes ☐ No	
	Process: ☐ **Outcome:** ☐	**S**pecific: ☐ Yes ☐ No **M**easurable: ☐ Yes ☐ No **A**chievable: ☐ Yes ☐ No **R**ealistic: ☐ Yes ☐ No **T**ime-based: ☐ Yes ☐ No	
	Process: ☐ **Outcome:** ☐	**S**pecific: ☐ Yes ☐ No **M**easurable: ☐ Yes ☐ No **A**chievable: ☐ Yes ☐ No **R**ealistic: ☐ Yes ☐ No **T**ime-based: ☐ Yes ☐ No	

Program Components and Logic Model

Your non-clinical HIV TLC program's core components should be aligned with your stated goal and objectives; that is, your activities, outputs, outcomes, and impacts should be directly related to achieving your program goal and objectives. Being thoughtful and realistic in planning your agency's program increases the likelihood that your prevention activities will reach the intended audiences and achieve desired outcomes. Depicting your program components in a graphic representation, such as a logic model, is a very useful way to illustrate the relationships.

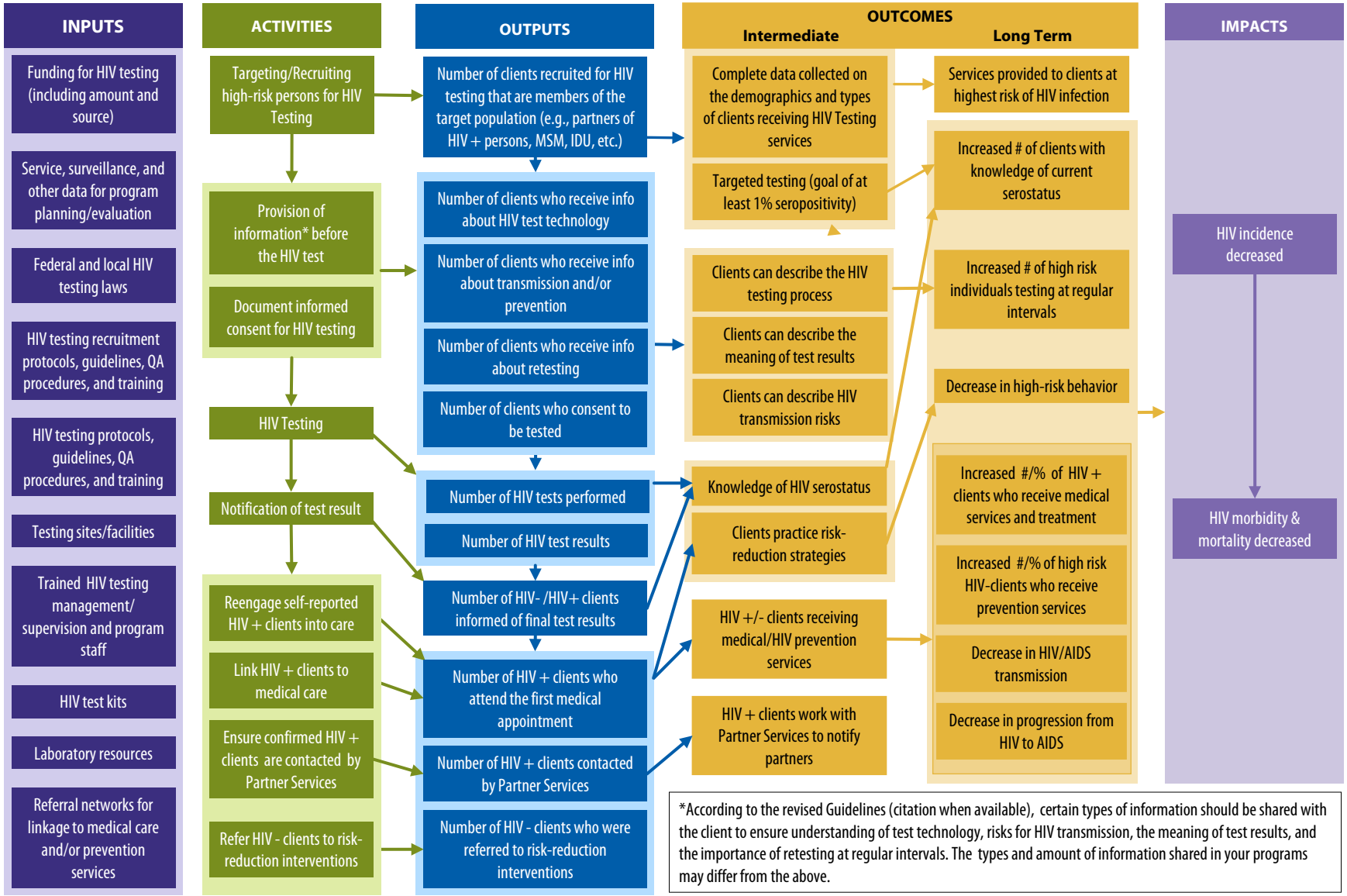
A logic model is often displayed as a flowchart, map, or table to portray the sequence of steps leading to program results and how they relate to one another (i.e., activities must be implemented before outputs are produced; intermediate outcomes must be achieved before long-term outcomes and impacts). A logic model serves as the foundation for M&E because it will describe how the program is intended to operate and how results are to be achieved. Creating a logic model for your non-clinical HIV TLC program will help ensure that your M&E team and additional stakeholders understand all the components of your HIV testing program. Development of a program logic model should be integral to the program planning process, because it can build understanding and clarity among program staff and stakeholders. The involvement of stakeholders in constructing or reviewing your logic model can promote a shared vision and ownership of your non-clinical HIV TLC program plan, clarify expectations of results, and foster buy-in for an evaluation.

An example of a logic model in Figure 3.1 illustrates possible priorities and components for a non-clinical HIV TLC program. This model is for illustrative purposes, however, it may be a helpful starting place if you do not yet have a logic model for your non-clinical HIV TLC program. If you do use this as a starting place, remember to tailor the model to reflect your program's target population, as well as your program activities and intended outcomes. For example, your agency may focus on commercial sex workers in high prevalence ZIP codes. During your formative evaluation with this target population, you discovered that condom use was not consistent with "main" or "regular" partners, and that these regular partners may be short-lived relationships. Therefore you may want to prioritize HIV testing as a means to link this population with a particular intervention or program, perhaps delivered by a partner agency that supports commercial sex workers in building knowledge/skills for regular condom use with main or regular partners. Building in these activities and connections to your logic model will serve to visually outline how all the components of your program work together to achieve your intended results.

For additional information on how formative evaluation activities can assist in planning your non-clinical HIV TLC program, review Chapter 2: Formative Evaluation and Implementation Planning in the Implementation Guide.

Figure 3.1. HIV Testing and Linkage to Care in Non-Clinical Settings Logic Model

Problem Statement: An estimated 56,300 new HIV infections occur in the United States, each year. Available evidence suggests that the majority of new infections are caused by persons unaware of their HIV infection, and an estimated one-quarter of those who are infected with HIV do not know they are infected. CDC's Revised Guidelines for HIV Testing in Nonclinical Settings emphasize targeting high risk populations, utilizing testing algorithms, and linking HIV-positive and HIV-negative persons to medical care and/or prevention interventions.



Steps to Constructing Your Logic Model

It is important to remember that stakeholders should be involved in the development or modifications to your logic model. It may take time to engage stakeholders and construct a logic model on which everyone can agree. To increase effectiveness, allow yourself enough time to develop a draft, request feedback from stakeholders, and revise it accordingly. Stakeholders can help you do the following:

- Target specific populations or recruit for HIV prevention activities
- Identify and describe priority prevention and service needs of specific populations
- Identify particular services or partner agencies to which you link your clients

The following activities are recommended when convening program staff and other stakeholders in constructing a logic model:

1. Revisit the problem your non-clinical HIV TLC program was implemented to address, the goal of your program, and the program objectives (see the section on formative evaluation in chapter 2 of the Implementation Guide for assistance in identifying the goals of your program and the various program components).
2. Describe the components of the program (inputs, activities, outputs, short-term outcomes, long-term outcomes).
3. Discuss how the program components are related (e.g., Which input is necessary to carry out a certain activity? Which activities and outputs correspond?).
4. Depict the program component relationships identified by program staff and stakeholders in a logic model.
5. Review the logic model to make sure it depicts the understanding of the program. Ask stakeholders for feedback and make any needed revisions.
6. Share the final copy with all stakeholders.

In the text box to follow, Jacob Dougherty of Diverse and Resilient, Inc. discusses the value of revisiting programs that did not have SMART objectives or logic models.

My agency recently realized in examining our HIV-related programs that some programs that have been going on for many years did not have SMART objectives or a logic model in place, making it difficult to truly monitor the success of the program.

We set about writing or updating logic models for all of our programs, and started the process by having a staff meeting in which the executive director explained the process of writing logic models, and staff in attendance brainstormed some ideas. Then each program manager met individually with stakeholders for their specific programs to brainstorm what should be included in the program's logic model. Finally, the draft logic models were sent for final review to the stakeholders before being implemented.

Jacob Dougherty
Data Manager
Diverse and Resilient, Inc.
Milwaukee, WI

Exercise 5. Listing the Components of Your HIV Program and Constructing a Logic Model

Taking the time to list the components of your non-clinical HIV TLC program will help you think about how you can build a program logic model. Tool 5 will help you catalog the inputs, activities, outputs, outcomes, and impacts that you desire for your program. Tool 6 is the Logic Model Template. This template will allow you to insert your program components into the logic model.


Tools and Templates: Tool 5—Program Components Table

Use this tool to document the inputs, activities, outputs, and outcomes of your program.


Tools and Templates: Tool 6—Logic Model Template

Use the Logic Model Template to insert your identified program components into a logic model.

Instructions for Completing Tool 5. Program Components Table

What is the purpose of this tool? Use this tool to identify all the components of your program (input, activity, output, short-term outcome, long-term outcome) before constructing the logic model.

Who should complete this tool? You may choose to complete this table individually or as a group activity. Your agency may choose to have program managers complete a logic model for each program they oversee and/or have your executive director complete a comprehensive logic model for all prevention efforts.

When should this tool be completed? Complete this table each time a logic model is drafted or revised. Revisit this tool on a regular basis—for example, when completing yearly program planning activities.

How should this tool be completed? Begin to complete this tool by considering all of the elements that are necessary for your agency to meet its SMART program objectives (Tool 4). Use the right column to specify all program elements that fall under each category. An example is provided.

Example:

Component	Example Program Component
Inputs	• Staff • Funding • HIV test kits • Testing procedures
Activities	• Recruitment • HIV testing • Linkage to services
Outputs	• Number of clients recruited • Number clients tested • Number of clients linked to services
Outcomes	• Increased client knowledge of HIV status • Increased client access to prevention, care, support, and treatment resources
Impacts	• Decreased HIV transmission rates • Decreased HIV incidence • Decreased HIV morbidity and mortality

Tool 5. Program Components Table

Component	Program Component
Inputs	
Activities	
Outputs	
Outcomes	
Impacts	

Instructions for Completing Tool 6. Logic Model Template

What is the purpose of this tool? This tool will help you create a logic model. Completing a logic model will help you document the components of your program, the desired outcomes and impacts, and how they relate to one another. Using this program illustration can help you talk about the program's purpose and potential impacts with agency staff and community members.

Who should complete this tool? You may choose to complete this table individually or as a group activity. Your agency may choose to have program managers complete a logic model for each program they oversee and/or have your executive director complete a comprehensive logic model for all prevention efforts.

When should this tool be completed? You may choose to complete a program logic model at the start of the program year and revise at least once a year to reflect changes in program inputs, activities, or desired outcomes.

How should this tool be completed? Refer back to Tool 5: Program Components Table and use the following template to insert your program components into the logic model. If you have more items to list under a heading, the template allows you to add more boxes as necessary. **Be sure to use arrows to show how each component is related.** When you are finished, review the logic model with all stakeholders and make sure that the relationships you identified and the progression from inputs to activities to outputs to outcomes make sense and are feasible. If you feel that you have missed a few components, you can go back and insert them.

Tool 6. Logic Model Template

Problem Statement:

Inputs	Activities	Outputs	Intermediate Outcomes	Long-Term Outcomes	Impacts

Step 3. Focus the Evaluation Design

After describing your program and your agency's desired results in a logic model, you will next need to determine how you will gauge the progress of your non-clinical HIV TLC program. The third step in CDC's Framework for Program Evaluation, focusing the evaluation design, will help you determine the non-clinical HIV TLC program elements which are most important to monitor and evaluate for your agency. Once you have decided which program components to monitor and evaluate, you will focus data collection on these program components. Data collection is discussed in detail in Step 4: Gathering Credible Evidence.

To assist you in determining your agency's key M&E questions, you will need to review your program goals and SMART objectives (as discussed in the prior step). One tool you may wish to use to help document the connections between your activities, SMART objectives, aligned monitoring questions, and measures and targets is the M&E Worksheet for HIV Testing and Linkage in Non-Clinical Settings (Exhibit 3.3). This exhibit also is presented as Tool 8 at the end of this chapter. The first column of the worksheet contains the activities from your program logic model. When completing this worksheet, you should complete the worksheet for all listed activities. By doing this, you will have a blueprint for your program and can review all activities to determine your objectives and targets. This will help you track your activities, as well as help determine which activities are of highest priority for M&E.

For the purposes of this evaluation guide, we list the two activities of (1) notifying clients of their HIV test results and (2) linking HIV-positive clients to medical care from the HIV Testing and Linkage in Non-Clinical Settings Logic Model. The second column of this table, SMART objectives, are a way to outline your expectations for program performance for the stated activity. For these two activities, example SMART objectives follow:

- By the end of Fiscal Year 2014, 90% of clients will have knowledge of their serostatus through receipt of their test result.
- By the end of Fiscal Year 2014, 85% of HIV-positive clients will attend their first medical appointment within 30 days of a positive result.

Exhibit 3.3. M&E Worksheet for HIV Testing and Linkage in Non-Clinical Settings

Evaluation Question(s):				
HIV Testing and Linkage Key Program Activities	**Aligned SMART Objectives**	**Monitoring Questions**	**Measures to Address Monitoring Question and Objective**	**Targets**
Notification of test result	By the end of Fiscal Year 2014, 90% of clients will have knowledge of their serostatus through receipt of their test result.			
Link HIV + clients to medical care	By the end of Fiscal Year 2014, 85% of HIV-positive clients will attend their first medical care appointment within 30 days of a positive result.			

Focusing Your Monitoring and Evaluation Activities

Once you have populated your M&E worksheet with your HIV testing and linkage program activities and associated SMART objectives, you are ready to determine what type of evaluation to conduct. As discussed in Chapter 2, there are two kinds of program M&E we are focusing on for this guide: Process and Outcome.

Process monitoring and evaluation help you look at your non-clinical HIV TLC program's implementation in two ways. For example:

- Process monitoring asks: How are we delivering program activities and who are we reaching?
- Process evaluation asks: Are we doing what we planned and are there ways to be more effective?

While outcome monitoring and evaluation help you determine if your non-clinical HIV TLC program is having its intended effect in two ways:

- Outcome monitoring asks: Are we meeting our goals and objectives?
- Outcome evaluation asks: Are our program activities making a measurable impact on clients and the community?

The selection of the type of M&E your agency will conduct (process or outcome), depends on the activities you select to monitor and evaluate. Those decisions should be based on stakeholders' information needs, how stakeholders will use results, and available resources.

In Step 1, you identified the stakeholders who will be the primary users of the evaluation findings. Because it is important to know why stakeholders are interested in conducting an evaluation and how they will use the results, they should discuss their expectations and needs (e.g., What aspect of the program am I most interested in? How can I use the evaluation results?). An HIV testing supervisor, for example, might expect that an evaluation of the implementation of non-clinical HIV TLC program would provide feedback on whether staff are providing quality testing services (process evaluation). The evaluation might be used to improve the quality of testing sessions. In that example, the supervisor would want to focus the evaluation on one activity within the logic model: conduct HIV testing.

Evaluation findings can also be used to decide how to allocate resources, to decide whether to expand the locations where a program activity is carried out, to document the level of success in achieving objectives, to target other populations, to solicit more funds, and to make policy changes.

Once program staff and stakeholders have identified their expectations, you will need to prioritize the various uses of the evaluation. Resource requirements and availability will play a role in prioritizing uses and focusing the evaluation.

The use of evaluation findings will determine when results are needed and, subsequently, the level of effort needed to produce timely results. For instance, if you plan to conduct a process evaluation of a relatively new non-clinical HIV TLC activity, you will want to generate evaluation results early in implementation to improve the activity. Evaluations that need to produce results in a shorter timeframe or that need to collect detailed data from numerous sources may require more staff time and may take staff away from program implementation. You also need to consider whether sufficient funding is available to carry out an evaluation. If you need to seek external funding, you may need additional time to produce evaluation results.

Developing Monitoring and Evaluation Questions

Once you have determined with your stakeholders the type of M&E you will conduct, you will need to craft your M&E questions. In this section, we will discuss the development of monitoring and evaluation questions and how they align with SMART objectives.

As with any part of the M&E process, it is important to involve your stakeholders in the development of monitoring and evaluation questions to help you determine the priorities to address. Often agencies are faced with reduced resources and it is important to determine which M&E activities are most important to the agency and its stakeholders. By documenting your program's logic model and defining your SMART objectives, you have already identified many of the elements you want to monitor and evaluate. Evaluation questions help you look

at your program's overall effect, while monitoring questions provide data to help you answer the evaluation questions.

Process Monitoring and Evaluation Questions

Process M&E questions help you look at various areas of program implementation, including the activities provided and the populations reached. These questions relate to the activities and outputs in your program logic model and your SMART process objectives. Process evaluation may be conducted periodically throughout the life of a program. For example, Exhibit 3.4 illustrates how a SMART objective relates to a process monitoring and evaluation question.

Exhibit 3.4. Mapping a SMART Objective to a Process Monitoring and Evaluation Question

Sample SMART Objective	Process Monitoring Question	Process Evaluation Question
Establishes the intended result.	**Provides data to answer evaluation question.**	**Demonstrates progress toward meeting the intended result.**
By the end of Fiscal Year 2014, 90% of clients will have knowledge of their serostatus through receipt of their test result.	Among all test results, how many were provided to persons who received HIV testing?	To what extent are test results being provided to clients who received HIV testing?

The following process M&E example questions developed for this guide may be tailored to reflect your non-clinical HIV TLC program, its objectives, and your local program M&E needs:

Example Process Monitoring Questions

- How many clients tested for HIV were members of the target population?
- Of those persons provided with an HIV test, how many were provided with information on the HIV testing?
- Among all test results, how many were provided to persons who received HIV testing?
- Among persons who tested positive for HIV, how many were referred to medical care?
- Among persons who tested positive for HIV and were referred to medical care, how many attended their first medical appointment?
- Among persons who test positive for HIV, how many were referred to/or contacted by Partner Services for assistance in notifying partners?
- Among persons who tested negative for HIV, how many were referred to prevention interventions?

Example Process Evaluation Questions

- How effectively is the program identifying high-risk persons for HIV testing? What could be done differently to reach high-risk persons for HIV testing?
- To what extent are test results being provided to clients who received HIV testing?

Outcome Monitoring and Evaluation Questions

Outcome M&E questions address the level of achievement in the outcomes listed in your logic model. For example, Exhibit 3.5 illustrates how a SMART objective relates to an outcome monitoring and question.

Exhibit 3.5 Mapping a SMART Objective to an Outcome Monitoring and Evaluation Question

Sample SMART Objective	Outcome Monitoring Question	Outcome Evaluation Question
Establishes the intended result.	**Provides data to answer evaluation question.**	**Demonstrates progress toward meeting the intended result.**
By the end of Fiscal Year 2014, 85% of HIV-positive clients will attend their first medical appointment within 30 days of a positive result.	What percentage of persons testing HIV positive who are referred to medical care attend their first medical appointment?	To what extent is the program linking HIV-positive individuals to medical care?

The following outcome M&E example questions developed for this guide can be tailored to reflect your non-clinical HIV TLC program, its objectives, and your local M&E needs.

Example Outcome Monitoring Questions

- What proportion of persons tested for HIV provided consent prior to testing?
- What proportion of persons tested for HIV can describe the HIV testing process and the testing technology used?
- What proportion of persons tested for HIV can describe HIV transmission risks and prevention methods?
- What proportion of persons tested for HIV can describe the period during which HIV infection may not be detectable (e.g., acute infection)?
- What proportion of persons tested for HIV can describe the benefits to testing and retesting for HIV?
- What proportion of persons who receive HIV test results can report their serostatus?
- What proportion of persons testing for HIV has been tested previously?
- What proportion of persons who are HIV positive and not in care are referred to medical care?
- What proportion of persons testing HIV positive who are referred to medical care attend their first medical appointment?
- What proportion of persons who are high-risk HIV negative and referred to prevention services access prevention services?

