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**Toolkit for monitoring and evaluating
adolescent sexual and reproductive
health interventions in safe spaces**

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Table of abbreviations

ASRH	Adolescent sexual and reproductive health
GBV	Gender-based violence
IAWG	Inter-Agency Working Group
M&E	Monitoring and evaluation
MSC	Most-significant-change
ODI	Overseas Development Institute
PRM	Participatory Ranking Methodology
SRH	Sexual and reproductive health
UNICEF	United Nations Children's Fund
WGSS	Women and girls' safe spaces
WHO	World Health Organization
WRC	Women's Refugee Commission

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Cover photo: A facilitator meets with adolescent girls in Cox's Bazar © WRC 2019

1. Introduction

Why was this toolkit created?

Access to sexual and reproductive health (SRH) information and services is fundamental to the physical health and psychosocial well-being of adolescent girls. Emergencies increase the risk of gender-based violence (GBV) for adolescent girls and may exacerbate their health risks, diminish educational opportunities and expose them to other human rights violations, including early marriage and early pregnancy.¹ Delaying pregnancy, protecting girls from sexual violence and exploitation and managing menstruation with dignity ensures girls stay in school, integrate into peer and community groups and develop the skills necessary for healthy and empowered transitions into adulthood. Safe spaces have widely been recognized as a key strategy for the protection and empowerment of adolescent girls, especially those affected by crises or displacement.^{2,3}

As part of humanitarian response, women and girls' safe spaces (WGSS) are often established as a place for women and girls to feel physically and emotionally safe and as a point of referral and service delivery. Key services offered by WGSS may include:

- support to GBV survivors (including referrals to case workers, health providers, lawyers or legal associations and police)

- psychosocial and recreational activities (such as support group sessions, one-on-one counselling, vocational training, livelihood activities)
- information and awareness-raising (on, for example, available health services and how to access them, risk-identification and risk reduction strategies, women's rights and life skills) and
- outreach and prevention activities (safety audits, safety mapping, home visits)

Supporting adolescent girls through safe spaces has demonstrated improved gender equity and health outcomes, including delaying marriage and increasing the use of contraception.⁴ Further, programmes aimed at reducing violence against girls through interventions delivered in safe spaces have been successful when accompanied by SRH information.⁵

This toolkit was created by drawing on learnings and experiences from assessments and pilots in three humanitarian settings (Lebanon, Iraq and Bangladesh). Through observations of programme activities and discussions with adolescent girls, their parents and caregivers and other key stakeholders, it is evident that WGSS can be an ideal space for adolescent girls to receive valuable SRH information. While it was observed that SRH information is often being shared in WGSS, there was

1 UNFPA and Save the Children USA, *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* (September 2009).
 2 K.G. Santhya and S.J. Jejeebhoy, "Sexual and reproductive health and rights of adolescent girls: Evidence from low- and middle-income countries," *Global Public Health* 10, no. 2 (2015): pp. 189–221.
 3 J. Svanemyr et al., "Creating an enabling environment for adolescent sexual and reproductive health: A framework and promising approaches," *The Journal of Adolescent Health* 56, no. 1 Suppl (January 2015): pp. S7–14.
 4 G. Medhin and A. Erulkar, "Evaluation of a safe spaces program for girls in Ethiopia," *Girlhood Studies* 10, no. 1 (2017): pp. 107–125.
 5 K.G. Santhya and S.J. Jejeebhoy, "Sexual and reproductive health and rights of adolescent girls: Evidence from low- and middle-income countries," *Global Public Health* 10, no. 2 (2015): pp. 189–221.

rarely a standardized mechanism in place to monitor and evaluate the SRH components of interventions for adolescent girls. This document seeks to fill this gap by presenting tools and guidance for planning and implementing monitoring and evaluation of adolescent sexual and reproductive health (ASRH) interventions administered in WGSS.

Who is this toolkit for?

This toolkit is designed for practitioners working with adolescent girls in safe spaces. It can be used at any stage of an intervention, but ideally it should be used during the programme design phase prior to activities starting in the WGSS. While the toolkit is focused on SRH interventions

for adolescent girls attending WGSS, the principles of the guidance can be applied to a range of interventions targeting youth in safe spaces and beyond.

What is included in this toolkit?

This toolkit presents guidance on setting up a monitoring and evaluation (M&E) system for ASRH interventions delivered in WGSS. The approaches presented herein provide guidance on how adolescent girls can actively participate in all aspects of the design, monitoring and evaluation process (see Figure 1). For each stage, guidance is supported by tools to be used to ensure a robust M&E system.

Box 1. What is needed to implement a sexual and reproductive health (SRH) intervention for adolescent girls in a safe space?