Example Outcome Evaluation Questions

- How completely is the program collecting information on client demographics and high-risk behaviors?
  - What factors or practices have an impact on successfully collecting client information?
- To what extent is the program linking HIV-positive individuals to medical care?
  - What factors and/or strategies are associated with the observed proportion of HIV-positive persons linked to medical care?
- To what extent is the program linking high-risk individuals to prevention services?
  - What factors or practices have an impact on successfully linking high-risk individuals to prevention services?
- How effectively is the program recruiting high-risk individuals?
  - Is the program meeting the target goal of 1% seropositivity?

Revisiting the M&E Worksheet presented earlier (here as Exhibit 3.6), we add the following corresponding M&E questions:

Exhibit 3.6. M&E Worksheet for HIV Testing and Linkage in Non-Clinical Settings

Evaluation Question(s): **1. To what extent are test results being provided to clients who received HIV testing?** **2. To what extent is the program linking HIV-positive individuals to medical care?**				
HIV Testing and Linkage Key Program Activities	**Aligned SMART Objectives**	**Monitoring Questions**	**Measures to Address Monitoring Question and Objective**	**Targets**
Notification of test result	By the end of Fiscal Year 2014, 90% of clients will have knowledge of their serostatus through receipt of their test result.	Among all test results, how many were provided to persons who received HIV testing?		
Link HIV-positive clients to medical care	By the end of FY 2014, 85% of HIV-positive clients will attend their first medical appointment within 30 days of a positive result.	What percentage of persons testing HIV positive who are referred to medical care attend their first medical appointment?		

Prioritizing Monitoring and Evaluation Questions

Once you have documented your M&E questions, you may need to narrow down the number of questions according to the purpose and uses of the evaluation and available resources. The following criteria can help you to determine the importance, utility, and feasibility of each question considered for your program evaluation needs.

A question should be prioritized if it

- is important to your program staff and stakeholders,
- reflects key goals and objectives of the program,
- reflects key elements of the program logic model,
- will provide information stakeholders can act upon to make program improvements,
- can be answered using available resources (e.g., budget, personnel) and within the appropriate timeframe,
- will be supported (in terms of resources needed to answer the question if none are available) by the program.

Questions that do not meet all of the above criteria should be considered lower priority.

Exercise 6. Documenting and Prioritizing Your M&E Questions

Tool 7 will help you document and prioritize your M&E questions. Once you have prioritized your questions, review the list and make sure that each question is clear to stakeholders.

Tools and Templates: Tool 7—Document and Prioritize M&E Questions Table

Take the time to consider your program logic model and SMART objectives in order to focus in on a list of priority M&E questions for your program.

Instructions for Completing Tool 7. Document and Prioritize M&E Questions Table

What is the purpose of this tool? This tool will allow you to document your M&E questions and inventory their importance to stakeholders, alignment with program goals and objectives, and the feasibility to answer each.

Who should complete this tool? Non-Clinical HIV TLC program managers or coordinators may choose to complete this table individually or as a group activity with program staff and community members. If completing individually, make sure to gather input from multiple stakeholders, including agency leaders, HIV testing and linkage staff, and community members.

When should this tool be completed? Complete this tool in the beginning of your M&E process and revisit it each time you review your M&E plan. This may be yearly or more frequently if necessary.

How should this tool be completed? List all proposed M&E questions in the first column. For each question, check the boxes to indicate whether the question meets the criteria below:

1. Does this question reflect the priorities of your HIV testing and linkage staff?
2. Does this question reflect the priorities of your external stakeholders, including community groups?
3. Does this question provide information that is a priority or requirement of your funders or required by statue, regulation, or policy?
4. Does this question align with your program SMART objectives and goals?
5. Does this question align with your program logic model and the elements contained within?
6. Does this question provide information that can be used to make program improvements?
7. Can this question be answered with data or resources that are currently available?
8. Can the program provide resources in order to answer this question?
9. Is this question feasible to ask given current staff availability, levels of skill, and other responsibilities?

Questions that do not meet all nine of the criteria should be considered of lower priority.

Tool 7. Document and Prioritize M&E Questions Table

List the evaluation questions in this column and then decide if the question meets the criteria listed in the column to the right by checking the appropriate box. You can check as many boxes as applicable.	Criteria: 1—Important to program staff 2—Important to community groups 3—Important to/or required by funders 4—Reflects key goals and objectives of the program 5—Reflects key elements of the program logic model 6—Provides information that can be acted upon to make program improvements 7—Can be answered with available resources 8—Will be supported by the program (in terms of resources) 9—Will not place an undue burden on staff to collect data								
Evaluations Questions	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Example: To what extent are test results being provided to clients who received HIV testing?	☒	☒	☒	☒	☒	☒	☒	☒	☒
	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐

Determining Measures and Targets

At this point, you have illustrated the implementation of your non-clinical HIV TLC program in a logic model, documented the intended results for the program through SMART objectives, and defined and prioritized M&E questions to assess your program's progress.

Let's revisit the M&E worksheet presented earlier in this chapter (Exhibit 3.7). Measures, the fourth column in the M&E worksheet table, help you answer your M&E questions and determine whether you are accomplishing your objectives. Measures provide a reference point for program planning, management, and reporting; allow you to assess trends and identify problems; and may act as early warning signals for when corrective action is needed.

Reviewing progress toward measures can help you to identify a potential problem. For instance, by verifying change, measures help to demonstrate progress when things go right and provide early warning signals when things go wrong. The type of measure you use will depend on your M&E questions. *Quantitative measures* document numbers, percentages, averages, and other statistics. *Qualitative measures* assess people's reactions, perceptions, attitude, and beliefs.

In this section, we will discuss both quantitative and qualitative measures and how you can use SMART objectives and corresponding M&E questions to define each type of measure. We will also discuss the importance of baselines and how to set targets for your quantitative measures.

Exhibit 3.7. M&E Worksheet for HIV Testing and Linkage in Non-Clinical Settings

Evaluation Questions: 1. To what extent are test results being provided to clients who received HIV testing? 2. To what extent is the program linking HIV-positive individuals to medical care?				
HIV Testing and Linkage Key Program Activities	**Aligned SMART Objectives**	**Monitoring Questions**	**Measures to Address Monitoring Question and Objective**	**Targets**
Notification of test result	By the end of Fiscal Year 2014, 90% of clients will have knowledge of their serostatus through receipt of their test result.	Among all test results, how many were provided to persons who received HIV testing?		
Link HIV-positive clients to medical care	By the end of Fiscal Year 2014, 85% of HIV-positive clients will attend their first medical appointment within 30 days of a positive result.	What percentage of persons testing HIV positive who are referred to medical care attend their first medical appointment?		

Quantitative Measures and Targets

Quantitative measures calculate the frequency of certain activities and help to answer monitoring questions and assess progress toward meeting the objective. This type of measure is often used when you are looking for a number, percentage, proportion, or average. Measures used to determine proportions or percentages require the division of two separate data elements: a numerator on the top and a denominator on the bottom.

For example, for the first activity, notification of test result, the monitoring question is asking about the proportion of test results provided to persons receiving an HIV test. In this case, the denominator is the total number of HIV test results, and the numerator is the total number of HIV test results provided to the client. Dividing these two numbers and then multiplying by 100 will provide a percentage of clients who will have knowledge of their serostatus through receipt of their test result.

For the second activity, link HIV-positive clients to medical care, the monitoring question also indicates the need for a proportion. To calculate this proportion, you can divide the denominator (the total number of clients who tested positive for HIV and were referred to medical care) by the numerator (the number of clients who were referred and attended their first medical appointment). Dividing these two numbers and then multiplying by 100 will provide a percentage of HIV-positive clients who were linked to medical care.

Another example of a quantitative measure is an average. An average that may be of interest to your non-clinical HIV TLC program is the average number of days it takes to link an HIV-positive client to medical care. To calculate the average, you will need to add together the

total number of days for all HIV-positive clients referred to medical care to attend their first medical appointment and then divide that total by the number of clients who are referred to medical care and attend their first appointment.

For the measures you develop, it is important to thoughtfully set realistic yet challenging targets. Targets establish clear expectations for staff members, stakeholders, and funders. Since you considered the M for measurable in your SMART objectives, crafting these targets should be directly tied to your SMART objectives. When setting targets, reflect on your agency's capacity and use monitoring data from recent years to gauge a viable reach for your non-clinical HIV TLC program efforts. This will help to establish a baseline, or starting place, from which to measure improvement.

A few questions to consider when setting targets for your non-clinical HIV TLC program measures follow:

- How are clients recruited for testing?
- What test technology will be used?
- How will HIV-positive results be flagged?
- How are HIV-positive test results returned to clients?
- How quickly can your agency provide HIV-positive results to clients?
- Has your agency's HIV-positive test yield increased or decreased over time?
- How are referrals made for persons testing HIV positive?
- What local agencies accept referrals? What is your agency's relationship with these agencies?
- What mechanisms exist to track client referrals?
- Are staff members available to track referrals and conduct follow-up to ensure linkage?

The answers to these questions will assist your agency in determining what are feasible targets given the maturity, capacity, and goals of your non-clinical HIV TLC program. There are many ways to approach target settings, and no approach is right or wrong. However, it is important to be realistic about what you can accomplish. Setting targets too high, too quickly (e.g., 100% of clients testing HIV positive will be linked to medical care in year 1) may frustrate and demoralize staff rather than motivate them. Setting targets too low (e.g., 20% of clients testing HIV positive will be linked to medical care in year 1) suggests little effort is required and may invite cynicism and disinterest among staff and stakeholders. It will be most beneficial for your program to periodically review your measures to monitor progress toward reaching the target set in the objectives over time and make adjustments as needed.

Tip: Using Existing Measures

You may already be required to report on measures developed by funding organizations and programs. Those measures offer valuable information and should be used as a point of reference when selecting measures to evaluate your program. However, predefined measures may not always be best matched with your evaluation questions, and you may need to develop your own measures.

Qualitative Measures

Qualitative measures use observations, provider accounts, and other nonnumeric data to provide additional context and detail to the counts presented in quantitative measures. Qualitative data are particularly useful in providing context or explaining the context, since the data help to answer the "why" of an observed finding. Therefore, qualitative information is helpful in program planning, refinement, or redirection during implementation, and should be included in M&E planning. For example, the following questions may be answered with qualitative measures:

- What factors and/or strategies did staff members identify as associated with a decrease in the proportion of new HIV diagnoses?
- What specific strategies did staff members think were most successful in linking high-risk HIV-negative clients to risk-reduction interventions?
- What factors and/or strategies did staff members identify as associated with an increase in the number of HIV-positive persons being linked to medical care?

To answer questions like the one above, you may choose to abstract data from staff documentation, notes, or other data sources, as well as talk directly to staff members.

For agencies that are new to the M&E process, start with a small number of measures and targets. With a smaller set of measures and targets, you can refine your data collection and analysis capacity within your agency, before expanding the scope of M&E.

Benjamin Tsoi
Director of HIV Testing
Bureau of HIV/AIDS Prevention and Control
New York City Department of Health and Mental Hygiene

Combining Quantitative and Qualitative Measures for Program Improvement

In many cases, programs may combine quantitative and qualitative measures into their data quality assurance approach to ensure a program is meeting its goals and/or identify areas in need of improvement. In the case study included below, Angela Wood from Family Medical and Counseling Services in Washington, DC, describes the way her agency operationalizes quality assurance and program improvement. The process begins with a review of quantitative measures to assess program performance and incorporates qualitative elements like staff interviews to further investigate potential concerns. For more information on the ways that you can incorporate quantitative and qualitative strategies into your quality assurance approach, review Chapter 9: Quality Assurance and Monitoring and Evaluation in the Implementation Guide for non-clinical HIV TLC programs.

Family Medical and Counseling Services (FMCS) implements a practical program evaluation and continuous quality improvement program that is designed to measure progress toward five selected quality improvement indicators: HIV offer rate, acceptance rate, testing rate, positivity rate, and linkage to care rate for the HIV testing program in the Department of Motor Vehicles. The quality improvement indicators are included in our organizational quality improvement plan.

The HIV testing manager reviews progress toward the indicators on a monthly basis. When actual performance falls below the identified benchmark/expected goal, our quality improvement and/or quality assurance process is initiated. For example, if our testing rate (meaning received testing at the DMV/requested testing at the DMV) falls below 80%, the HIV testing manager may conduct further study to identify factors that are contributing to low performance. This review may include analysis of aggregate and individual performance data, electronic chart audits, and individual and group discussions with staff. If the review reveals a group-level problem, corrective actions target the entire staff. If the review reveals an individual staff issue, the manager may initiate further chart audits, direct observations, or increased supervision until the issue has been resolved and performance reaches the expected level. Hence, in our model the quality assurance activities are triggered by less than acceptable performance on identified quality improvement indicators.

Angela Fulwood Wood
Chief Operations Officer
FMCS, Inc.
Washington, DC

Guidelines for Selecting Measures

- Ensure that measures are linked to the M&E questions and are able to document change (using the M&E worksheet will help).
- Use standard measures as much as possible to compare changes over time and between program target groups.
- Use qualitative measures that can provide answers to the "why" questions.
- Consider the cost and difficulty of data collection and analysis associated with using the measures you select.
- Make sure the measures provide information to assess and/or improve your program's performance and/or outcomes, such as measures that show progression from a baseline.
- Focus on those measures that are going to help you in making decisions about the program.

Revisiting the M&E Worksheet presented earlier (here as Exhibit 3.8), we add the following corresponding measures and associated targets.

Exhibit 3.8. M&E Worksheet for HIV Testing and Linkage in Non-Clinical Settings

Evaluation Questions: 1. To what extent are test results being provided to clients who received HIV testing? 2. To what extent is the program linking HIV-positive individuals to medical care?				
HIV Testing and Linkage Key Program Activities	**Aligned SMART Objectives**	**Monitoring Questions**	**Measures to Address Monitoring Question and Objective**	**Targets**
Notification of test result	By the end of Fiscal Year 2014, 90% of clients will have knowledge of their serostatus through receipt of their test result.	Among all test results, how many were provided to persons who received HIV testing?	(1) What percentage of test results were returned to clients? (2) What factors and/or strategies are associated with increasing the number of test results returned to clients?	90%
Link HIV-positive clients to medical care	By the end of Fiscal Year 2014, 85% of HIV-positive clients will attend their first medical appointment within 30 days of a positive result.	What percentage of persons testing HIV positive who are referred to medical care attend their first medical appointment?	(1) What percentage of HIV-positive clients were linked to care? (2) What factors and/or strategies are associated with an increase in the number of HIV-positive persons being linked to medical care?	85%

Exercise 7. Completing the M&E Worksheet

Now that we have walked through the components of the M&E worksheet, which can assist you in focusing the design of your evaluation, it is your turn to complete the worksheet for your non-clinical HIV TLC program.

Tools and Templates: Tool 8—M&E Worksheet for HIV Testing and Linkage in Non-Clinical Settings

The worksheet that follows is structured in the same way as the sample you have seen in the previous sections. It is meant to help you inventory critical program activities, SMART objectives, monitoring and evaluation questions, measures, and realistic targets. This worksheet should be tailored or expanded to meet your local M&E needs.

Instructions for Completing Tool 8. M&E Worksheet for HIV Testing and Linkage in Non-Clinical Settings

What is the purpose of this tool? This tool can help you inventory critical program activities, SMART objectives, M&E questions, measures, and targets to take a more comprehensive look at your M&E efforts. This worksheet should be tailored or expanded to meet your local M&E needs.

Who should complete this tool? Those overseeing HIV testing programs, including managers and coordinators, should work with staff members performing M&E activities to complete this tool.

When should this tool be completed? Complete this tool in the beginning of your M&E process and revisit it each time you review your M&E plan. This may be yearly or more frequently if necessary.

How should this tool be completed? Complete the worksheet by first populating your HIV testing and linkage program activities from your logic model (Tool 6) and then inserting your aligned SMART objectives (Tool 4). Next insert your prioritized M&E questions (Tool 7) and draft measures and associated targets.

Example:

Evaluation Question: To what extent are test results being provided to clients who received HIV testing?				
HIV Testing and Linkage Key Program Activities	**Aligned SMART Objectives**	**Monitoring Questions**	**Measures to Address Monitoring Question and Objective**	**Targets**
Notification of test result.	By the end of Fiscal Year 2014, 90% of clients will have knowledge of their serostatus through receipt of their test result.	Among all test results, how many were provided to persons who received HIV testing?	(1) What percentage of test results were returned to clients? (2) What factors and/or strategies are associated with increasing the number of test results returned to clients?	90%

Tool 8. M&E Worksheet for HIV Testing and Linkage in Non-Clinical Settings

Evaluation Questions: 1. 2. 3.				
HIV Testing and Linkage Key Program Activities	**Aligned SMART Objectives**	**Monitoring Questions**	**Measures to Address Monitoring Question and Objective**	**Targets**

Step 4. Gather Credible Evidence

The fourth step in CDC's Framework for Program Evaluation is gathering credible evidence to support your M&E activities. As part of Step 4, you will determine data sources and data collection methods to answer your M&E questions, demonstrate the effects of your program activities, and show your progress toward program objectives.

Data collection involves eliciting client information, documenting HIV test results, and recording any services provided, including linkage or referrals. As with other M&E activities, planning for data collection should include identifying staff, assigning roles and responsibilities, and sharing these assignments with stakeholders to build understanding around the program. It is also important to consider the tools, training, and procedures that you will need to ensure data that are collected align with your program objectives and M&E questions.

Solidifying a Data Collection Plan

Just as an M&E plan serves as a road map for your M&E activities, a data collection plan helps you determine how, when, and by whom data will be collected to answer M&E questions. Collecting standardized data ensures that you can accurately describe the clients you serve and the activities you deliver as a part of your HIV testing and linkage program.

Identifying Data Sources

As mentioned previously, data help to illustrate what a program is doing and who it is reaching. It is important to decide whether existing data sources (secondary data sources) can be used, or whether you will need to collect new data (primary data sources). Understanding the advantages and disadvantages of different data sources and different data collection methods will help you to make the best use of your resources, and also inform how you will interpret your findings.

As part of your non-clinical HIV TLC program implementation, you may already be collecting a lot of data that would be useful for your evaluation questions. Depending on the evaluation questions and measures, some secondary data sources may be the most appropriate and time- and cost-effective sources to use. Although not an exhaustive list, valuable data can be found in the following existing program-related data sources:

- Program activity records (e.g., HIV testing forms)
- Log books (e.g., referral logs, testing logs, recruitment and/or outreach logs)
- Intake forms
- Training logs
- Surveillance records (e.g., case reports)
- Data from case management
- Laboratory reporting data
- Partner Services reports
- Census data
- Behavioral surveillance
- Health survey data
- Health utilization data (e.g., emergency room or substance use treatment admissions)
- Agency financial records
- Annual reports

Before using secondary data sources, however, make sure they meet the information needs for your program M&E questions. Although large ongoing surveillance systems have the advantages of routine data collection and existing resources and infrastructure, they may not always provide the specific information that would be helpful to the evaluation questions. National-level surveys have aggregated data and may not provide the level of detail you need.

If neither program- nor national-level data sources can provide the information you need to answer the evaluation questions, you may need to collect new data. Sources of primary data include the following:

- Client self-reported demographic and risk surveys
- Interviews with consumers, clients, and/or staff
- Focus group reports
- Feedback surveys program staff.

Exhibit 3.9 presents advantages and disadvantages of primary and secondary data sources.

Exhibit 3.9. Example Data Sources for HIV Testing and Linkage Programs

Data Sources	Advantages	Disadvantages
Primary Data Sources: • Program clients • Target populations • Program managers • Community members	• Information is obtained directly from the appropriate individuals • You are able to ensure that you get all the information you need in the format you want • Can obtain permission directly from individuals to collect and use personal information	• It may be costly and time-consuming to collect new data from individuals • Self-reports from individuals may be unreliable • Individuals may provide socially desirable responses (e.g., tell you want you want to hear)
Secondary Data Sources: • Grant proposals • Administrative records • Registration/enrollment forms • Surveillance reports • Database records • Web pages • Minutes of meetings • Brochures	• Data are available and accessible, requiring reasonable resources • You may know how the data were collected if gathered by your program • Data can be used to supplement self-reported information	• Value of the data depends on how accurately and consistently they we rerecorded • Existing records may not have all the data you need, or in the format you want • Due to privacy considerations, program may not have permission from clients to use information in their existing records for evaluation purposes

Determining Data Collection Methods

Once you have selected the best data sources to respond to the measures that will help to answer your M&E questions, you will need to determine the most appropriate method of getting the data from those sources. If you determine that all the data you need are available in existing data sources (program records, patient records, etc.), then your next task will be to conduct a thorough document review to extract the necessary data points. However, if the necessary data are not readily available, then you will need to obtain the data yourself.

There are two primary methods for collecting evaluation data: quantitative and qualitative methods.

Quantitative methods are structured or standardized formats used to collect numerical data mainly via close-ended questions. Surveys are common quantitative techniques used in program evaluation.

Qualitative methods are semistructured and structured methods aimed at generating in-depth, descriptive information by using open-ended questions. Examples of commonly used qualitative evaluation methods include the following:

- Focus groups
- Key informant/in-depth interviews
- Observations
- Document reviews

The data collection method you select should be based on your M&E questions. Figure 3.2 provides guidance on how you should use your M&E questions to help you to choose the appropriate data collection method. Exhibit 3.10 presents the advantages and disadvantages of different data collection methods.

Figure 3.2. How to Select Appropriate Data Collection Methods

What Are Your M&E Questions?	
If you are trying to learn the following: • How many? • How much? • What percentage? • How often? • What is the average amount? • What is the coverage?	**If you are trying to learn the following:** • What worked best? • What did not work well? • What do the numbers mean? • How has this impacted the problem? • What factors influenced success or failure?
Choose Quantitative Methods	**Choose Qualitative Methods**
Provide data as numbers	Use observations and words as raw data
Use close-ended questions	Use open-ended questions
Ask "how many?"	Ask "how?" and "why?"
Collect data using surveys	Collect data using interviews, observation, written documents
Are population-oriented	Are case-oriented
Attempt to generalize results	Do not attempt to generalize results
Use large sample size	Use small sample size

Exhibit 3.10. Advantages and Disadvantages of Possible Data Collection Methods

Method	Description	Advantages	Disadvantages
Quantitative Methods			
Surveys and questionnaires	• Data collection tools with a series of questions (items) and predetermined response choices • May be completed by respondents or surveyors • May target either the general population (e.g., all people aged 15 to 49 years) or specific risk populations (e.g., sex workers, injecting drug users)	• Anonymous completion possible • Can be administered to groups of people at the same time • Can be efficient and cost-effective	• Forced response choices may miss certain responses from participants • Wording may bias responses • Impersonal
Qualitative Methods			
Interviews (in-depth)	• Include open-ended but predetermined questions • Conducted one-on-one • Expect respondents to answer using their own terms • Can be conducted in person or by telephone • Generate responses to be documented in thorough, detailed notes or transcription	• Can build rapport with participant • Can probe to get additional information • Can get breadth or depth of information	• Time-consuming and expensive • Interviewing styles and wording may affect responses
Focus groups	• Are used to gather detailed, qualitative descriptions of how programs operate and how stakeholders perceive them • Usually conducted in small groups (6 to 8 people) of targeted samples of stakeholders • Expect respondents to answer using their own terms • Include open-ended but predetermined questions • Generate responses to be documented in thorough, detailed notes or transcription	• Can get common impressions quickly • Can be efficient way to get breadth or depth of information in a short time	• Need experienced facilitator • Can be difficult and costly to schedule group of 6 to 8 people • Time-consuming to analyze responses
Observation	• Are conducted to view and hear actual program activities • May be focused on programs overall or participants in programs • Involve instruments (e.g., checklists) • Audio and videotaping are options when direct observation is not feasible	Can view program operations and behaviors as they occur	• If not structured, it may be difficult to interpret data • May influence behaviors of program participants • May be expensive and time-consuming to record each individual event

Exhibit 3.10. Advantages and Disadvantages of Possible Data Collection Methods (continued)

Method	Description	Advantages	Disadvantages
Document Review	• Involves the review and analysis of documents (e.g., agendas, outlines, intake and tracking forms, other service records, financial records, calendars, process logs and forms) • Makes use of information that is routinely collected during implementation of a program	• Can document historical information about your program • Does not interrupt program or client routine • Information already exists	• May be time-consuming • Available information may not be complete or of good quality

When assessing the advantages and disadvantages of using secondary or primary data sources as well as the data collection methods, keep in mind the following questions:

- When do you need the data?
- Which data sources and methods will be seen as credible by your stakeholders?
- What is the level of data quality? Are the data reliable and correctly captured?
- What is the culturally and linguistically appropriate method to use with your target population(s)?
- Which data sources and collection methods can you afford and manage?
- Will you need to collect confidential information? What are the ethical issues in collecting confidential information?
- Do you want to gather information that is representative of your entire target population(s)? Or do you want to examine the range and diversity of experiences or tell a story about your target population(s)?
- Do you have the skills and expertise necessary to use the method you have chosen and interpret data generated from that method?

Identifying Points for Data Collection

A key consideration in collecting M&E data for non-clinical HIV TLC programs is to determine at which point during the HIV testing encounter you should document M&E information. One way to do this is to sketch out the workflow of your non-clinical HIV TLC program in a graphic activity/process flowchart. By mapping out what activities you do and when you do them, or the steps you take in a typical testing encounter, you may be able to determine the best opportunities to documenting specific M&E data. (For additional information on factors to consider when determining your workflow, please see Chapter 6: Implementing HIV Testing in Non-Clinical Settings and Chapter 8: Outreach Settings in the companion Implementation Guide.) Once you have sketched out your workflow, compare the activities to your SMART objectives and aligned M&E questions to begin honing in on the most appropriate time to document your M&E data.

Let us take the M&E worksheet that was completed in the last section as an example (Exhibit 3.11). In this worksheet, there are two evaluation questions that are priorities for an agency: (1) To what extent are test results being provided to clients who received HIV testing? and (2) To what extent is the program linking HIV-positive individuals to medical care? For both of these questions, there are program activities, SMART objectives, monitoring questions, and measures and targets to address the monitoring question and objective.

Exhibit 3.11. Example M&E Worksheet

Evaluation Questions: **1. To what extent are test results being provided to clients who received HIV testing?** **2. To what extent is the program linking HIV-positive individuals to medical care?**				
HIV Testing and Linkage Key Program Activities	**Aligned SMART Objectives**	**Monitoring Questions**	**Measures to Address Monitoring Question and Objective**	**Targets**
Notification of test result	By the end of Fiscal Year 2014, 90% of clients will have knowledge of their serostatus through receipt of their test result.	Among all test results, how many were provided to persons who received HIV testing?	(1) What percentage of test results was returned to clients? (2) What factors and/or strategies are associated with increasing the number of test results returned to clients?	90%
Link HIV-positive clients to medical care	By the end of Fiscal Year 2014, 85% of HIV-positive clients will attend their first medical appointment within 30 days of a positive result.	What percentage of persons testing HIV positive who are referred to medical care attend their first medical appointment?	(1) What percentage of HIV-positive clients were linked to care? (2) What factors and/or strategies are associated with an increase in the number of HIV-positive persons being linked to medical care?	85%

To address these two evaluation questions, the agency will need to determine if they have current data sources available to collect the information to answer the questions. If not, the agency will need to determine what data sources need to be drafted, and where in the testing encounter they will collect the information.

For this example, the agency is funded by their health department to conduct HIV testing, and staff members have been using the health department HIV test form for years. Since a critical component to an HIV testing program is to ensure that clients are aware of their serostatus, the form has a place to document whether or not a client received his or her test results. Also included on the form are areas to document whether a client tests HIV positive, and whether or not the client attended his or her first medical appointment. It is important to note that linkage to care will not be documentable during the testing encounter—it will likely be completed separately from the testing encounter during follow-up or other subsequent client encounters. Thus for both questions, the agency has an existing data source to

calculate their measures. However, this only addresses the quantitative measures, not the qualitative measures.

For the two qualitative measures (What factors and/or strategies are associated with increasing the number of test results returned to clients? and What factors and/or strategies are associated with an increase in the number of HIV-positive persons being linked to medical care?), the agency decided to convene focus groups with staff members to gather their impressions of facilitating strategies to return test results and linking HIV-positive clients to medical care. They will need to draft a focus group discussion guide to aid in collecting this information (considerations on developing data collection instruments are addressed later in this chapter).

After the agency identified the data sources to address their questions, they needed to determine when in the HIV testing workflow to collect the quantitative information and when to conduct the staff focus groups. By examining their capacity for testing, the timing of the testing encounter and the workflow, the agency concluded that each tester could complete the testing encounter form within 5 minutes of concluding an encounter with a client. During this time, the tester could document receipt of the result and whether or not that client was referred to medical care. They also realized in speaking with their testers that staff have an investment with their clients and would like to be actively involved in following up on the referral and documenting linkage of the client's attendance at their first medical appointment. In order for them to do this, the agency held the last hour of every work day as administrative time where the staff members could perform quality assurance reviews on their test forms and make calls to medical providers with which the agency had agreements to document that the client made it to care. It was during this time that the testers could collect the linkage to care data.

To address their qualitative measures, the agency determined that due to resource constraints, they could assess these measures once a year or as warranted on the basis of ongoing monitoring. In discussions with their testers and reviewing testing volume data, the agency staff determined convening the focus groups annually just before the December holidays would work with a historically lower volume of clients and to catch staff just before many left for vacation.

This is one example of how an agency may determine how and when to collect their M&E data. Exercise 9 can help your agency determine what data sources are needed, what methods to use the collect the data, and what point is best to collect the data. Additional factors you may want to consider when identifying points for data collection are located in Chapter 9: Quality Assurance and Monitoring and Evaluation, as well as the Yield Analysis Tool, in the Implementation Guide for Non-Clinical HIV TLC programs.

Exercise 8. Identifying Data Sources and Data Collection Methods

In Exercise 7, you filled in your M&E questions and measures. In Exercise 8, you will fill in the data sources and data collection methods to answer your M&E questions.

Tools and Templates: Tool 9—Identifying Data Sources and Data Collection Methods Table

Once you have articulated your program and drafted M&E questions and measures, you will need to determine what data you need to collect from which data sources. This tool assists you in aligning your data with your questions.

Instructions for Completing Tool 9. Identifying Data Sources and Data Collection Methods Table

What is the purpose of this tool? This tool will allow you to identify data sources, both those that already exist and those that are needed to help answer the measure. Additionally, you can document data collection methods and at what point in the testing process you will collect the data.

Who should complete this tool? Those overseeing HIV testing programs, including managers and coordinators, should work with staff performing M&E activities to complete this worksheet.

When should this tool be completed? Complete this tool in the beginning of your M&E process and revisit it each time you review your M&E plan. This may be yearly or more frequently if necessary.

How should this tool be completed? As you list all the data sources to which you have access, indicate whether they are existing data sources or sources from which you will need to do primary data collection. Then identify which data collection method you will use to gather information and at what point in the testing process you will collect the data for each measure.

Example:

Evaluation Question: To what extent is the program linking HIV-positive individuals to medical care?					
Measures	**Numerator/ Denominator**	**Data Source**	**Existing or New?**	**Data Collection Method**	**At What Point Are Data Collected?**
Percentage of HIV-positive clients linked to medical care	Numerator: Number of clients testing HIV positive who were referred to medical care and attended their first appointment within the last quarter	1. HIV testing form 2. Referral logs	1. ☒ Existing ☐ New 2. ☒ Existing ☐ New	Document review	During testing encounter and through follow-up for 30 days
	Denominator: Number of clients who tested positive for HIV within the last quarter and were referred to medical care	1. HIV testing form 2. Referral logs	1. ☒ Existing ☐ New 2. ☒ Existing ☐ New	Document review	During testing encounter

Tool 9. Identifying Data Sources and Data Collection Methods Table

Evaluation Question:					
Measures	**Numerator/ Denominator**	**Data Source**	**Existing or New?**	**Data Collection Method**	**At What Point Are Data Collected?**
	Numerator:		☐ Existing ☐ New		
	Denominator:		☐ Existing ☐ New		
	Numerator:		☐ Existing ☐ New		
	Denominator:		☐ Existing ☐ New		
	Numerator:		☐ Existing ☐ New		
	Denominator:		☐ Existing ☐ New		
Evaluation Question:					
Measures	**Numerator/ Denominator**	**Data Source**	**Existing or New?**	**Data Collection Method**	**At What Point Are Data Collected?**
	Numerator:		☐ Existing ☐ New		
	Denominator:		☐ Existing ☐ New		
	Numerator:		☐ Existing ☐ New		
	Denominator:		☐ Existing ☐ New		
	Numerator:		☐ Existing ☐ New		
	Denominator:		☐ Existing ☐ New		

Developing Data Collection Instruments

Now that you have selected the data collection method(s), the next step is to develop the data collection instruments you will use to collect the data and determine when data will be collected, who will collect it, and what other logistics are involved. Each data collection method uses a different type of data collection instrument and also requires different levels of time and resource commitment. In this step, you will start developing data collection instruments and laying out the logistics for collecting your data. Remember, as discussed in the earlier section, your agency will most likely already be collecting HIV testing data as part of funding or other requirements. These data can provide valuable information regarding how many tests are performed, the demographics of persons testing, the results of the tests, and whether the persons testing HIV positive were referred and linked to medical care. For other types of M&E questions, you may need to draft new tools or modify existing ones. For example, if you will use focus groups, you will need focus group discussion guides; if you will conduct surveys, you will need survey questionnaires; and if you will use document review or observation, you will need checklists to help focus data collection.

The design of data collection instruments will influence the quality and credibility of data. Therefore, it is important to seek advice from individuals who have experience with developing evaluation instruments and to field test the instruments to make sure they will capture the appropriate information. Field testing also will help you to determine how long it takes to complete the data collection activity, whether the order of questions flows well, and whether instructions and questions are clearly understood. Exhibit 3.12 provides some tips for developing data collection instruments

Exhibit 3.12. Tips to Consider When Developing Data Collection Instruments

Types of Instruments	Tips
Survey questionnaires	• Keep questions simple, short, focused, and easy for respondents to complete. • Use simple and culturally appropriate language. • Include closed-ended questions with multiple answers. • Do not combine questions. (For example, "Were you satisfied with the testing and linkage services?" A person could have been satisfied with the testing service, but not with the linkage services.) • Include only questions that ask for the information you really need to know and plan to analyze. • Make sure your response options are not overlapping or partial. (For example, "How old are you?" Response options: younger than 15; younger than 20; younger than 30. The response options overlap because a 19-year-old person can check both younger than 20 and younger than 30. The options are not comprehensive because a 42-year-old person would not have a response to select.) • Consider if the questionnaire will be self-administered or administered by another person and include appropriate instructions.

Exhibit 3.12. Tips to Consider When Developing Data Collection Instruments (continued)

Types of Instruments	Tips
Interview guide	• Ask open-ended questions. • Allow some flexibility for the interviewer to probe and ask follow-up questions. • Include only questions and probes that ask for the information you really need to know. • Leave enough space on the interview guide for the interviewer to write responses, as well as comments on interviewees' body language and the surrounding environment. • Train all interviewers to use and follow the interview guide. • Record interviews, with participants' permission.
Focus group discussions guides	• Ask open-ended questions. • Include clear instructions for the facilitator and notetaker. • Allow some flexibility for the facilitator to probe and ask follow-up questions. • Include only questions and probes that ask for the information you really need to know. • Arrange for a notetaker to document participants' responses. • Leave enough space on the discussion guide for the notetaker to write responses, as well as comments on participants' body language and the surrounding environment. • Train all facilitators and notetakers to use and follow the interview guide. • Record focus group discussions, with participants' permission.
Observation checklist	• Include a list of the actions, behaviors, or environment that you want the observer to record, as well as time intervals, if applicable.
Document review checklist	• Include the information you need to abstract. • Keep in mind the confidentiality policies and procedures of the organization from which you will be collecting data.

Documenting Data Collection Procedures

Once you have identified the data collection methods, you should lay out the policies and procedures for data collection in a program operational guide. This will help ensure that the staff are collecting data in a similar and standardized way. These data collection procedures should provide detailed information for the entire data collection process—from data collection, to data entry, to data disposal. Consider including the following information:

- **When will you collect data and at what intervals?** You will need to determine when and how frequently to collect data. Will you be collecting data before and/or after a particular intervention? Will you be collecting data at one particular time in your program (e.g., quarterly or at completion of the program)? Your data collection procedures should provide guidance on your data collection schedule.
- **Who will collect the information?** How will you train data collectors? You should first determine if your program staff members have the specific skills required to collect data using the method you have selected (e.g., experience/training in moderating focus groups, administering face-to-face surveys). Data collection activities can be time consuming. Be sure that when you assign program staff to data collection activities, you do not take them away from other program responsibilities. If program

staff are available but do not have the required skills, you should provide in-service training to them. Another option is to recruit qualified data collectors who have expertise with the methods.

- **From whom will you collect data?** You should determine your target population even before you start developing your data collection instruments. Are you going to target a relatively specific group (e.g., pregnant clients) or assess trends among a more general population (e.g., the target community at large)? Are you going to collect information from all participants or a subset of your target population (sample)? The interpretation of your results will be influenced by who you collect data from, so be sure to clearly describe those target populations.
- **How will you maintain the security and confidentiality of the information collected?** Your evaluation should ensure the privacy of your clients. You can maintain their confidentiality by stripping any identifiers (name, address, identification number) from the data gathered. Your data security and confidentiality procedures should cover all aspects of the data collection, storage, and management process (e.g., transfer of data from those who collect data to those who enter data, storage and destruction of recorded tapes).
- **How will you manage the data you collect?** Data management includes making decisions about how data will be stored and synthesized and how data quality will be ensured. You should decide early in the process whether data will be kept in paper format or whether data will be transferred to an electronic file to facilitate analysis. You should also consider how data will be stored (either in electronic databases or physical storage files) to (1) minimize the chances of losing data, (2) make it easy to retrieve data, and (3) maintain security of sensitive and confidential information. You should also set up processes to ensure the quality of data you collect**.**

Tip

For more information on developing policies and procedures for data collection at your agency, refer to the Implementation Guide for HIV Testing and Linkage Programs.

Programs do not need to locate many data sources to answer useful M&E questions. With just three data variables (number of clients tested, number of clients confirmed HIV positive, number [of] HIV-positive clients linked to medical care), a program can learn a wealth of information about program effectiveness.

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New York City Department of Health and Mental Hygiene

Exercise 9. Completing the Data Collection Template

In Exercise 8, you aligned your data sources and collection methods with your M&E questions and SMART objectives. In Exercise 9, you will identify from whom or where you will gather information, who will collect data and when, and what security and confidentiality issues to consider for each data collection method.

Tools and Templates: Tool 10—Data Collection Template

After you have selected the data collection method(s), use this template to help you document from whom or where you will gather information, who will collect data and when, and what security and confidentiality issues to consider for each data collection method.

Instructions for Completing Tool 10: Data Collection and Entry Template

What is the purpose of this tool? This tool will help you identify methods, sources, and timelines for data collection. Additionally, you can outline who will be responsible for each collection method and any security or confidentiality issues that should be considered.

Who should complete this tool? Program managers or coordinators may choose to complete this table individually or as a group activity with program staff. If completing individually, make sure to gather input from HIV testing staff.

When should this tool be completed? Complete this tool in the beginning of your M&E process and revisit it each time you review your M&E plan or if there are significant staff changes. This may be yearly or more frequently if necessary.

How should this tool be completed? Use Tool 9, the Identifying Data Sources and Data Collection Methods Table, to complete the first column. As shown in the following example, for each data collection method, fill out columns with (1) the data collection method; (2) the data source and whether it is existing or new; (3) who will collect the data; (4) when data will be collected, including dates and place in the program cycle; and (5) any security and confidentiality issues you have to consider.

Example:

Data Collection Method	Data Source (Who/Where/What/ Existing or New?)	Data Collector(s) (Staff Person)	Data Collection Schedule (Dates/Frequency and Place in Program Cycle)	Security or Confidentiality Issues
Document review	HIV testing form; existing source	Data manager	February 15 to 28, 2014	All identifying information should be stripped out and shredded (if photocopies are made)

Tool 10. Data Collection and Entry Template

Data Collection Method	Data Source (Who/Where/What/ Existing or New?)	Data Collectors (Staff Person)	Data Collection Schedule (Dates/Frequency and Place in Program Cycle)	Security or Confidentiality Issues

Step 5. Justify Conclusions

The data collected as a part of HIV testing and linkage programs should be used to document program activities, monitor and evaluate progress toward goals and objectives, and inform program improvement actions. In the previous section, we discussed the ways that you plan for data collection. In this section, we will discuss the fifth step in CDC's Framework for Program Evaluation, justify conclusions, to help you manage, analyze, report, and use the data you collected for program improvement.

Just as integrating data collection in your program operational policies and procedures improves the quality of data, instituting policies and procedures around data management and analysis will ensure that M&E findings will be trustworthy.

Data Management

A system to manage your M&E data ensures uniform data handling. Data management comprises policies and procedures to ensure the proper storage, transfer, cleaning, and verification of data. Consider the following substeps to manage your non-clinical HIV TLC program data:

- **Determine data management responsibilities.** Designate one or more individuals to manage the data, which includes coding, storage, retrieval, and distribution data entry and analysis. The person(s) should be appropriately trained to conduct those tasks.
- **Transfer/transcribe the data.** Data entry is the transfer of collected data to a centralized database. Your policies or procedures should include details on when, where, and who will enter collected data. It should also include information on data disposal to ensure any identifying data is not compromised.
  - For quantitative data, you may want to transfer the data from complex data collection forms to new forms, such as answer sheets, that have been designed to make it easier to enter data into a database.
  - For qualitative data, it is important to use word processing software to transcribe notes taken by hand or information that was audio recorded.
- **Code the data.** Apply the codes (code scheme) you developed when designing the instrument(s) and modify them, if necessary (i.e., add new codes or modify existing ones).
- **Modify the code book.** Finalize and apply the code book to increase the accuracy of coding and data entry, which will facilitate the data analysis.
- **Consider which computer software to use for data entry and analysis.** This may include Excel or a more robust data analytic software such as SPSS or SAS.
- **Revise data for completeness and accuracy.** Be sure to closely review the data and reach out to data entry staff to fill in any missing data to the extent possible. See the section on data cleaning below for additional suggestions.

- **Monitor data entry.** This substep will ensure accuracy. For example, once the data are entered using the established codes or values, you may want to have a second person compare the data to check for correct entry.
- **Review the data management system.** Before implementing the system, review it (or have a colleague do so) to identify potential problems.

Time Saver

Data Compilation

In order to look at program data as a whole, it may be necessary to combine and aggregate data elements. As a part of your non-clinical HIV TLC program, data may be collected from different sources or entered it into separate databases. Data compilation allows you to gather the data that is essential to your M&E activities and combine them in order to observe and examine program efforts. Planning for compiling data *before* you enter the data will save you time.

Data Cleaning

After entering data (and compiling, if applicable), it is important to identify any errors or missing data elements in individual records or duplication of records in the database. This is known as data cleaning, and it helps to ensure the data you are using to answer M&E questions and measures are complete and convey the total program. Once identified, any records that have missing or inaccurate data should be corrected, if possible.

Performing data cleaning at regular intervals (e.g., monthly) also allows you to identify areas that may require additional clarification or training around data collection. For example, if you notice that a variable is frequently coded incorrectly, you may want to investigate the source of the problem and whether it is at the data collection or the data entry level.

Tip

For more information on developing policies and procedures for data management at your agency, refer to the Implementation Guide for HIV Testing and Linkage Programs.

Data Analysis

Data analysis is the process of systematically applying statistical and other analytic techniques to describe, compare, and summarize data for reporting and dissemination to stakeholders. Data analysis tasks fall under three broad steps: (1) developing a data analysis plan, (2) conducting data analysis, and (3) reporting results. The data analysis plan will describe the techniques and resources you will use to analyze and report the data. You should consider the following when developing the analysis plan:

- What type of data analysis will you need to perform for each measure/question in your M&E plan?
- What statistical methods or content analysis do you plan to use?

- What stratifications do you plan to examine among the data?
- What data aggregation systems or software will you need?
- What types of tables, figures, and other information will you need to develop and report?

As we discussed earlier in this guide, quantitative and qualitative data help answer important M&E questions and demonstrate the accomplishments of your program. As with other data collection and management activities, it is important that data analysis occurs often enough (e.g., quarterly) to use findings for program improvement and reporting to program stakeholders.

When thinking about timelines and assignments around data analysis, consider the following:

- Data reporting requirements and deadlines
- Timelines for sharing data with stakeholders
- Staff expertise and availability to conduct the analyses

Exercise 10. Considerations for Data Analysis

In this exercise, you will take some time to consider what kind of analyses for your data you are planning, who will coordinate and perform the analyses, how you would like to display the data, and what reports will be generated.

Tools and Templates: Tool 11—Data Analysis Considerations Table

Once you have determined your data collection methods, where you will gather information, who will collect data and when, answer the questions on this tool to help you develop the data analysis plan for the data.

Instructions for Completing Tool 11. Data Analysis Considerations Table

What is the purpose of this tool? This table will help you think about the ways to analyze data in order to answer M&E questions and eventually make recommendations for program improvement.

Who should complete this tool? Program managers or coordinators may choose to complete this table individually or as a group activity with program staff. If completing individually, make sure to gather input from HIV testing staff.

When should this tool be completed? Complete this tool in the beginning of your M&E process and revisit it each time you review your M&E plan or if there are significant staff changes. This may be yearly or more frequently if necessary.

How should this tool be completed? Under the response column, describe your approach to addressing each of the questions presented in the left column.

Example:

Considerations for Analysis Plan	Response
Who will analyze the data? Who will coordinate this effort?	The HIV data coordinator will lead a team of data analysts and will be responsible for setting timelines and delegating tasks.

Tool 11. Data Analysis Considerations Table*

Considerations for Analysis Plan	Response
Who will analyze the data? Who will coordinate this effort?	
What types of analyses will be conducted? (Specify both quantitative and qualitative procedures, as relevant. Do you plan to conduct only basic descriptive analysis? Or do you plan to compare between variables, or to correlate variables?)	
What is the timeframe for analysis? Will there be preliminary analyses?	
What criteria will you use to analyze and interpret your results?	
Who will be involved in interpreting results?	
Do you plan to compare your results with any similar programs?	
How will you deal with conflicting interpretations and judgments?	

*Adapted from: U.S. Department of Health and Human Services. (2005). *Introduction to program evaluation for public health programs: A self-study guide*. Retrieved January 12, 2012, from the Centers for Disease Control and Prevention Web site: http://www.cdc.gov/getsmart/program-planner/Introduction.pdf

Tool 11. Data Analysis Considerations Table (continued)

Considerations for Analysis Plan	Response
What are the limitations of your planned data analysis and interpretation process (e.g., potential biases, generalizability of results, reliability, validity)?	
How will be data be visually displayed, if applicable?	
What types of reports will be developed for which audiences?	

Quantitative Data Analysis[19]

Quantitative data are numbers that have been collected via surveys, logs, attendance records, or other methods. In quantitative analysis, data can be summarized by computing totals, percentages, and averages (means).

A variety of statistical approaches can be used to answer evaluation questions; some are more complex than others. Data from demographic, medical history, behavioral risk, and participant response surveys can be analyzed with simple descriptive statistical analyses (e.g., frequencies [modes], averages [means], and midpoints [medians]) and cross-tabulation procedures (i.e., comparison of a response or outcome by two or more subgroups). Simple statistical analysis of survey data can be conducted using spreadsheet software, as well as other statistical software packages. Exhibit 3.13 presents some software that may be used for quantitative data analysis.

The analysis plan should specify the quantitative analysis techniques that will be used and include details on how you will perform each of the following tasks:

- Entering the data into a database and checking for errors, including the data systems and software that will be used.
- Tabulating the data for each measure (e.g., providing counts/number, percentages, specifying the denominator).
- Stratifying your data by various demographic variables of interest (e.g., participants' race, sex, age, income level, geographic location).
- Making comparisons (e.g., between testing venues, between geographic areas) and the relevant statistical tests that will be used.
- Looking at your analyzed data over time to see how your results change by tracking the measures. Results that are not changing in the desired direction can alert you to look more closely at the program and work with stakeholders to improve it.

Exhibit 3.13. Software Resources for Quantitative Data Analysis

Quantitative Data Entry and Analysis Software Resources
Software for Basic Quantitative Data Entry and Analysis
• Microsoft Excel—http://www.office.microsoft.com/excel • Microsoft Access—http://www.office.microsoft.com/access
Software to Run Inferential Statistical Analysis
• SPSS—http://www.spss.com • SAS—http://www.sas.com • Stata—http://www.stata.com

[19] For more information on quantitative data analysis techniques, please refer to the following source: Creswell, J. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA: Sage Publications, Inc.

Exhibit 3.14 displays the data elements and calculations that are needed to answer the two example M&E questions.

Exhibit 3.14. Example Quantitative Calculations Needed

Monitoring Question	Data Elements Required	Calculation Needed
Among all test results, how many were provided to persons who received HIV testing in the past quarter?	• Numerator: Number of HIV tests returned to clients in the past quarter • Denominator: Total number of HIV tests conducted in the past quarter	Tally Division
What percentage of persons testing HIV-positive who are referred to medical care attend their first medical appointment?	• Numerator: Number of HIV tests returned to clients in the past quarter • Denominator: Total number of HIV tests conducted in the past quarter	Tally Division

Qualitative Data Analysis[20]

Qualitative data are generally presented through words and text organized around concepts, themes, or patterns. During quantitative studies, data collection and analysis can be separate processes. In qualitative studies, however, data analysis begins during data collection and includes preliminary thoughts or conclusions during initial observations and interviews. Data analysis continues throughout the entire evaluation, including during coding and analysis.

A common method used to analyze qualitative data is coding, which is the process used to distill raw field notes into usable findings. Coding consists of using a code word to label pieces of the text by selecting, focusing, and simplifying notes into summaries organized around themes or patterns, generally on the basis of the evaluation question(s).

During coding, the evaluator must keep a master list, also known as a codebook or code scheme, of all the codes that are developed and used and their definitions. The evaluator can modify the master list as the reading of notes progresses.

Increasingly, computers are being used to help with qualitative analysis. The data analysis plan should consider whether data will be analyzed manually or with analysis software and specify the qualitative analysis methods that will be used. Exhibit 3.15 presents some software packages that may be used to analyze qualitative data.

[20] For more information on qualitative data analysis techniques, please refer to Patton, M. Q. (2008). *Utilization-focused evaluation: The new century text (4th ed.)*. Thousand Oaks, CA: Sage Publications, Inc.

Exhibit 3.15. Software Resources for Qualitative Data Analysis

Qualitative Data Entry and Analysis Software Resources
Software to Organize Themes and Codes
• Microsoft Word—http://www.office.microsoft.com/word • Microsoft Excel—http://www.office.microsoft.com/excel (to manage key quotes)
Software to Conduct Qualitative Analysis

• AnSWR—http://www.cdc.gov/hiv/software/answr.htm (free CDC software that helps to coordinate and conduct large-scale, team-based analysis projects that integrate qualitative and quantitative techniques)
• EZ-Text—http://www.cdc.gov/hiv/software/ez-text.htm (free CDC software that helps to create, manage, and analyze semistructured qualitative databases)
• Commercially available qualitative data analysis packages
  ▪ NVivo—http://www.qsrinternational.com/products_nvivo.aspx
  ▪ ATLAS.ti—http://www.atlasti.com/
  ▪ Ethnograph—http://qualisresearch.com/

Exercise 11: Completing Your Data Analysis Planning Template

Now that we have reviewed the types of analyses you may wish to conduct for your non-clinical HIV TLC program, you can complete your data analysis plan. For each prioritized M&E question and measure, the plan should list the analysis procedure, time, and person responsible for managing the data. Be sure to review the plan with relevant stakeholders.

Tools and Templates: Tool 12—Data Analysis Planning Template

Once you have determined your data collection methods, where you will gather information, who will collect data and when, answer the questions on this tool to help you develop the data analysis plan for the data.

Instructions for Completing Tool 12. Data Analysis Planning Template

What is the purpose of this tool? This table will help you document monitoring questions, corresponding analysis activities, and individuals who will answer each.

Who should complete this tool? Program managers or coordinators may choose to complete this table individually or as a group activity with program staff. If completing individually, make sure to gather input from HIV testing staff.

When should this tool be completed? Complete this tool in the beginning of your M&E process and revisit it each time you review your M&E plan or if there are significant staff changes. This may be yearly or more frequently if necessary.

How should this tool be completed? For each M&E question and measure, decide how to analyze the data (i.e., for quantitative data, consider generating frequencies, averages, proportions or percentages; for qualitative data, you may code the text by themes and identify patterns). Next, include for each an analysis procedure (quantitative or qualitative) and the timeline schedule (e.g., survey data frequencies will be completed by mm/dd/yyyy). Finally, in the last column, document the roles and responsibilities of all individuals involved. This will help you to estimate the workload of each individual and develop a reasonable timeline for the analysis of your data.

Example:

Evaluation Question: To what extent are test results being provided to clients who received HIV testing?				
Monitoring Question	**Measure**	**Analysis Procedure**	**Analysis Timeline**	**Responsible Person(s)**
Among all test results, how many were provided to persons who received HIV testing in the past quarter?	Proportion of test results provided to persons who received HIV testing in the previous quarter.	Perform quantitative analysis through a division of the following: • Numerator: Number of HIV tests returned to clients in the past quarter • Denominator: Total number of HIV tests conducted in the past quarter	Proportions will be calculated within 30 days of the end of the quarter.	Data analysis tasks will be coordinated by the lead data coordinator.

Tool 12. Data Analysis Planning Template

Evaluation Question:				
Monitoring Question	**Measure**	**Analysis Procedure**	**Analysis Timeline**	**Responsible Person(s)**
Evaluation Question:				
Monitoring Question	**Measure**	**Analysis Procedure**	**Analysis Timeline**	**Responsible Person(s)**

Disseminating Findings

A dissemination plan will ensure that evaluation findings will be shared with stakeholders and other audiences. The plan should describe to whom and where results will be disseminated, and who will be responsible for disseminating them. Planning dissemination requires the following:

- Discussing the dissemination strategy with intended users and other stakeholders in advance.
- Matching the timing, style, tone, message source, vehicle, and format of reporting products to the audience.

Following are some strategies for getting the information to stakeholders:

- Mailings
- Web sites
- Community forums
- Conferences
- Media (television, radio, newspaper), depending on the policies of the sponsoring organization or agency
- Personal contacts
- E-mail lists
- Organizational newsletters

In the following example, Jacob Dougherty of Diverse and Resilient, Inc. emphasizes the value of regular meetings with program staff in which M&E findings are discussed.

One of the best ways to ensure good communication regarding program monitoring and outcomes is to have at least monthly meetings with program staff in which M&E data related to a program are presented. Having a meeting allows program staff to become knowledgeable about the progress a program is making toward its goals, as well as an opportunity for staff to brainstorm about possible challenges and how to overcome them.

Jacob Dougherty
Data Manager
Diverse and Resilient, Inc.
Milwaukee, WI

Exercise 12. Completing Your Dissemination Planning Template

After you have completed your data analysis plan, it is a good time to review your stakeholder reporting needs in a dissemination plan. Completing the template in this exercise will help you to determine your stakeholder information needs, your strategy for dissemination, and who will be responsible for disseminating the findings.

Tools and Templates: Tool 13—Dissemination Planning Template

To help you to plan to whom and how you will disseminate the results, complete the questions on this tool.

Instructions for Completing Tool 13. Dissemination Planning Template

What is the purpose of this tool? This tool will help you match stakeholder information needs and the frequency that the information will be disseminated. Additionally, you can identify program staff who will be responsible for generating each report.

Who should complete this tool? A program manager or the agency executive director may complete this tool, considering input of program staff.

When should this tool be completed? Complete this tool in the beginning of your M&E process and revisit it each time you review your M&E plan, significant staff changes take place, or if a new stakeholder information need arises. This may be yearly or more frequently if necessary.

How should this tool be completed? In Tool 13, record the following information in each of the designated cells:

- **Stakeholder:** Record each stakeholder who has a vested interest in your program and M&E findings. Reference the persons and group you identified in Tool 2 as a reference for this tool.
- **Information Needs:** Record the information needs or information that would benefit the identified stakeholder.
- **Dissemination Strategy:** Record the method and/or format for reporting the results to stakeholders (e.g., presentation, evaluation report, e-mail message).
- **Responsible Person(s):** Record a task lead for this reporting activity.
- **Frequency:** Record how often you will disseminate the information or M&E findings to the identified stakeholder.

Example:

Stakeholder	Information Needs	Dissemination Strategy	Responsible Person(s)	Frequency
Program Manager	To improve program delivery, the program needs information regarding the following: • HIV testing delivery • Quality of data collected • Identified gaps in knowledge or needs for training support	The data analysis team will disseminate regular status reports via e-mail to Sally. These reports will highlight key data related to program delivery, data quality, and recommendations for additional training or support.	Data coordinator	Quarterly

Tool 13. Dissemination Planning Template

Stakeholder	Information Needs	Dissemination Strategy	Responsible Person(s)	Frequency

Using Your M&E Data to Reach Conclusions and Make Recommendations for Program Improvement

After data analysis, you can begin using your findings to assess your SMART objectives and M&E questions, reach conclusions, and make recommendations for program improvement. Interpretation of evaluation results should be done with the program goals in mind. Interpreting evaluation results requires the following steps:

1. Organize the findings.

   Before any findings can be reviewed and interpreted, all evaluation findings need to be organized by evaluation question and measure(s). When organizing the findings, think about the program goals, the type of evaluation (process or outcome) that you have conducted, and the expected results.

2. Understand the context.

   Even with the best possible data, we cannot always explain the findings. All findings are context specific. That means the findings need to be interpreted within the larger context within which the program was implemented, which might have influenced data collection and data analysis.

3. Assess the findings.

   The main purpose of program evaluation is to use the findings for program improvement. Therefore, the evaluation results should be reviewed carefully so that relevant aspects of the program can be modified, if needed. Findings should help strengthen current activities or change what is not working. If the program goals and objectives are not met, it would be necessary to examine the consequences and determine why that happened and make recommendations for improvement.

4. Identify and describe the limitations.

   Even with the right evaluation questions and best possible data collection methods, the findings may have certain limitations. These limitations need to be identified and described. The limitations may be due to data sources, instruments that were used to collect the data, how data were collected (methods), and how data were analyzed (qualitative versus quantitative). You need to describe these limitations, if any, and how the interpretation may have certain limitations. Since the intention of this program evaluation project is not to measure attribution, but contribution, one of the foreseen limitations is that results will not be generalizable.

5. Synthesize the findings.

   The final step in data interpretation is to connect all the findings to the evaluation questions and provide a comprehensive picture. The description should be very informative, succinct, and yet comprehensive. It should highlight the findings about

the program activity evaluated. The findings should provide the information needed for recommendation and further modification.

The summary of evaluation findings can be presented along with your program's objectives and M&E questions to give stakeholders a better understanding of how effective each program component is in meeting the predefined target. To reach conclusions about your program, it may be useful to align each SMART objective and evaluation question with the evaluation findings similar to Exhibit 3.16. For additional considerations regarding findings and recommendations, you may find it helpful to refer to Chapter 9: Quality Assurance and Monitoring and Evaluation and the yield analysis tool in the Implementation Guide for HIV Testing and Linkage in Non-Clinical Settings.

Exhibit 3.16. Reaching Conclusions and Making Recommendations

Evaluation Questions: **1. To what extent are test results being provided to clients who received HIV testing?** **2. To what extent is the program linking HIV-positive individuals to medical care?**				
SMART Objectives	**Monitoring Questions**	**M&E Findings**	**Conclusions**	**Recommendations**
By the end of Fiscal Year 2014, 90% of clients will have knowledge of their serostatus through receipt of their test result.	Among all test results, how many were provided to persons who received HIV testing?	90% of clients who received an HIV test were provided with a test result within 3 days of the testing event.	The program is meeting its objective.	Continue to deliver trainings and support existing procedures around HIV testing and results provision.
By the end of Fiscal Year 2014, 85% of HIV-positive clients will attend their first medical appointment within 30 days of a positive result.	What percentage of persons testing HIV positive who are referred to medical care attend their first medical appointment?	73% of clients who tested positive for HIV attended their first appointment within 30 days of a positive result.	The program is having trouble meeting its objective.	Conduct focus groups with linkage staff to determine which resources, trainings, or additional procedures may be needed to improve effective linkage for HIV-positive clients.

As you can see in Exhibit 3.16, your M&E findings can show whether objectives are being met or not. In both cases, it is important to gather information around what is working and what is not contributing to a successful program. Remember that M&E activities are meant to be cyclical, and it is important to revisit objectives, M&E questions, and targets often to ensure they are feasible and appropriate for your program.

In the example from Neena Smith-Bankhead from AID Atlanta, she describes how program data that was going unused became the source of University student projects that provided an immediate benefit to their programs and allowed them to make evidence-based decisions on improving the quality of their data. This is also an example of how agencies can work with

community partners to yield a "win-win-win" situation for staff, students, and the agency's clients.

AID Atlanta has disseminated and collected pre- and post-tests and satisfactions forms from many of its interventions for years. Unfortunately, often times after they were reviewed briefly by staff to take note of trends, not much more was done with any of those documents. However, in 2004 to 2005, we developed a relationship with Kennesaw State University to use our data as evaluation projects for their students. The students learned about data collection and program evaluation in CBOs, and AID Atlanta was finally able to learn the benefits of their programs through having the satisfaction surveys and pre- and post-tests analyzed. Specific outcomes from this relationship also included:

1. *A more detailed analysis of the results of the pre- and post-tests*
2. *A more detailed analysis of our members' satisfaction with our program services*
3. *Suggestions and recommendations about questions that are yielding questionable results and how to either revise the question, or remove it altogether*
4. *Suggestions on how to maximize the efficiency of the data collection process to ensure that the data itself is clean and complete (we found that some people were using older tests, some staff were not matching the pre-tests with the post-tests, and some forms were illegible for certain questions so the responses may be inaccurate)*
5. *Regular presentations from the Kennesaw team to the staff to present the findings (including the bad-data findings) helped staff to focus more on ensuring that their data was complete and accurate, as well as collected and analyzed in a timely manner.*
6. *Thoughts on automating the data collection process to help minimize user error in data collection, including using iPods, iPads, e-mailed surveys, etc. This transformation is still in progress.*

AID Atlanta currently works with three different universities to assist with data collection, management, and analysis for our various programs. One university works with our pre- and post-tests, and others assist with other needs, including follow-up assessments with people who received positive and negative HIV test results, linkage to care studies/analysis, and focus groups with stakeholders of various programs. We get the technical support for managing our data, and the recommendations and suggestions for university faculty who specialize in public health and program evaluation, and the students get the experience with "real" data and CBOs, as well as opportunities to present findings as appropriate to staff, colleagues, and at small conferences.

Neena Smith-Bankhead
Director, Department of Education and Volunteer Services
AID Atlanta, Inc.

Exercise 13. Logging Your M&E Findings and Recommendations

Once you have analyzed and synthesized your M&E data, you will need to draft your findings and craft recommendations. This exercise will help you organize and document your findings as they relate to your SMART objectives and M&E questions, as well as catalogue your recommendations.

Tools and Templates: Tool 14—Evaluation Findings and Recommendations Table

This template is meant to help you align your SMART objectives, M&E questions, and findings in order to make conclusions and generate recommendations for the program going forward.

Instructions for Completing Tool 14. Evaluation Findings and Recommendations Table

What is the purpose of this tool? This tool can help you align your M&E questions and program objectives with M&E findings so that you can reach conclusions and make recommendations for program improvement.

Who should complete this tool? Program managers or coordinators may choose to complete this table individually or as a group activity with program staff. If completing individually, make sure to share recommendations with program staff.

When should this tool be completed? Complete this tool on a quarterly or more frequently if needed.

How should this tool be completed? For each of your prioritized evaluation questions, SMART objectives and monitoring questions (crafted in Tool 7), list your conclusions and recommendations.

Example:

Evaluation Question: To what extent are test results being provided to clients who received HIV testing?					
SMART Objectives	**Monitoring Questions**	**M&E Findings**	**Conclusions**	**Recommend-ations**	**Timeframe to Implement Recommend-ations**
By the end of Fiscal Year 2014, 90% of clients will have knowledge of their serostatus through receipt of their test result.	Among all test results, how many were provided to persons who received HIV testing?	70% of clients who received an HIV test were provided with a test result within 3 days of the testing event.	The program is not meeting its stated objective.	Implement new trainings to support the effective delivery of HIV testing and results provision.	Deliver training on testing procedures within 1 month. After 30 days, perform shadowing sessions of HIV testing encounters to ensure proper test and results provision.

Tool 14. Evaluation Findings and Recommendations Table

Evaluation Question(s):					
SMART Objectives	**Monitoring Questions**	**M&E Findings**	**Conclusions**	**Recommenda-tions**	**Timeframe to Implement Recommenda-tions**
Evaluation Question(s):					
SMART Objectives	**Monitoring Questions**	**M&E Findings**	**Conclusions**	**Recommenda-tions**	**Timeframe to Implement Recommenda-tions**

Step 6. Ensure Use and Share Lessons Learned

Evaluation is a process for systematically documenting what happens in your programs, applying your judgment and experience to make sense of that information, and then using it to guide decisions and solve problems. It is not the documentation that results in the learning and utility, but *reflection* on that experience. Reflection means thinking about the information you have and adjusting your actions accordingly. For evaluation efforts to be successful, you and your colleagues must be willing to engage in programmatic self-reflection. Sometimes this self-reflection will identify accomplishments and achievements; while other times it will identify weaknesses and problems that need correcting.

The last step in CDC's Framework for Program Evaluation focuses on sharing your evaluation findings with stakeholders and incorporating the lessons learned into the future directions of your non-clinical HIV TLC program. An evaluation is most effective when the results are used to make programmatic decisions by stakeholders. Therefore, you need to go beyond dissemination (e.g., writing the evaluation report, conducting an oral presentation) and use the findings for program improvement. Evaluations that are not used can be viewed as a misuse of effort and resources. As discussed in the previous section, it is important to share findings that are both negative and positive so program processes can be modified to become more efficient and effective.

Promoting Evaluation Use

Any M&E activity should be judged on the basis of its utility and actual use. In other words, utilization-focused evaluation considers "how real people in the real world apply evaluation findings and experience the evaluation process."[21] The following tips can be used to promote the use of program evaluation, some of which were addressed in the previous steps:

- Involve stakeholders throughout the evaluation, since this can increase understanding and ownership of the evaluation. Those who are fully engaged may be more likely to be whole-heartedly committed, take an interest in the findings, and use them to strengthen the program.
- Decide and specify, during an initial consultation with stakeholders, how evaluation results will be used. Every decision made during the evaluation should be based on how it will influence the evaluation findings use.
- Consider the uses of the evaluation when prioritizing the questions to be answered during the evaluation.
- Be aware and address how contextual factors might affect the use of evaluation findings (e.g., organizational culture and characteristics, evaluator credibility, resource constraints, etc.).

[21] Patton, M. Q. (1997). *Utilization-focused evaluation* (3rd ed.). Thousand Oaks, CA: Sage Publications.

- Build evaluation capacity among stakeholders, which can contribute to adopting evaluation findings over time.
- Choose methods of sharing evaluation findings that will encourage evaluation use. Remember that the methods you use with stakeholders may impact their willingness to make programmatic decisions.
- Build follow-up time in the evaluation process to facilitate the use of results after the report has been submitted.
- Assess how findings and recommendations were used, including lessons learned from the evaluation process.
- Have a postevaluation meeting with stakeholders 1 month after the completion of the evaluation process and assess progress toward addressing the recommendations and findings of the evaluation. If there are recommendations that you failed to implement, determine the reasons. Next develop an action plan with a timeline, and determine the person(s) responsible.
- Follow up 3 months later to determine the status of the action plan and reconvene accordingly.

Examples From the Field

In the following case studies, you will read how agencies use M&E practices in three main areas: stakeholder engagement, targeting and recruitment, and monitoring "real time" progress toward goals. In these cases you will note a variety of approaches, with no one "right" way to integrate M&E into program improvement processes.

In the first case study, Jamie Anderson of the Kansas Department of Health and Environment describes Kansas' approach to stakeholder engagement and their overall quality assurance approach for non-clinical HIV TLC programs. She discusses the responsibilities and goals of the stakeholder group and the data they will review to provide recommendations for program improvement.

Stakeholder Engagement and Use of M&E Data for Decision Making

In 2010, the Ryan White Part B Statewide Planning Body and Kansas HIV Prevention's Community Planning Group combined to form the Kansas Advisory Council on HIV/AIDS (KACHA). Within KACHA is a standing quality management committee (QMC). This committee is devoted to developing and continually improving a high-quality continuum of HIV preventative treatment and supportive services that meet the identified needs of people at risk for HIV and those living with HIV/AIDS in Kansas. The QMC drives the statewide HIV Kansas quality program. This committee has five responsibilities:

- *Strategic Planning—Prioritizing quality management goals and projects, identifying performance measures, planning for program evaluation, and determining how best to establish and sustain the quality management program.*
- *Facilitating Innovation and Change—Removing barriers to achieving and sustaining improvements (policy changes, for example) and ensuring all providers have a stake in quality improvement.*

- *Providing Guidance and Reassurance—Guiding the progress of quality-related activities to ensure quality improvement (QI) teams are staying on track.*
- *Allocating Resources—Ensuring that staff has the time, tools, knowledge, and data to do QI work.*
- *Establishing a Common Culture—Speaking with a constant and consistent voice to encourage the new culture of making decisions based on data, not blaming individuals, and being open to new ways of doing work.*

In support of this mission, Kansas has established eight goals for the Quality Management program. These goals are supported by the gathering/reporting of data needed to measure program/service quality and then implementing improvement activities based upon this data.

- *Develop and implement a statewide quality management program with active participation by agencies and consumers.*
- *Facilitate improved medical case management practices by implementing and improving Part B medical case management standards/expectations statewide.*
- *Improve alignment across regions by monitoring core performance measures across Part B recipients.*
- *Promote consistent quality within and between agencies.*
- *Improve communication and coordination with Medicaid for AIDS Drug Assistance Program (ADAP).*
- *Facilitate the ability of agencies to be involved in quality management to better meet client needs and assist with QI projects in which to do so.*
- *Ensure that all HIV testing providers provide testing services following at least the minimum standards set by the State Testing Program.*
- *Facilitate effective HIV prevention activities with community prevention providers by ensuring that all providers are adequately trained and receive appropriate technical and capacity building assistance.*

Outcomes/targets for the performance measures will be determined by the QMC after baseline data are determined. The effectiveness of the QM Program will be assessed as follows:

- *Quarterly—Outcome measurements will be reviewed to determine progress.*
- *Ongoing review of chosen performance measures.*
- *Ongoing subjective review from providers and consumers to see if changes are really happening.*
- *Annually review and update QM plan.*
- *Annually complete the QM Assessment Tool (QMC).*

Jamie Anderson
HIV Counseling, Testing, and Linkage Director
Kansas Department of Health and Environment
Bureau of Disease Control and Prevention

In the second example, Jacob Dougherty of Diverse and Resilient, Inc. describes how his agency approached the challenge of finding where to focus their recruitment efforts for a new non-clinical HIV TLC program.

Targeting and Recruitment: Implementing a New Non-Clinical HIV TLC Program—How Do You Know Where to Go?

When we were just starting out with a new HIV testing program, it was difficult to determine where exactly to go for outreach and testing efforts in the field. For example, we did not have any data on the number of our agency's target population for testing that go to a specific venue where we were considering doing outreach efforts. In these cases, we relied on non-traditional sources of data. We held focus groups with members of the target population and looked for patterns in their responses to the question "Where do you go to hang out?"

Identifying and establishing partnerships with other organizations that serve similar populations is also important in this case. This allowed us to avoid duplicating services and also helped establish connections with our target population. In these early efforts, it's also important to remember that not every venue will yield the results that you expect.

Jacob Dougherty
Data Manager
Diverse and Resilient, Inc.
Milwaukee, WI

In the next case study, Jon Stockton of the Washington State Department of Health describes the approach a local health jurisdiction took to enhance the reach and efficiency of their HIV testing efforts with high-risk populations.

Targeting and Recruitment: Combining Services to Increase Recruitment Among High-Risk Individuals

A South Sound local health jurisdiction (LHJ) in Washington State integrated STD disease investigation (which includes STD disease investigation specialists [DIS]) and HIV testing services into one department based on resource considerations and to combine efforts to reach high-risk individuals. STD disease investigators within the department were cross-trained to provide HIV testing services and partner services. STD DIS offer every client investigated for a communicable disease a free HIV test after completion of partner elicitation. Communicable diseases investigators follow an algorithm that describes intensity of reaching index patients based on diagnosed STD. For example, a heterosexual male diagnosed with chlamydia receives a set number of contacts to reach the client and conduct an interview before closing the case.

In order to increase recruitment for HIV testing among high-risk populations, the LHJ revised their algorithm to prioritize communicable diseases based on risk factor and diagnosed disease, as shown in their surveillance and testing data. STD case reports that identified MSM, males with diagnosed gonorrhea, and African American females were prioritized to ensure that the index patient was interviewed and a HIV test was provided. STD cases for prioritized populations are left open for longer periods of time and are reviewed by the program lead to ensure that cases are interviewed and receive an HIV test.

This recruitment model is especially beneficial for sites that have limited personal and resources dedicated to traditional outreach and recruitment models. LHJs can partner with community-based organizations to help deliver HIV testing services to clients that are unable to travel to a site.

Jon Stockton
HIV Counseling and Testing Coordinator
Washington State Department of Health

Angela Wood from FMCS provides oversight to a non-clinical HIV TLC program in a branch of the Department of Motor Vehicles in Washington, DC. In her case study, she discusses the importance of integrating M&E data into a real-time quality improvement process to make adjustments to their program as soon warranted by M&E findings.

Real-Time Data for Program Monitoring and Improvement

FMCS currently provides HIV testing to individuals accessing services at the Department of Motor Vehicles (DMV) in Washington, DC. This comprehensive HIV testing program utilizes the OraQuick ADVANCE Rapid HIV-1/2 Antibody test and provides immediate access to follow-up care services for persons with reactive test results and immediate access to behavior change support services for high-risk HIV-negative individuals.

The inclusion of ongoing program evaluation is critical to the success of any testing program, but is it imperative to the implementation of HIV testing in public service venues such as the DMV. FMCS implements a practical program evaluation and continuous quality improvement program that is designed to measure progress toward five selected quality improvement indicators: HIV offer rate, acceptance rate, testing rate, positivity rate, and linkage to care rate. Our program design is consistent with the Plan, Do, Study, Act model and emphasizes the importance of consistent measurement of progress toward identified program goals; the identification and implementation of corrective actions when program performance falls below identified goal; and the ongoing monitoring of identified measures to ensure that changes positively impact progress toward identified goals.

Our evaluation and quality improvement activities are embedded in our program activities. We utilize a combination of manual data collection, a program-specific Microsoft Excel database, and our Electronic Medical Record to collect, analyze, and report evaluation and quality improvement data. We analyze our program data at daily, weekly, and monthly intervals to ensure that we have our most current data at our fingertips and can make appropriate changes to our program strategy.

On a daily basis, our program staff manually collect and report the number of individuals accessing services at the DMV during our hours of operation; the number of individuals who are offered an HIV test; the number of individuals who accept HIV testing at the DMV; the number of individuals tested for HIV, and the number of individuals testing HIV positive. This information is submitted to our program coordinator and is entered into an Excel data base that calculates the offer rate, acceptance rate, HIV testing rate, and positivity rate.

Angela Fulwood Wood
Chief Operations Officer
FMCS, Inc.
Washington, DC

Conclusion

In this Evaluation Guide, we walked through the six steps of CDC's Framework for Program Evaluation to discuss the concepts and practices that contribute to a comprehensive M&E approach for non-clinical HIV TLC programs. Thoughtfully engaging with each of the six steps can lead to better program planning, more targeted services, consistent service provision, and high-quality data.

The exercises presented in the guide help to illustrate the types of program M&E questions and other information that are helpful to document in conjunction with agency staff and community partners. This information forms the foundation of your M&E plan, which outlines the goals, objectives, key players, and measures of success for your non-clinical HIV TLC program. Remember that engaging agency staff and community representatives during the M&E process fosters collaboration, understanding, and contributes to a representative M&E plan.

As pointed out in this Evaluation Guide, M&E is an iterative process and your M&E findings are most valuable when they transition from recommendations into program improvement actions. Plan ahead to revisit the concepts, considerations, and exercises from this guide on a regular basis so that the M&E process becomes an integrated and seamless component of your non-clinical HIV TLC program.

Appendix A. Glossary

Acquired Immunodeficiency Syndrome (AIDS): The final stage of HIV infection. A person infected with HIV is diagnosed with AIDS when he or she has one or more opportunistic infections, such as pneumonia or tuberculosis, and/or has a dangerously low number of CD4+ T cells (less than 200 cells per cubic millimeter of blood).

Anonymous HIV testing: HIV testing in which client-identifying information is not linked to testing information, including the request for tests or test results.

Capacity building: Activities that strengthen the core competencies of an organization and contribute to its ability to develop and implement an effective HIV prevention intervention and sustain the infrastructure and resource base necessary to support and maintain the intervention.

Case management: A service generally provided through an ongoing relationship with a client that includes comprehensive assessment of medical and psychosocial support needs, development of a formal plan to address needs, provision of assistance in accessing services, and monitoring of service delivery.

Centers for Disease Control and Prevention (CDC): The lead Federal agency for protecting the health and safety of people in the United States, providing credible information to enhance health decisions, and promoting health through strong partnerships. Based in Atlanta, Georgia, this agency of the U.S. Department of Health and Human Services serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States.

Client: Any person served by a health department or other health or social services provider.

Clinical setting: A setting in which both medical diagnostic and treatment services are provided.

Comprehensive Risk Counseling and Services (CRCS): An intensive, individualized client-centered counseling for adopting and maintaining HIV risk-reduction behaviors. CRCS is designed for HIV-positive and HIV-negative individuals who are at high risk for acquiring or transmitting HIV and STDs and struggle with issues such as substance use and abuse, physical and mental health, behavior change, and social and cultural factors that affect HIV risk. CRCS was formerly referred to as HIV prevention case management (PCM).

Confidentiality: Ensuring that information is accessible only to those authorized to have access.

Counseling and testing: A process through which an individual receives information about HIV transmission and prevention, information about HIV tests and the meaning of tests results, and is provided testing to detect the presence of HIV antibodies. Counseling was a focus in CDC's 2001 CTR Guidelines, but in the forthcoming Guidelines there is a shift to brief information provision.

Data analysis: The process of organizing, classifying, tabulating, and examining the information collected and presenting the results so they can be easily understood by stakeholders.

Data management: Policies and procedures that ensure the proper storage, transport, and disposal of data.

Data security: The protection of public health data and information systems in order to prevent unauthorized access or release of identifying information and accidental data loss or damage to the systems. Security measures include measures to detect, document, and counter threats to data confidentiality or the integrity of data systems.

Evaluation: The systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and inform decisions about future programming.

Evaluation Question: Question in the monitoring and evaluation plan that serves as the basis for deciding which data to collect. This information then should guide decision making regarding program improvement.

High risk: Clients who report any of the following may be at high risk for HIV transmission or acquisition:

- Recent unprotected anal and/or vaginal sex with an HIV-positive partner(s) or partner(s) of unknown HIV status
- Recent sharing of drug injection equipment with an HIV-positive partner(s) or partner(s) of unknown HIV status
- Current or recent past diagnosis of and/or treatment of a sexually transmitted disease in self or partner
- Symptoms of viral illness

Human Immunodeficiency Virus (HIV): A virus disabling immune system composed either of two strains of a retrovirus, HIV-1 or HIV-2, that destroys the immune system's helper T cells, the loss of which causes AIDS.

HIV testing in non-clinical settings: A testing strategy that involves testing persons on the basis of characteristics that increase their likelihood of being infected with HIV. These

characteristics can include the presence of sexually transmitted diseases, behavioral risks, or attendance at venues frequented by high-risk persons.

Incentive: Compensation for a person's time and participation in a particular activity, (e.g., voucher for transportation, food, money, or other small reward).

Incidence: The number of new cases in a defined population within a certain time period (often a year). It is important to understand the difference between HIV incidence, which refers to new HIV infections, and new HIV diagnoses. New HIV diagnoses represent persons newly identified as HIV infected, usually through HIV testing. These persons may have been infected recently or at some time in the past.

Informed consent: An individual receives and understands information sufficient to obtain his/her consent to undergo HIV testing.

Intervention: A specific activity (or set of related activities) intended to reduce the risk of HIV transmission or acquisition. Interventions may be either biomedical or behavioral and have distinct process and outcome objectives and procedures outlining the steps for implementation.

Linkage to medical care: A person is seen by a health care provider (e.g., physician, physician assistant, nurse practitioner) to receive medical care for his/her HIV infection, usually within a specified time. Linkage to medical care is the outcome of the referral. Linkage should be verified by following up with the provider. This requires a valid release of information form signed by the client in advance of the referral.

Logic model: A framework that guides an organization's activities by visually depicting the main elements of an intervention and illustrating the linkage between components. Logic models often include a problem statement, inputs, activities, outputs, immediate outcomes, intermediate outcomes, and impacts.

Men who have sex with men (MSM): Men who report sexual contact with other men and men who report sexual contact with both men and women, whether or not they identify as gay or homosexual.

Monitoring: The regular observation, tracking, and recording of activities taking place in a program or project. It includes the process of systematically observing and routinely gathering information on all aspects of the program. Monitoring also involves providing feedback about the progress of the program to the stakeholders and implementers to be used in making decisions for improving program performance.

Monitoring and evaluation (M&E) plan: A comprehensive planning document for all M&E activities. An M&E plan documents the key M&E questions to be addressed, including what indicators are collected; how, how often, from where, and why they will be collected; what baselines, targets, and assumptions will be included; how the indicators are going to be

analyzed or interpreted; and how or how often reports will be developed and distributed on these indicators.

National HIV/AIDS Strategy: On July 13, 2010, the White House released the National HIV/AIDS Strategy (NHAS). This ambitious plan is the nation's first-ever comprehensive coordinated HIV/AIDS road map with clear and measurable targets to be achieved by 2015. The National HIV/AIDS Strategy was developed with three primary goals in mind: (1) Reducing the number of people who become infected with HIV; (2) Increasing access to care and optimizing health outcomes for people living with HIV, and (3) Reducing HIV-related health disparities.

Non-Clinical setting: A setting which does not provide both medical diagnostic and treatment services.

Non-Clinical HIV testing and linkage to care (TLC) program: Used in the Evaluation Guide to represent non-clinical HIV testing and linkage to care and other prevention services programs.

Outcome monitoring: The routine documentation and review of program-associated outcomes (e.g., individual-level knowledge, attitudes, and behaviors, or access to services, service delivery, community or structural factors) in order to determine the extent to which program goals and objectives are being met.

Partner Services (PS): A systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can be offered HIV testing and learn their status, and, if already infected, services to help them prevent transmission to others.

Prevalence: The total number of cases of a disease in a given population at a particular point in time. HIV/AIDS prevalence refers to persons living with HIV, regardless of time of infection or diagnosis date. Prevalence does not give an indication of how long a person has had a disease and cannot be used to calculate rates of disease. It can provide an estimate of risk that an individual will have a disease at a point in time.

Prevention Case Management (PCM): See Comprehensive Risk Counseling and Services (CRCS).

Privacy: The right of an individual to keep oneself and his or her information concealed or hidden from the unauthorized access and view of others.

Program: Collection of services or projects within an agency or jurisdiction designated to meet a social or health services need in a community. Plan or system under which action may be taken toward achieving a goal.

Program activities: Specific actions directly related to program objectives that occur during non-clinical HIV testing and linkage to care programs, including provision of information, testing, and referral and linkage services.

Program inputs: Resources needed to implement your non-clinical HIV testing and linkage to care program, such as funding, staff, test kits, and materials.

Program impacts: The long-term, cumulative effects of programs on a population over time.

Program outputs: The immediate products or results of a service delivered as a part of your non-clinical HIV testing program, such as number of test results or number of clients informed of their test results.

Program planning: The process of defining goals, objectives, and activities relevant for specific target populations.

Process evaluation: Evaluation that assesses planned versus actual program performance over a period of time for the purpose of program improvement and future planning.

Process monitoring: The routine documentation and review of program activities, populations served, and resources used in order to improve the program.

Qualitative data: Detailed descriptions of situations, events, people, interactions, and observed behaviors; direct quotations from people about their experiences, attitudes, beliefs, and thoughts; or excerpts or passages from documents, correspondence, records, and case histories. Qualitative data come from open-ended interviews, focus groups, observations, document review, and questionnaires without predetermined, standardized categories.

Quantitative data: Numeric information representing predetermined categories that can be treated as ordinal or interval data and subjected to statistical analysis. Quantitative data come from structured questionnaires, tests, standardized observation instruments, and program records.

Quality assurance: Systematic monitoring and evaluation of the various aspects of a project, service, or facility to ensure that standards of quality are being met.

Recruitment: The process by which individuals are identified and invited to become participants in HIV testing and linkage to care programs.

Referral: Referral is the process by which a client's immediate needs for medical care or risk-reduction services are assessed and prioritized, and the client is provided with information and/or assistance in accessing referral services. A referral may be either passive or active. Linkage takes a further step by verifying that the referral was successfully completed.

- Passive Referral: In a passive referral, a client is provided with information, such as agency name and location, about one or more referral services. It is then up to the client to make decisions about whether and which services to access.
- Active Referral: An active referral begins with assessment and prioritization of a client's immediate needs for medical and/or risk-reduction services. In an active referral, a client is provided with assistance in accessing referral services, such as setting up an appointment or being given transportation.
- Linkage: Linkage means that a referral has been verified as having been successfully completed. If a client keeps his or her first appointment or receives the referral service (if the referral requires keeping only a single appointment) the referral can be considered as having been successfully completed. Optimally, feedback on a client's satisfaction with referral services should be part of the linkage process.

SMART objective: Process and outcome objectives which link directly to a logic model and are Specific, Measurable, Achievable, Realistic, and Time-based (SMART).

Stakeholders: People or organizations that are invested in the program, are interested in the results of the evaluation, and/or have a stake in what will be done with the results of the evaluation.

Targeting: Use of data or information to direct HIV testing, linkage, and HIV risk-reduction services to high-risk populations and settings in which high-risk persons can be accessed, with the purpose of ensuring that services are available and accessible by persons who need them.

Target populations: The primary groups of people that the applicant will serve. Target populations are defined by both their risk(s) for HIV infection or transmission, as well as their demographic characteristics and the characteristics of the epidemic within this population.

Testing technology: Type of test or test method used to perform HIV testing on an individual or specimen.

Appendix B. Resources

CDC's Effective Interventions Web Site (http://effectiveinterventions.org)

This Web site includes information and guidance documents on a myriad of HIV prevention interventions, including biomedical, behavioral, and structural interventions. Additionally, this site includes information and guidance on a number of public health strategies and social marketing initiatives.

Prevention Training Centers (http://depts.washington.edu/nnptc/index.html)

The National Network of STD/HIV Prevention Training Centers provide resources and training to increase the knowledge and skills of those working in the field of HIV prevention. This Web site contains information on each of the regional centers and the training programs that are available through each.

National HIV Prevention Program Monitoring and Evaluation (NHM&E) Service Center (1-888-736-7311 or http://nhmeservice@cdc.gov)

This group provides technical assistance to CDC-funded grantees on the collection, management, and use of NHM&E data. Additionally, this group can provide guidance on preparing for M&E at your agency.

National HIV Prevention Program Monitoring and Evaluation (NHM&E) Online Training (http://www.nhmetraining.net)

This site provides a set of computer-based training modules that can be used to increase capacity, knowledge, and skills related to the collection, management, and use of NHM&E data. Courses are available on topics such as M&E guidance and tools, Partner Services, and HIV testing.

Data Quality and Assurance Standards for HIV Counseling, Testing, and Referral Data (http://www.cdc.gov/hiv/testing/resources/guidelines/qas/overview.htm)

This resource provides recommendations and practices for improving the quality of HIV testing, counseling, and referral data. The document is organized to follow the CTR data life cycle and covers topics including data collection, data entry, data management, data analysis, data verification, and data submission.

Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action (http://www.cdc.gov/nchhstp/programintegration)

This document, created by the Program Collaboration and Service Integration (PCSI) group within the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, is meant to promote common practices for securing data and encourage the sharing and of use of data across programs.

Appendix C. Toolkit

The following appendix includes all the tools discussed in the Evaluation Guide. Prior to each tool, we provide information on the purpose of the tool, how new and established programs can use the tool, how health departments or funders can use the tool, as well as detailed instructions on who should complete the tool, the timing of completion, and how to complete it.

Tool 1. Stakeholder Identification Table

About Tool 1: Involving internal and external stakeholders in the M&E process for your non-clinical HIV TLC program is critical and ensures that M&E activities reflect the priorities and needs of your agency and community. Tool 1 helps you think about those persons who are involved in the planning, delivery, consumption, and advocacy of your program. You should complete Tool 1 to identify those groups, representatives, and individuals who are impacted by your program and can advocate for the services. If possible, complete a first draft of this tool before you reach out to stakeholders so that you can identify commonalities among the stakeholders in terms of information needs and/or anticipated challenges. If you identify groups as stakeholders in this tool, make sure to identify a specific individual who can serve as a representative for that group in the M&E process. Agencies may also choose to use this tool as a means to create or identify members for a community advisory board.

When completing this tool, be sure to gather input from multiple individuals with differing perspectives and experiences, including agency leaders (i.e., executive director), program managers and directors, staff providing HIV testing and linkage, and community representatives. Gathering this input will ensure that a comprehensive list of stakeholders is identified for your non-clinical HIV TLC program. You may wish to revisit this tool after initially engaging stakeholders, since they may identify others who should be involved.

How New Programs Can Use This Tool: As a new program who is planning to implement a non-clinical HIV TLC program, building partnerships with your community and within your agency will be major milestones. This tool is designed to help you identify all of the individuals who are interested, invested, and involved in your program, as well as those who will benefit from receiving M&E findings. Working through this tool can also help you establish a community board of advisors who can offer input on program strategies and approaches, help you plan and target your services, and provide feedback on your program.

How Established Programs Can Use This Tool: Agencies who have already implemented a non-clinical HIV TLC program can complete and revisit this tool on a regular basis to ensure that their M&E stakeholder group or advisory board are inclusive of multiple perspectives and representative of those planning, delivering, and receiving HIV TLC services.

How Health Departments and Other Funders Can Use This Tool: Health departments and other funders may find this tool helpful for use with local grantees or contractors. You may ask grantees to include this tool in a grant application to identify those individuals and groups within their agency and community with whom they will engage as a part of program planning, delivery, and improvement. Health departments or other funders may also wish to adapt this tool for use with other interventions or services.

Instructions for Completing Tool 1. Stakeholder Identification Table

What is the purpose of this tool? This tool can help you catalogue individuals within your agency and the community you serve who can contribute to your M&E plan and who will benefit from M&E findings. You may also choose to involve the persons or groups identified in this tool in your agency's advisory board or HIV prevention planning group.

Who should complete this tool? You may choose to complete this tool for each program or for each non-clinical HIV TLC setting/venue. In each case, involve those persons who are familiar with the program, such as managers and coordinators, when identifying stakeholders.

When should this tool be completed? Complete this tool at the beginning of your M&E process, each time you revise your M&E plan, after you have started discussions with your stakeholders, or as a means to creating and updating an advisory board. You may choose to do this yearly or more frequently if needed.

How should this tool be completed? Use the questions provided in the left column to start identifying stakeholders for the program. You may modify the table to list as many stakeholders as you think of for each question. Record the following in each of the designated cells:

- **Stakeholder's Position or Group:** Record the stakeholder group or individual stakeholder position. If you have identified an organization or a group as a stakeholder, be sure to specify one individual that can represent that group.
- **Internal or External:** Record whether this individual works within your agency or is a part of the community.
- **Information Needs:** Record the information that will benefit the stakeholder or that the stakeholder is specifically requesting.
- **Concerns or Anticipated Challenges:** Record any concerns or challenges you may have with communicating, engaging, or sharing findings with this stakeholder.
- **Stakeholder Name and Contact Information:** Record the name, e-mail address, phone number and any other contact information that will help you maintain contact with this stakeholder.

Example:

Questions	Stakeholder's Position or Group	Internal or External?	Information Needs	Concerns or Anticipated Challenges	Stakeholder Name and Contact Information
Who is managing the program?	Program coordinator	Internal	Information to improve HIV testing delivery, enhance data quality, inform staff training	None	Sally Jones, sjones@emailcarrier.com (512) 555-1234

Tool 1. Stakeholder Identification Table

Agency/Program:	**Participants:**
Target Population:	
Date Completed:	

Questions	Stakeholder's Position or Group	Internal or External?	Information Needs	Concerns or Anticipated Challenges	Stakeholder Name and Contact Information
Who is managing the program?					
Who is collecting or analyzing data?					
Who represents the populations you serve?					
Who represents your priority groups and/or your advisory board?					
Who can serve (is serving) as a champion for your program in the community?					

Tool 1. Stakeholder Identification Table (continued)

Questions	Stakeholder's Position or Group	Internal or External?	Information Needs	Concerns or Anticipated Challenges	Stakeholder Name and Contact Information
Who will use the evaluation findings?					
Who receives submitted data?					
Who relies on the information for make program changes?					
Who funds or approves (including changes to) the program?					
Who is not a current supporter of your program who could benefit from evaluation findings?					
Are there any detractors for your program?					

Tool 2. Monitoring and Evaluation Preparation Work Plan

About Tool 2: Tool 2 assists in guiding your agency through the various activities of conducting M&E of a non-clinical HIV TLC program. Consider the information you recorded in Tool 1 to help you think about the stakeholders you will engage as a part of the M&E process.

The tool is divided into four sections with corresponding activities. For each activity in the tool, you should identify a task lead and establish an agreed upon deadline. Additionally, list any anticipated challenges and strategies to address these challenges. To ensure relevance for an extended period of time, you may choose to identify a staff role or position (i.e., program manager) instead of an individual's proper name (i.e., Sally Jones).

Consider completing this tool as a part of a team retreat or group meeting and be sure to gather input from multiple individuals with differing responsibilities, including agency leaders (i.e., executive director), program managers and directors, and staff providing HIV testing and linkage. Engaging these individuals during the completion of this tool will help you solidify roles and responsibilities in a timely manner and facilitate engagement among agency staff around the M&E process. After completing the tool, consider distributing it to and discussing it with agency staff members in order to foster understanding regarding M&E for your program.

How New Programs Can Use This Tool: As an agency without an established non-clinical HIV TLC program, this tool can assist you in managing the M&E activities throughout the life cycle of your program. Completing this tool will help you ensure that agency staff share an understanding of the M&E process, individuals are identified as point persons for specific M&E activities, the M&E team has adequate materials and support, timelines are shared, and there are documented procedures for communication and feedback.

How Established Programs Can Use This Tool: If you have already established a non-clinical HIV TLC program, you can use tool to aid in the management or refinement of the M&E activities of your program.

How Health Departments and Other Funders Can Use This Tool: Health departments and other funders may find this tool helpful for use with local grantees or contractors, especially those new to implementing HIV TLC programs or those who are new to M&E. Those agencies funding programs may ask agencies to complete this tool as a condition of their funding for HIV testing and linkage to show thoughtful planning and preparation for M&E activities.

Instructions for Completing Tool 2. Monitoring and Evaluation Preparation Work Plan

What is the purpose of this tool? This tool can help you document individuals within your agency who will complete M&E activities, a timeline for those activities, as well as challenges and strategies to address those challenges.

Who should complete this tool? Consider completing this inventory as a group activity at your agency so that you can immediately identify responsible parties and clarify roles and responsibilities for M&E activities. You may choose to involve the executive director, program managers or coordinators, grant writers, HIV testing and linkage staff, and others as necessary.

When should this tool be completed? Complete this tool in the beginning of your M&E process after you have completed Tool 1 in this toolkit. Revisit it each time you review your M&E plan or if there are significant staff changes. This may be yearly or more frequently if necessary.

How should this tool be completed? To complete this work plan, begin by indicating a person(s) to be responsible for each activity. You may choose to identify a staff role instead of a particular individual. Next, set a realistic timeline by which the task should be complete. In the third column, list any challenges that may delay the completion of the activity. Finally, consider strategies that will address any challenges you document.

Example:

Activity	Responsible Person(s)	Timeline	Challenges	Strategies to Address Identified Challenges
Contact internal stakeholders, program staff, and senior leaders who will participate in M&E activities.	Program manager	Within 4 weeks.	Many of the agency's senior leaders are out of the office over the next month and it may be difficult to solidify commitments from this group.	The program manager will use multiple methods of communication to reach out to internal stakeholders, and will provide both digital and print-based options for documenting commitment to participate in M&E activities.

Tool 2. Monitoring and Evaluation Preparation Work Plan

Agency/Program:	**Participants:**
Target Population:	
Date Completed:	

Activity	Responsible Person(s)	Timeline	Challenges	Strategies to Address Identified Challenges
Developing a Shared Understanding *				
Contact internal stakeholders, program staff, senior leaders who will participate in M&E activities.				
Contact external stakeholders such as clients, providers, and community members who will participate in M&E activities.				
Share the purpose and goals of M&E with program staff and senior leaders.				
Obtain input and feedback from program staff and senior leaders regarding M&E activities.				
Share the purpose and goals of M&E with external stakeholders.				
Obtain input and feedback from external stakeholders regarding M&E activities.				

*Reference the list of stakeholders you identified in Tool 1 when completing this section.

Tool 2: Monitoring and Evaluation Preparation Work Plan (continued)

Activity	Responsible Person(s)	Timeline	Challenges	Strategies to Address Identified Challenges
Staffing an M&E Team				
Identify an M&E coordinator or M&E team lead.				
Identify individuals for the following M&E activities:				
Engaging internal and external stakeholders				
Constructing an M&E plan including documenting practices and completing the M&E toolkit				
Data collection				
Data entry and management				
Data analysis				
Data quality assurance				
Documentation and distribution of findings				
Communicate M&E team roles and responsibilities with program staff and senior leaders.				
Orient and train program staff for their role and responsibilities.				
Orient and train program staff to use data collection tools accurately.				

Tool 2. Monitoring and Evaluation Preparation Work Plan (continued)

Activity	Responsible Person(s)	Timeline	Challenges	Strategies to Address Identified Challenges
Orient and train program staff to collect, enter, and manage data accurately.				
Orient and train program staff on data collection practices.				
Orient and train program staff on data reporting requirements.				
Obtain input/feedback from program staff on the importance and processes for data QA.				
Provide training and technical assistance on data collection, entry, management, and application (when applicable).				
Obtaining or Creating Materials				
Inventory M&E training materials, reference or guidance documents, and save in a central location for ongoing access.				
Obtain supplies for the M&E team.				
Obtain technology for the M&E team (i.e., computers, software, data collection and management system, data analysis tools).				

Tool 2. Monitoring and Evaluation Preparation Work Plan (continued)

Activity	Responsible Person(s)	Timeline	Challenges	Strategies to Address Identified Challenges
Make adaptations or develop data collection tools, when applicable.				
Perform the document review process on all materials before distribution.				
Obtain technology (i.e., data collection software or devices), when applicable.				
Establish Structure and Operations				
Plan and document regular communication methods (i.e., e-mail, meetings) between program staff and M&E team.				
Plan and document regular communication methods (i.e., e-mail, meetings) between the M&E team and external stakeholders.				
Plan and document ways to incorporate data and M&E findings in the agency's decision-making process.				

Tool 3. Monitoring and Evaluation Organizational Capacity Inventory

About Tool 3: Completing Tool 3 will help you identify not only the resources that are readily available, but will also help you think about the ways that you can mitigate challenges or request additional support from community partners or funders to fill the gaps in resources.

Agencies may choose to complete Tool 3 at the agency or program level. In both cases, be sure to gather input from multiple individuals with differing perspectives and experiences, including agency leaders (i.e., executive director), program managers and directors, grant writers, staff providing HIV testing and linkage, and community representatives. Gathering this input will ensure that the inventory is reflective of your agency, HIV TLC program, and is up to date.

Although Tool 3 presents a set of resources that will be useful in the M&E process in the left column, you should take inventory of local M&E needs and modify the table to include specific resources that are relevant to your program and community.

How New Programs Can Use This Tool: If your agency has yet to implement a non-clinical HIV TLC program, this tool can help you think about the resources that are necessary to conduct thorough M&E and make a judgment about your current capacity. There may be resources in this tool that you have not considered, and by completing the inventory, you will be able to determine the resources you have readily available and the areas where your program needs additional support.

Although it is not required that you have all of the resources in this inventory to begin M&E for your program, it is encouraged that new programs complete this inventory and establish a plan to fill any gaps in resources prior to implementing M&E activities.

How Established Programs Can Use This Tool: If you have already implemented a non-clinical HIV TLC program at your agency, you can complete and revisit this tool on a regular basis to ensure that you have the resources necessary to support ongoing M&E efforts. Changes in staff availability, policies and procedures, funding sources, and data reporting requirements can affect the availability of resources. For this reason, many programs complete inventories like Tool 3 as a part of their yearly program planning process or more frequently if necessary.

How Health Departments and Other Funders Can Use This Tool: Health departments and other funders may choose to use this tool with grantees or contractors as a readiness activity when completing the grant application process or yearly program plans. If used in this way, grantees can use the "anticipated challenges" column on the right to explain the ways that they will bridge the resource gap before implementing their non-clinical HIV TLC program. Health departments or other funders may also wish to adapt this tool for use with other interventions or services.

Instructions for Completing Tool 3. Monitoring and Evaluation Organizational Capacity Inventory

What is the purpose of this tool? This tool will help you inventory the M&E-related resources you have available immediately, those that will be available in the future, and any gaps that may need to be filled for your non-clinical HIV TLC program.

Who should complete this tool? Within an agency, you may have different contacts for program, budget, technical, and training questions. For this reason, consider completing this inventory as a group activity. You may choose to involve the executive director, program manager or coordinator, grant writers, HIV testing and linkage staff, and others as necessary.

When should this tool be completed? Complete this tool at the beginning of your M&E process or each time you revise your M&E plan. You may choose to do this yearly or more frequently if needed.

How should this tool be completed? To complete this checklist, indicate by "checking" the appropriate box whether the resource is available now, whether it will be available in the future, or if you need additional support from internal or external partners to obtain that resource. For example, do you have immediately available staff, will staff be available in the near future, or do you need to request additional staff from the agency or a community partner? Record any anticipated challenges to obtaining or implementing each resource in the far right box.

Example:

Resource	Available Now	Will be Available in the Future	Need Additional Support	Anticipated Challenges
Available staff with technical knowledge (i.e., agency staff, contractors or consultants, volunteers)	☐	☒	☐	Among our agency staff, no one has both the time and expertise to conduct thorough monitoring and evaluation of our HIV testing in non-clinical settings, but we will be reaching out to a local University to partner with a graduate student who has the time and expertise to dedicate to these tasks. This partner is expected to join the team next semester.

Tool 3. Monitoring and Evaluation Organizational Capacity Inventory

Agency/Program:	**Participants:**
Target Population:	
Date Completed:	

Resource	Available Now	Will be Available in the Future	Need Additional Support	Anticipated Challenges
Available staff with technical knowledge (i.e., agency staff, contractors or consultants, volunteers)	☐	☐	☐	
Funding	☐	☐	☐	
Materials (i.e., office supplies and equipment)	☐	☐	☐	
Technology (i.e., computers, analysis software, data management system, geographic information system)	☐	☐	☐	
Reference Tools (i.e., M&E and data collection training materials, evaluation guides, programmatic guidelines)	☐	☐	☐	
Data collection requirements	☐	☐	☐	
Existing data resources (i.e., surveillance, M&E, and others as appropriate)	☐	☐	☐	
Available trainings (i.e., data collection, data entry, HIV testing)	☐	☐	☐	

Tool 4. SMART Program Objectives Worksheet

About Tool 4: Tool 4 is designed to help you inventory your non-clinical HIV TLC program process and outcome objectives and determine if they are SMART:

- **S**pecific: The objective clearly specifies what you want to accomplish.
- **M**easurable: The objective is stated in a way that can measure if the objective is being met.
- **A**chievable: The objective can be attained with a reasonable amount of effort and application.
- **R**ealistic: The objective can be attained, given available resources, timeframes, and experience.
- **T**ime-based: The objective specifies when it will be achieved.

Agencies may choose to complete Tool 4 at the agency or program level (e.g., by target population). In both cases, be sure to gather input from multiple individuals with differing perspectives and experiences, including agency leaders (i.e., executive director), program managers and directors, staff providing HIV testing and linkage, and community members. Gathering this input will ensure that program objectives are feasible and reflect the priorities of the agency and community. You may choose to complete Tools 4, 5, and 6 as a part of a team retreat or group meeting.

Consider sharing the completed tool with staff and grant writers to foster a shared understanding of the program objectives. Revisit this tool on a regular basis, for example as a part of your yearly program planning activities, to recalibrate objectives to agency and community priorities.

How New Programs Can Use This Tool: As a new program that is implementing a non-clinical HIV TLC program, it is important to set objectives that are attainable and feasible. Remember that M&E is a process, and you should begin with objectives that reflect your agency's capacity and priorities. Complete this tool as a part of your program planning process prior to implementation. Reviewing each of your objectives and their desired results will help you determine which critical program elements should be included in your program logic model (Tools 5 and 6). Remember that objectives can be modified in the future to reflect desired improvements in your program.

How Established Programs Can Use This Tool: If you have already implemented a non-clinical HIV TLC program, complete this tool to ensure that each of your program objectives is SMART. For program objectives that do not meet the SMART criteria, take this opportunity to modify them to ensure that your M&E activities are able to provide information on how well the program is meeting its objectives and where there are areas for improvement.

How Health Departments and Other Funders Can Use This Tool: Health departments and other funders may use this tool with grantees and contracts to provide technical assistance on the documentation of program objectives for agencies that are new to M&E or are implementing a new non-clinical HIV TLC program. Additionally, some funding agencies may ask grantees to complete this tool as a condition of their funding or include it in their grant application. By reviewing the information in this tool, funders can easily determine if contractors are setting objectives that are in line with jurisdictional goals and can provide assistance to agencies who may establish objectives that are not in line with their current capacity.

Instructions for Completing Tool 4. SMART Program Objectives Worksheet

What is the purpose of this tool? This tool can be used to document each of your non-clinical HIV TLC program objectives and identify whether they related to process or outcome M&E and if they are SMART. If you already have specified program objectives (e.g., stated your program plan or other program document), you may use this worksheet to determine if the objectives are SMART. If you have not prepared program objectives, you may use this worksheet to draft them.

Who should complete this tool? Non-Clinical HIV TLC program staff, such as managers and coordinators, may choose to complete this tool on their own and then share with interested parties, including grant writers, funders, and HIV testing and linkage staff.

When should this tool be completed? This tool may be completed at the beginning of each program year and revisited, as necessary, to add or edit program objectives.

How should this tool be completed? To complete the tool, begin by recording any existing program objectives in the second column and indicate whether they are process or outcome items. Next, check the boxes in the third column to determine if each objective meets the SMART criteria. If any of the criteria are not met, use the third column to revise your objective to make it specific, measurable, achievable, realistic, and time-based.

Example:

Program Objective (If Existing)	Process or Outcome?	SMART?	Revised Objective
HIV test results will be returned to clients.	**Process**: ☐ **Outcome**: ☒	**S**pecific: ☐ Yes ☒ No **M**easurable: ☒ Yes ☐ No **A**chievable: ☒ Yes ☐ No **R**ealistic: ☐ Yes ☒ No **T**ime-based: ☐ Yes ☒ No	By the end of Fiscal Year 2014, 90% of clients will have knowledge of their serostatus through receipt of their test result.

Tool 4.SMART Program Objectives Worksheet

Agency/Program:	**Participants:**
Target Population:	
Date Completed:	

Program Objective (If Existing)	Process or Outcome Objective?	SMART?	Revised Objective
	Process: ☐ **Outcome**: ☐	**S**pecific: ☐ Yes ☐ No **M**easurable: ☐ Yes ☐ No **A**chievable: ☐ Yes ☐ No **R**ealistic: ☐ Yes ☐ No **T**ime-based: ☐ Yes ☐ No	
	Process: ☐ **Outcome:** ☐	**S**pecific: ☐ Yes ☐ No **M**easurable: ☐ Yes ☐ No **A**chievable: ☐ Yes ☐ No **R**ealistic: ☐ Yes ☐ No **T**ime-based: ☐ Yes ☐ No	
	Process: ☐ **Outcome**: ☐	**S**pecific: ☐ Yes ☐ No **M**easurable: ☐ Yes ☐ No **A**chievable: ☐ Yes ☐ No **R**ealistic: ☐ Yes ☐ No **T**ime-based: ☐ Yes ☐ No	
	Process: ☐ **Outcome**: ☐	**S**pecific: ☐ Yes ☐ No **M**easurable: ☐ Yes ☐ No **A**chievable: ☐ Yes ☐ No **R**ealistic: ☐ Yes ☐ No **T**ime-based: ☐ Yes ☐ No	

Tool 5. Program Components Table

About Tool 5: Tool 5 serves as a preparation exercise for Tool 6, Logic Model Template, in which you will build a logic model. It is meant to serve as an inventory of the HIV TLC program components which are necessary for you to meet your established SMART program objectives (Tool 4: SMART Program Objectives Worksheet). It is recommended that you complete this activity prior to program implementation in order to ensure that your program is well thought out and stakeholders agree on the main components of your non-clinical HIV TLC program.

Agencies may choose to complete Tool 5 at the agency or program level. In both cases, be sure to gather input from multiple individuals with differing perspectives and experiences, including agency leaders (i.e., executive director), program managers and directors, staff providing HIV testing and linkage, and community members. You may choose to complete Tools 4, 5, and 6 as a part of a team retreat or group meeting. Revisit this table each time you revised your logic model, for example as a part of yearly program planning activities.

How New Programs Can Use This Tool: This tool is designed to help you document all of the elements that contribute to your non-clinical HIV TLC program, including inputs, activities, outputs, short-term and long-term outcomes. By completing this tool, you will be ready to build your program logic model.

How Established Programs Can Use This Tool: If you have already implemented a non-clinical HIV TLC program, use this tool to revitalize your program logic model. Pay special attention to those programs that have operated under the same goals and objectives for an extended period of time. Completing this tool for an existing program may reveal additional program components, resources, and activities which are not accounted for in the current logic model.

How Health Departments and Other Funders Can Use This Tool: Health departments and other funders may find this tool useful when working with grantees and contractors, especially on providing technical assistance or training on the development of logic models. Funders may choose to have grantees include Tools 4, 5, and 6 in their grant application or at the beginning of a project in order to document program objectives, program components, and the ways that program elements will connect to produce the desired outcomes of non-clinical HIV TLC programs.

Instructions for Completing Tool 5. Program Components Table

What is the purpose of this tool? Use this tool to identify all the components of your program (input, activity, output, short-term outcome, long-term outcome) before constructing the logic model.

Who should complete this tool? You may choose to complete this table individually or as a group activity. Your agency may choose to have program managers complete a logic model for each program they oversee and/or have your executive director complete a comprehensive logic model for all prevention efforts.

When should this tool be completed? Complete this table each time a logic model is drafted or revised. Revisit this tool on a regular basis—for example, when completing yearly program planning activities.

How should this tool be completed? Begin to complete this tool by considering all of the elements that are necessary for your agency to meet its SMART program objectives (Tool 4). Use the right column to specify all program elements that fall under each category.

Example:

Component	Program Component
Inputs	• Staff • Funding • HIV test kits • Testing procedures
Activities	• Recruitment • HIV testing • Linkage to medical care
Outputs	• Number of clients recruited • Number clients tested • Number of clients linked to medical care
Outcomes	• Increased client knowledge of HIV status • Increased client access to prevention, care, support, and treatment resources
Impacts	• Decreased HIV transmission rates • Decreased HIV incidence • Decreased HIV morbidity and mortality

Tool 5. Program Components Table

Agency/Program:	**Participants:**
Target Population:	
Date Completed:	

Component	Program Component
Inputs	
Activities	
Outputs	
Outcomes	
Impacts	

Tool 6. Logic Model Template

About Tool 6: Tool 6 is designed to help you take the information documented in Tool 4, SMART Program Objectives Worksheet, and Tool 5, Program Components Table, and combine them into a HIV TLC program logic model. In this tool, you are presented with boxes to populate your program's inputs, activities, outputs, short-term and long-term outcomes, and desired impacts. It is suggested that you complete this exercise before implementing your non-clinical HIV TLC program to ensure that there is a logical progression and flow to your program and that the components necessary to meet your program objectives are accounted for and incorporated in your logic model. Keep in mind that the main purpose in a logic model is to show the ways that resources feed into activities, which lead to results. To represent these connections, it is suggested that you insert arrows so that each box is connected to at least one additional box to the right.

Agencies may choose to complete Tool 6 at the agency or program level (e.g., by target population). In both cases, be sure to gather input from multiple individuals with differing perspectives and experiences, including agency leaders (i.e., executive director), program managers and directors, staff providing HIV testing and linkage, and community members. You may choose to complete Tools 4, 5, and 6 as a part of a team retreat or group meeting. Gathering this input will ensure that all critical program components and connections are accounted. Consider sharing and discussing the completed logic model with agency staff and stakeholders. Discussing a program logic model is a great way to create a shared understanding of your program, emphasize the importance of support and collaboration, and demonstrate your goals to the community.

This tool is meant to serve as a template and should be modified to fit your program. Revisit this exercise each time you revise your logic model—for example, as a part of yearly program planning activities.

How New Programs Can Use This Tool: This tool is designed to help you in the planning and implementation of a non-clinical HIV TLC program. If you have not yet implemented your program, creating a program logic model will ensure that agency leaders, program managers, HIV testing and linkage staff, grant writers, and community groups understand and agree with program processes and desired outcomes. As a new program, you may also find this tool useful in facilitating community support and partnerships.

How Established Programs Can Use This Tool: If you have already established a non-clinical HIV TLC program, you can complete this tool to ensure that program components, processes, and desired outcomes remain aligned and logical. Take this opportunity to ensure that each of your programs has a documented logic model, especially those programs that have operated under the same goals and objectives for an extended period of time. Completing this tool for an existing program may reveal

additional program components, resources, and activities which are not accounted for in the current logic model. This tool may also be useful if you are planning to implement a non-clinical HIV TLC in a new setting or venue.

How Health Departments and Other Funders Can Use This Tool: Health departments and other funders may find this tool helpful for use with grantees and contractors. This tool can be used to provide technical assistance to agencies that are new to non-clinical HIV TLC program implementation and logic modeling. Some funders may ask grantees to complete a program logic model as a condition of their funding at the beginning of a project or at the beginning of each program year.

Instructions for Completing Tool 6. Logic Model Template

What is the purpose of this tool? This tool will help you create a logic model. Composing a logic model will help you document the components of your program, the desired outcomes and impacts, and how they relate to one another. Using this program illustration can help you talk about the program's purpose and potential impacts with agency staff and community members.

Who should complete this tool? You may choose to complete this table individually or as a group activity. Your agency may choose to have program managers complete a logic model for each program they oversee and/or have your executive director complete a comprehensive logic model for all prevention efforts.

When should this tool be completed? You may choose to complete a program logic model at the start of the program year and revise at least once a year to reflect changes in program inputs, activities, or desired outcomes.

How should this tool be completed? Refer back to Tool 5, Program Components Table, and use the following template to insert your program components into the logic model. If you have more items to list under a heading, the template allows you to add more boxes as necessary. **Be sure to use arrows to show how each component is related.** When you are finished, review the logic model with all stakeholders and make sure that the relationships you identified and the progression from inputs to activities to outputs to outcomes make sense and are feasible. If you feel that you have missed a few components, you can go back and insert them.

Tool 6. Logic Model Template

Agency/Program:	**Participants:**
Target Population:	
Date Completed:	

Problem Statement:

Inputs	Activities	Outputs	Intermediate Outcomes	Long-term Outcomes	Impacts

Tool 7. Document and Prioritize M&E Questions Table

About Tool 7: Tool 7 is designed to help you document and prioritize proposed M&E questions for your HIV TLC program. This tool should be completed to ensure that you are asking M&E questions which are important to agency staff, funders, program goals and objectives, and are feasible to collect.

Agencies may choose to complete Tool 7 at the agency or program level. In both cases, be sure to gather input from multiple individuals with differing perspectives and experiences, including agency leaders (i.e., executive director), program managers and directors, staff providing HIV testing and linkage, and community members. Gathering this input will ensure that M&E questions are feasible and reflect the priorities of the program, agency, and community.

It is recommended that you complete this tool before beginning your M&E activities; however, remember that M&E is an iterative process. If you are not able to ask all of the M&E questions which you document in this tool, keep in mind that additional questions can be added as your M&E capacity changes.

How New Programs Can Use This Tool: This tool is designed to assist you in determining which M&E questions will be of the highest priority for your non-clinical HIV TLC program. It will help you to decide which questions are most important to your agency, community, and funding members. As a new program, it is recommended that you start with a small and highly feasible set of M&E questions, and add to them as agency capacity increases.

How Established Programs Can Use This Tool: If you have already implemented a non-clinical HIV TLC program, you can use this tool to re-evaluate your M&E questions to ensure they are aligned with the priorities of your agency, program, funders, and community members.

How Health Departments and Other Funders Can Use This Tool: Health departments and other funders may find this tool helpful for use with grantees and contractors. This tool can be used to provide technical assistance to agencies that are new to non-clinical HIV TLC program implementation and M&E. Some funders may ask grantees to document a set of M&E questions as a condition of their funding at the beginning of a project or at the beginning of each program year.

Instructions for Completing Tool 7. Document and Prioritize M&E Questions Table

What is the purpose of this tool? This tool will allow you to document your M&E questions and inventory their importance to stakeholders, alignment with program goals and objectives, and the feasibility to answer each.

Who should complete this tool? Non-Clinical HIV TLC program managers or coordinators may choose to complete this table individually or as a group activity with program staff and community members. If completing individually, make sure to gather input from multiple stakeholders including agency leaders, HIV testing and linkage staff, and community members.

When should this tool be completed? Complete this tool in the beginning of your M&E process and revisit it each time you review your M&E plan. This may be yearly or more frequently if necessary.

How should this tool be completed? List all proposed M&E questions in the first column. For each question, check the boxes to indicate whether the question meets the criteria below:

1. Does this question reflect the priorities of your HIV testing and linkage staff?
2. Does this question reflect the priorities of your external stakeholders, including community groups?
3. Does this question provide information that is a priority or requirement of your funders, or required by statue, regulation, or policy?
4. Does this question align with your program SMART objectives and goals?
5. Does this question align with your program logic model and the elements contained within?
6. Does this question provide information that can be used to make program improvements?
7. Can this question be answered with data or resources that are currently available?
8. Can the program provide resources in order to answer this question?
9. Is this question feasible to ask given current staff availability, levels of skill, and other responsibilities?

Questions that do not meet all nine of the criteria should be considered of lower priority.

Tool 7. Document and Prioritize M&E Questions Table

Agency/Program:	**Participants:**
Target Population:	
Date Completed:	

List the evaluation questions in this column and then decide if the question meets the criteria listed in the column to the right by checking the appropriate box. You can check as many boxes as applicable.	**Criteria:** **1—Important to program staff** **2—Important to community groups** **3—Important to/or required by funders** **4—Reflects key goals and objectives of the program** **5—Reflects key elements of the program logic model** **6—Provides information that can be acted upon to make program improvements** **7—Can be answered with available resources** **8—Will be supported by the program (in terms of resources)** **9—Will not place an undue burden on staff to collect data**								
Evaluations Questions	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Example: To what extent are test results being provided to clients who received HIV testing?	☒	☒	☒	☒	☒	☒	☒	☒	☒
	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐

Tool 8. M&E Worksheet for Non-Clinical HIV TLC Programs

About Tool 8: This worksheet will help you document the major M&E components for your non-clinical HIV TLC program and ensure that they are aligned with one another. These components include SMART objectives found in Tool 4, program activities found in Tools 5 and 6, and M&E questions found in Tool 7. In addition to these items, this tool also requires qualitative/quantitative measures and targets.

Agencies may choose to complete Tool 8 at the agency or program level. In both cases, be sure to gather input from multiple individuals with differing perspectives and experiences, including agency leaders (i.e., executive director), program managers and directors, staff providing HIV testing and linkage, and community members. You may choose to complete this tool as a part of a team retreat or group meeting. Revisit this worksheet each time you revised your logic model—for example, as a part of yearly program planning activities.

How New Programs Can Use This Tool: This tool is designed to assist you in aligning the major components that will inform your M&E effort. By completing this tool, you will be able to provide a comprehensive look at your non-clinical HIV TLC program to agency staff and community members.

How Established Programs Can Use This Tool: If you have already implemented a non-clinical HIV TLC program, use this tool to inventory your existing program objectives, M&E questions, program activities, measures and targets to ensure alignment.

How Health Departments and Other Funders Can Use This Tool: Health departments and other funders may find this tool useful when working with grantees and contractors, especially when it comes to providing technical assistance or training to agencies who are new to program implementation and/or M&E. Funders may choose to have grantees include Tool 8 in their grant application or at the beginning of a project in order to document program objectives, M&E questions, program activities, measures, and targets to ensure that the program can measure its progress toward the desired outcomes of non-clinical HIV TLC programs.

Instructions for Completing Tool 8. M&E Worksheet for HIV Testing and Linkage in Non-Clinical Settings

What is the purpose of this tool? This tool can help you inventory critical program activities, SMART objectives, M&E questions, measures, and targets to take a more comprehensive look at your M&E efforts. This worksheet should be tailored or expanded to meet your local M&E needs.

Who should complete this tool? Those overseeing HIV testing programs, including managers and coordinators, should work with staff members performing M&E activities to complete this tool.

When should this tool be completed? Complete this tool in the beginning of your M&E process and revisit it each time you review your M&E plan. This may be yearly or more frequently if necessary.

How should this tool be completed? Complete the worksheet by first populating your HIV testing and linkage program activities from your logic model (Tool 6) and then inserting your aligned SMART objectives (Tool 4). Next insert your prioritized M&E questions (Tool 7) and draft measures and associated targets.

Example:

Evaluation Questions:				
To what extent are test results being provided to clients who received HIV testing?				
HIV Testing and Linkage Key Program Activities	**Aligned SMART Objectives**	**Monitoring Questions**	**Quantitative or Qualitative Measures to Address Monitoring Question and Objective**	**Targets**
Notification of test result	By the end of Fiscal Year 2014, 90% of clients will have knowledge of their serostatus through receipt of their test result.	Among all test results, how many were provided to persons who received HIV testing?	(1) What percentage of test results were returned to clients? (2) What factors and/or strategies are associated with increasing the number of test results returned to clients?	90%

Tool 8. M&E Worksheet for HIV Testing and Linkage in Non-Clinical Settings

Agency/Program:	**Participants:**
Target Population:	
Date Completed:	

Evaluation Questions:				
HIV Testing and Linkage Key Program Activities	**Aligned SMART Objectives**	**Monitoring Questions**	**Quantitative or Qualitative Measures to Address Monitoring Question and Objective**	**Targets**

Tool 9. Identifying Data Sources and Data Collection Methods Table

About Tool 9: This tool will help you document the sources and methods you will leverage to gather data to inform the progress of your non-clinical HIV TLC program toward its stated objectives. It will also prepare you to complete Tool 10. The tool aligns a measure with its M&E question and then allows you to record the numerator and denominator for that measure. You may find that the data source or collection method will be different for the numerator and denominator. When completing this tool, refer to the measures you recorded in Tool 8.

Agencies may choose to complete Tool 9 at the agency or program level. In both cases, be sure to gather input from multiple individuals with differing perspectives and experiences, paying special attention to program managers and directors, staff members providing HIV testing and linkage services, and data managers. You may choose to complete this activity as a part of a team retreat or group meeting. Consider sharing and discussing the completed tool with staff to foster a shared understanding of data sources and data collection methods.

Revisit this tool on a regular basis—for example, as a part of your yearly program planning activities, to reflect any changes in data sources, and/or identify any need to acquire new data sources or methods.

How New Programs Can Use This Tool: As a new program that is implementing a non-clinical HIV TLC program, it is important to document the data sources and methods you will use to monitor the progress of your program. Additionally, it is critical to identify any gaps in data sources or data collection materials before you implement non-clinical HIV TLC services. Complete this tool as a part of your program planning process prior to implementation. Reviewing each of your measures and determining data sources will ensure that you are able to track and demonstrate your program's progress to agency staff and community members.

How Established Programs Can Use This Tool: If you have already established a non-clinical HIV TLC program, you can use tool to inventory existing data collection methods and data sources. You may find that there are new data sources available or that new data collection materials need to be developed.

How Health Departments and Other Funders Can Use This Tool: Health departments and other funders may find this tool useful when working with grantees and contractors, especially around providing technical assistance or training to agencies that are new to program implementation and/or M&E. It may also be useful to help grantees identify gaps in data sources and/or the need to develop new data collection materials. Funders may choose to have grantees include Tool 9 in their grant application or complete it at the beginning of a project in order to document their intended data sources and data collection methods, which will help them monitor and evaluate the progress of their program.

Instructions for Completing Tool 9. Identifying Data Sources and Data Collection Methods Table

What is the purpose of this tool? This tool will allow you to identify data sources, both those that already exist and those that are needed to help answer the measure. Additionally, you can document data collection methods and at what point in your testing program the data are collected.

Who should complete this tool? Those overseeing HIV testing programs, including managers and coordinators, should work with staff performing testing and M&E activities to complete this worksheet.

When should this tool be completed? Complete this tool in the beginning of your M&E process and revisit it each time you review your M&E plan. This may be yearly or more frequently if necessary.

How should this tool be completed? For each prioritized evaluation question in Tool 8, list the associated measures and the data sources to which you have access, and indicate whether they are existing data sources or sources from which you will need to do primary data collection. Then identify which data collection method you will use to gather information and at what point during the testing process you will collect the data.

Example:

Evaluation Question:					
To what extent is the program linking HIV-positive individuals to medical care?					
Measures	**Numerator/ Denominator**	**Data Source**	**Existing or New?**	**Data Collection Method**	**At What Point Are Data Collected?**
Percentage of HIV-positive clients linked to medical care	Numerator: Number of clients testing HIV positive who were referred to medical care and attended their first appointment within the last quarter	HIV testing form	☒ Existing ☐ New	Document review	During testing encounter and through follow-up for 30 days
	Denominator: Number of clients who tested positive for HIV within the last quarter and were referred to medical care	HIV testing form Referral logs	☒ Existing ☐ New	Document review	During testing encounter

Tool 9. Identifying Data Sources and Data Collection Methods Table

Agency/Program:	**Participants:**
Target Population:	
Date Completed:	

Evaluation Question:					
Measures	**Numerator/ Denominator**	**Data Source**	**Existing or New?**	**Data Collection Method**	**At What Point Are Data Collected?**
	Numerator:		☐ Existing ☐ New		
	Denominator:		☐ Existing ☐ New		
	Numerator:		☐ Existing ☐ New		
	Denominator:		☐ Existing ☐ New		
	Numerator:		☐ Existing ☐ New		
	Denominator:		☐ Existing ☐ New		
	Numerator:		☐ Existing ☐ New		
	Denominator:		☐ Existing ☐ New		

Tool 9. Identifying Data Sources and Data Collection Methods Table (continued)

Evaluation Question:					
Measures	**Numerator/ Denominator**	**Data Source**	**Existing or New?**	**Data Collection Method**	**At What Point Are Data Collected?**
	Numerator:		☐ Existing ☐ New		
	Denominator:		☐ Existing ☐ New		
	Numerator:		☐ Existing ☐ New		
	Denominator:		☐ Existing ☐ New		
	Numerator:		☐ Existing ☐ New		
	Denominator:		☐ Existing ☐ New		
	Numerator:		☐ Existing ☐ New		
	Denominator:		☐ Existing ☐ New		

Tool 10. Data Collection and Entry Template

About Tool 10: This tool can to assist in documentation of data collection assignments and identify security and confidentiality concerns. It is recommended that you complete this tool prior to implementing non-clinical HIV TLC services. To ensure relevance for an extended period of time, you may choose to identify a staff role or position (i.e., program manager) instead of an individual's proper name (i.e., Sally Jones).

Consider completing this tool as a part of a team retreat or group meeting and be sure to gather input from multiple individuals with differing responsibilities, including agency leaders (i.e., executive director), program managers and directors, and staff providing HIV testing and linkage. After completing the tool, consider distributing it to and discussing it with agency staff members in order to foster understanding regarding M&E for your program.

How New Programs Can Use This Tool: As a new program that is implementing a non-clinical HIV TLC program, it is important to solidify roles and responsibilities around the collection, entry, and review of data. Complete this tool as a part of your program planning process prior to implementation and review it frequently to ensure assignments remain relevant.

How Established Programs Can Use This Tool: If you have already implemented a non-clinical HIV TLC program, complete this tool to ensure that each of your data collection methods is assigned and monitored.

How Health Departments and Other Funders Can Use This Tool: Health departments and other funders may find this tool useful when working with grantees and contractors, especially around providing technical assistance or training to those who are new to program implementation or M&E. Funders may choose to have grantees include Tool 10 in their grant application or at the beginning of a project in order to document data collection methods and all corresponding assignments.

Instructions for Completing Tool 10:.Data Collection and Entry Template

What is the purpose of this tool? This tool will help you identify methods, sources, and timelines for data collection. Additionally, you can outline who will be responsible for each collection method and any security or confidentiality issues that should be considered.

Who should complete this tool? Program managers or coordinators may choose to complete this table individually or as a group activity with program staff. If completing individually, make sure to gather input from HIV testing staff.

When should this tool be completed? Complete this tool in the beginning of your M&E process and revisit it each time you review your M&E plan or if there are significant staff changes. This may be yearly or more frequently if necessary.

How should this tool be completed? Refer back to Tool 9 where you identified which data collection methods you will use. Put each method you will be using in the first column. As shown in the following example, for each data collection method, fill out columns with (1) the data collection method; (2) the data source and whether it is existing or new; (3) who will collect the data; (4) when data will be collected, including dates and place in the program cycle; and (5) any security and confidentiality issues you have to consider.

Example:

Data Collection Method	Data Source (Who/Where/What/ Existing or New?)	Data Collector(s) (Staff Person)	Data Collection Schedule (Dates/Frequency and Place in Program Cycle)	Security or Confidentiality Issues
Document review	HIV testing form; existing source	Data manager	February 15 to 28, 2014	All identifying information should be stripped out and shredded (if photocopies are made)

Tool 10. Data Collection and Entry Template

Agency/Program:	**Participants:**
Target Population:	
Date Completed:	

Data Collection Method	Data Source (Who/Where/What/ Existing or New?)	Data Collectors (Staff Person)	Data Collection Schedule (Dates/Frequency and Place in Program Cycle)	Security or Confidentiality Issues

Tool 11. Data Analysis Considerations Table[22]

About Tool 11: Tool 11 serves as a preparation exercise for Tool 12, Data Analysis Planning Template, in which you will align your M&E questions, measures, and data analysis assignments for your non-clinical HIV TLC program. This tool is designed to inventory the who, what, when, where, why, and how you will analyze data. It is recommended that you complete this activity prior to program implementation in order to ensure that your data analysis policies and procedures are well thought out and shared with agency staff.

Agencies may choose to complete Tool 11 at the agency or program level. In both cases, be sure to gather input from multiple individuals with differing perspectives and experiences, including agency leaders (i.e., executive director), program managers and directors, and staff members providing HIV testing and linkage. Engaging these individuals during the completion of this tool will help you solidify roles and responsibilities in a timely manner and facilitate engagement among agency staff in the M&E process. After completing the tool, consider distributing it and discussing it with agency staff in order to foster understanding regarding M&E for your program. Revisit this tool on a regular basis—for example, as a part of yearly program planning activities.

How New Programs Can Use This Tool: As a new program that is implementing a non-clinical HIV TLC program, it is important to solidify procedures for data analysis activities. Complete this tool in conjunction with Tool 12 as a part of your program planning process prior to implementation to ensure your data analysis procedures are thorough and aligned with program measures and objectives.

How Established Programs Can Use This Tool: As an established program, you can use this tool as a brainstorming exercise to consider new and innovative data analysis approaches that may be useful for your non-clinical HIV TLC program.

How Health Departments and Other Funders Can Use This Tool: Health departments and other funders may use this tool with grantees and contractors to provide technical assistance in the selection and documentation of data analysis approaches for agencies that are new to M&E or those that are implementing a new non-clinical HIV TLC program, or expanding services. Additionally, some funding agencies may ask grantees to complete this tool as a condition of their funding or include it in their grant application. By reviewing the information in this tool, funders can determine if grantees are developing a solid data analysis plan.

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[22] Adapted from: U.S. Department of Health and Human Services. (2005). *Introduction to program evaluation for public health programs: A self-study guide*. Retrieved January 12, 2012, from the Centers for Disease Control and Prevention Web site: http://www.cdc.gov/getsmart/program-planner/Introduction.pdf

Instructions for Completing Tool 11:.Data Analysis Considerations Table

What is the purpose of this tool? This table will help you think about the ways to analyze data in order to answer M&E questions and eventually make recommendations for program improvement.

Who should complete this tool? Program managers or coordinators may choose to complete this table individually or as a group activity with program staff. If completing individually, make sure to gather input from HIV testing staff.

When should this tool be completed? Complete this tool in the beginning of your M&E process and revisit it each time you review your M&E plan or if there are significant staff changes. This may be yearly or more frequently if necessary.

How should this tool be completed? Under the response column, describe your approach to addressing each of the questions presented in the left column.

Example:

Considerations for Analysis Plan	Response
Who will analyze the data? Who will coordinate this effort?	The HIV data coordinator will lead a team of data analysts and will be responsible for setting timelines and delegating tasks.

Tool 11. Data Analysis Considerations Table

Agency/Program:	**Participants:**
Target Population:	
Date Completed:	

Considerations for Analysis Plan	Response
Who will analyze the data? Who will coordinate this effort?	
What types of analyses will be conducted? (Specify both quantitative and qualitative procedures, as relevant. Do you plan to conduct only basic descriptive analysis? Or do you plan to compare between variables, or to correlate variables?)	
What is the timeframe for analysis? Will there be preliminary analyses?	
What criteria will you use to analyze and interpret your results?	
Who will be involved in interpreting results?	
Do you plan to compare your results with any similar programs?	

Tool 11. Data Analysis Considerations Table (continued)

Considerations for Analysis Plan	Response
How will you deal with conflicting interpretations and judgments?	
What are the limitations of your planned data analysis and interpretation process (e.g., potential biases, generalizability of results, reliability, validity)?	
How will be data be visually displayed, if applicable?	
What types of reports will be developed for which audiences?	

Tool 12. Data Analysis Planning Template

About Tool 12: This tool will help you align your non-clinical HIV TLC M&E questions (Tool 7), measures (Tool 8), and data analysis considerations (Tool 11). It also provides you an opportunity to document individual roles and responsibilities for data analysis tasks and set a timeline for their frequency or completion. It is recommended that you complete this activity prior to program implementation in order to ensure that your data analysis procedures are aligned with M&E questions and measures. Completing this tool will also ensure that each data analysis task has a designated point of contact.

Agencies may choose to complete Tool 12 at the agency or program level. In both cases, be sure to gather input from multiple individuals with differing perspectives and experiences, including agency leaders (i.e., executive director), program managers and directors, and staff members providing HIV testing and linkage. Engaging these individuals during the completion of this tool will help you solidify roles and responsibilities in a timely manner and facilitate engagement among agency staff in the M&E process. After completing the tool, consider distributing it to and discussing with agency staff members in order to foster understanding regarding M&E for your program. Revisit this table on a regular basis—for example, as a part of yearly program planning activities.

How New Programs Can Use This Tool: As a new program that is implementing a non-clinical HIV TLC program, it is important to solidify policies and procedures and points of contact for data analysis activities. Complete this tool in conjunction with Tool 11 as a part of your program planning process prior to implementation to ensure your data analysis procedures are thorough and aligned with program measures and objectives.

How Established Programs Can Use This Tool: As an established program, complete this tool to ensure that each of your program measures and M&E questions is aligned with a data analysis procedure and has an assigned task lead.

How Health Departments and Other Funders Can Use This Tool: Health departments and other funders may use this tool with grantees and contractors to provide technical assistance on the documentation of data analysis approaches for agencies that are new to M&E or those that are implementing a new non-clinical HIV TLC program. Additionally, some funding agencies may ask grantees to complete this tool as a condition of their funding or include it in their grant application. By reviewing the information in this tool, funders can determine if grantees are developing a solid data analysis plan that is well aligned with their non-clinical HIV TLC program.

Instructions for Completing Tool 12. Data Analysis Planning Template

What is the purpose of this tool? This table will help you document monitoring questions, corresponding analysis activities, and individuals who will answer each.

Who should complete this tool? Program managers or coordinators may choose to complete this table individually or as a group activity with program staff. If completing individually, make sure to gather input from HIV testing staff.

When should this tool be completed? Complete this tool in the beginning of your M&E process and revisit it each time you review your M&E plan or if there are significant staff changes. This may be yearly or more frequently if necessary.

How should this tool be completed? For each M&E question and measure, decide how to analyze the data (i.e., for quantitative data, consider generating frequencies, averages, proportions or percentages; for qualitative data, you may code the text by themes and identify patterns). Next, include for each an analysis procedure (quantitative or qualitative) and the timeline schedule (e.g., survey data frequencies will be completed by mm/dd/yyyy). Finally, in the last column, document the roles and responsibilities of all individuals involved. This will help you to estimate the workload of each individual and develop a reasonable timeline for the analysis of your data.

Example:

Evaluation Question: To what extent are test results being provided to clients who received HIV testing?				
Monitoring Question	**Measure**	**Analysis Procedure**	**Analysis Timeline**	**Responsible Person(s)**
Among all test results, how many were provided to persons receiving HIV testing in the past quarter?	Proportion of test results provided to persons receiving HIV testing in the previous quarter.	Perform quantitative analysis through a division of the following: • Numerator: Number of HIV tests returned to clients in the past quarter • Denominator: Total number of HIV tests conducted in the past quarter	Proportions will be calculated within 30 days of the end of the quarter.	Data analysis tasks will be coordinated by the lead data coordinator.

Tool 12. Data Analysis Planning Template

Agency/Program:	**Participants:**
Target Population:	
Date Completed:	

Evaluation Question:				
Monitoring Question	**Measure**	**Analysis Procedure**	**Analysis Timeline**	**Responsible Person(s)**
Evaluation Question:				
Monitoring Question	**Measure**	**Analysis Procedure**	**Analysis Timeline**	**Responsible Person(s)**

Tool 12. Data Analysis Planning Template (continued)

Evaluation Question:				
Monitoring Question	**Measure**	**Analysis Procedure**	**Analysis Timeline**	**Responsible Person(s)**
Evaluation Question:				
Monitoring Question	**Measure**	**Analysis Procedure**	**Analysis Timeline**	**Responsible Person(s)**

Tool 13. Dissemination Planning Template

About Tool 13: This tool will help you match each of your identified stakeholders (tool 1) and their information needs with a strategy to disseminate M&E findings to them on a regular basis. Additionally, you can use this tool to assign a point person for each reporting need. As you work through this tool, you may find that multiple stakeholders are requesting or would benefit from the same information and may choose to disseminate information to both parties according to one frequency.

Agencies may choose to complete Tool 13 at the agency or program level. In both cases, be sure to gather input from multiple individuals with differing perspectives and experiences including agency leaders (i.e., Executive Director), program managers and directors, staff providing HIV testing and linkage, grant writers, funders, and community members. Engaging these individuals during the completion of this tool will help you solidify roles and responsibilities around reporting tasks and ensure that your stakeholders will receive the information they need in a timely manner. After completing the tool, consider distributing it to, and discussing with, agency staff to foster understanding around M&E and reporting for your program. Revisit this table on a regular basis, for example as a part of yearly program planning activities.

How New Programs Can Use This Tool: If you have not yet implemented a non-clinical HIV TLC program, it is important to inventory the information that your stakeholders are requesting from your program and the ways that you will organize and disseminate these data. This tool can be used to document the information requested by your funding agencies, community partners, and internal staff. When you complete this tool, consider not only the information that is required to be submitted by your partners, but the information that would benefit potential program detractors or community representatives. You may find that disseminating information on the work your program is doing for the community will foster support and partnerships.

How Established Programs Can Use This Tool: If you have already established a non-clinical HIV TLC program, use this tool as an inventory of the data reports and information requests that you address on a regular basis.

How Health Departments and Other Funders Can Use This Tool: Health departments and other funders may use this tool with grantees and contractors to provide technical assistance around the dissemination and reporting on a new non-clinical HIV TLC program. Additionally, some funding agencies may ask grantees to complete this tool as a condition of their funding or include it in their grant application. By reviewing the information in this tool, funders can determine if grantees are considering the dissemination of information to all stakeholders of their non-clinical HIV TLC program.

Instructions for Completing Tool 13. Dissemination Planning Template

What is this tool used for? This tool will help you match stakeholder information needs and the frequency that the information will be disseminated. Additionally, you can identify program staff who will be responsible for generating each report.

Who should complete this tool? A program manager or the agency executive director may complete this tool considering input of program staff.

When should this tool be completed? Complete this tool in the beginning of your M&E process and revisit it each time you review your M&E plan, there are significant staff changes, or if a new stakeholder information need arises. This may be yearly or more frequently if necessary.

How should this tool be completed? In tool 13, record the following information in each of the designated cells:

- **Stakeholder:** Record each stakeholder who has a vested interest in your program and M&E findings. Reference the persons and group you identified in tool 2 as a reference for this tool.
- **Information Needs:** Record the information needs or information that would benefit the identified stakeholder.
- **Dissemination Strategy:** Record the method and/or format for reporting the results to stakeholders (e.g., presentation, evaluation report, e-mail message, etc.).
- **Responsible Person(s):** Record a task lead for this reporting activity.
- **Frequency:** Record how often you will disseminate the information or M&E findings to the identified stakeholder.

Example:

Stakeholder	Information Needs	Dissemination Strategy	Responsible Person(s)	Frequency
Program Manager	To improve program delivery, the program needs information regarding: • HIV testing delivery • Quality of data collected • Identified gaps in knowledge or needs for training support	The data analysis team will disseminate regular status reports via email to Sally. These reports will highlight key data related to program delivery, data quality, and recommendations for additional training or support.	Data coordinator	Quarterly

Tool 13. Dissemination Planning Template

Agency/Program:	**Participants:**
Target Population:	
Date Completed:	

Stakeholder	Information Needs	Dissemination Strategy	Responsible Person(s)	Frequency

Tool 13. Dissemination Planning Template (continued)

Stakeholder	Information Needs	Dissemination Strategy	Responsible Person(s)	Frequency

Tool 14. Evaluation Findings and Recommendations Table

About Tool 14: Tool 14 is designed help you to align your M&E questions (tool 7), SMART objectives (tools 4), and M&E findings in order to reach conclusions about the progress of the program and any additional support that is needed moving forward. To complete the tool, you will need to make recommendations for program improvement and establish a timeline for those recommendations to be implemented. Chapter 9 in the Implementation Guide provides an example of a yield analysis for your non-clinical HIV TLC program that you may find useful in completing this tool.

After completing this tool, you may want to revisit your program objectives, measures, and M&E questions to reflect any suggestions or goals related to program improvement. Additionally, share this tool with community partners and funding agencies to demonstrate the ways that your M&E findings inform program planning and improvement.

Agencies may choose to complete Tool 14 at the agency or program level. In both cases, be sure to gather input from multiple individuals with differing perspectives and experiences including agency leaders (i.e., Executive Director), program managers and directors, staff providing HIV testing and linkage, grant writers, funders, and community members. Engaging these individuals during the completion of this tool will help you solidify roles and responsibilities around implementing recommendations in a timely fashion.

How New Programs Can Use This Tool: As a new program, you can use this tool to complete the M&E process by documenting findings, conclusions, and recommendations for program improvement. Use this tool and the information contained within to jumpstart the next cycle of your M&E process. Share these recommendations with agency staff, community members, and partners as a way to determine which approaches are working in your non-clinical HIV TLC program and those areas that could use additional support or revision.

How Established Programs Can Use This Tool: If you have already implemented a non-clinical HIV TLC program, use this tool to document your programs strengths and weakness as reflected in M&E findings and record any recommendations for program improvement.

How Health Departments and Other Funders Can Use This Tool: Health departments and other funders may use this tool with grantees and contractors to provide technical assistance around the dissemination and reporting on a new non-clinical HIV TLC program. Additionally, some funding agencies may ask grantees to complete this tool as a condition of their funding or include it in their grant application. By reviewing the information in this tool, funders can determine if grantees are considering the dissemination of information to all stakeholders of their non-clinical HIV TLC program.

Instructions for Completing Tool 14.Evaluation Findings and Recommendations Table

What is this tool used for? This tool can help you align your M&E questions and program objectives with M&E findings so that you can reach conclusions and make recommendations for program improvement.

Who should complete this tool? Program managers or coordinators may choose to complete this table individually or as a group activity with program staff. If completing individually, make sure to share recommendations with program staff.

When should this tool be completed? Complete this tool on a quarterly or more frequently if needed.

How should this tool be completed? For each of your prioritized evaluation questions, SMART objectives and monitoring questions (crafted in tool 7), list your conclusions and recommendations.

Example:

Evaluation Question:					
To what extent are test results being provided to clients who received HIV testing?					
SMART Objectives	**Monitoring Questions**	**M&E Findings**	**Conclusions**	**Recommendations**	**Timeframe to Implement Recommendations**
By the end of FY 2014, 90% of clients will have knowledge of their serostatus through receipt of their test result.	Among all test results, how many were provided to persons receiving HIV testing?	70% of clients who received an HIV test were provided with a test result within 3 days of the testing event.	The program is not meeting its stated objective.	Implement new trainings to support the effective delivery of HIV testing and results provision.	Deliver training on testing procedures within 1 month. After 30 days, perform shadowing sessions of HIV testing encounters to ensure proper test and results provision.

Tool 14. Evaluation Findings and Recommendations Table

Agency/Program:	**Participants:**
Target Population:	
Date Completed:	

Evaluation Question(s)					
SMART Objectives	**Monitoring Questions**	**M&E Findings**	**Conclusions**	**Recommendations**	**Timeframe to Implement Recommendations**
Evaluation Question(s)					
SMART Objectives	**Monitoring Questions**	**M&E Findings**	**Conclusions**	**Recommendations**	**Timeframe to Implement Recommendations**

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