Delivering SRH information and services to adolescent girls is a fundamental right that can have far-reaching effects for both girls and their communities. However, launching an SRH intervention requires careful planning that considers the implementation capacity of the safe space. Answering “yes” to the following questions indicates that the basic mechanisms are in place to implement an ASRH intervention:

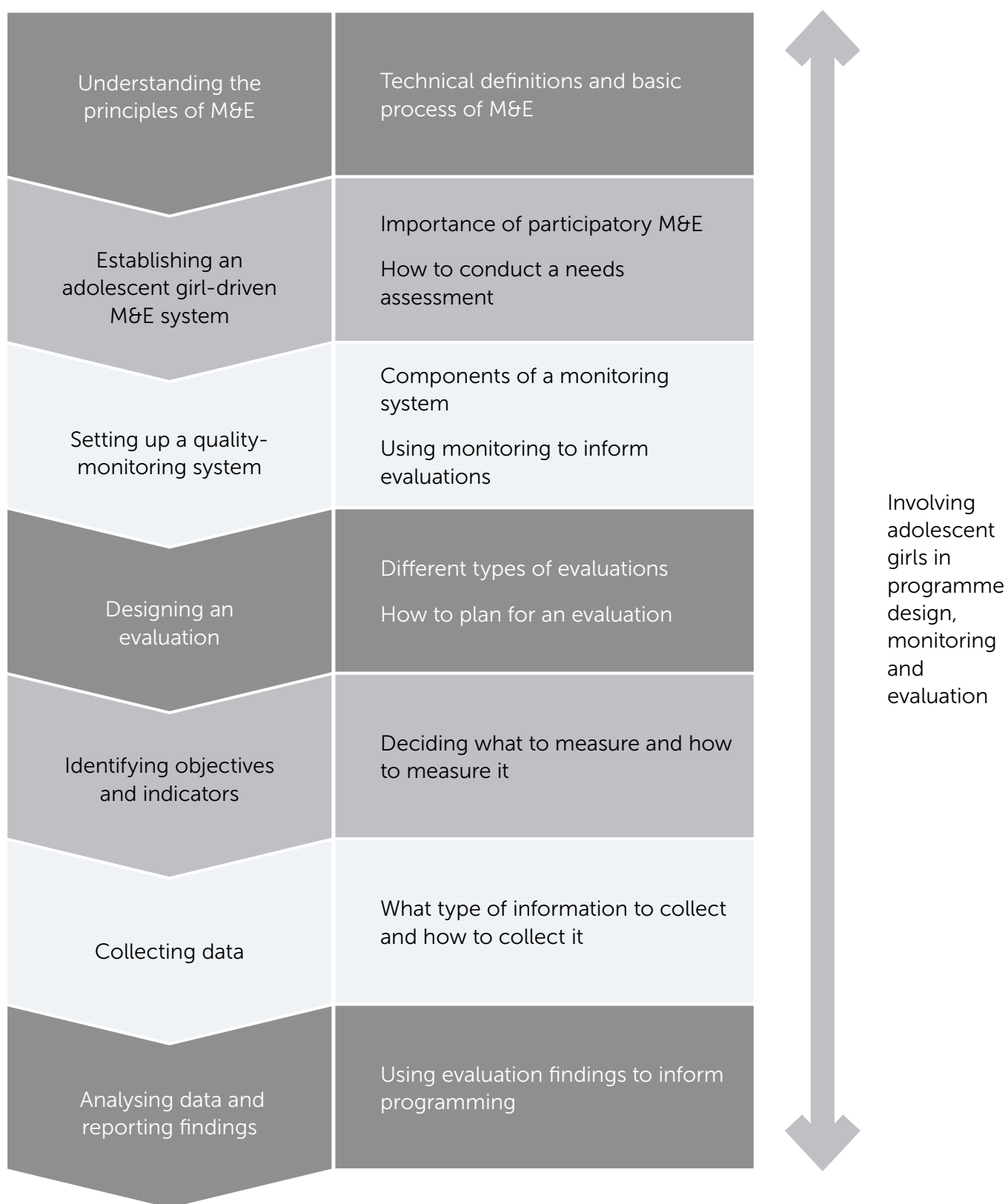
- Is the safe space set up in a way that makes girls feel protected once inside? (I.e., can girls participate in activities without fear of being seen or heard by people outside the space?)
- Do you offer activities just for adolescent girls, that provide them the opportunity to discuss issues relevant to them?
- Are you able to separate women and girls during activities? (I.e., is there a separate space for girls?)
- Do you have enough female staff to facilitate these sessions for girls?
- Are you able to offer one day or one half-day each week dedicated to adolescent girls?
- Is an all-female team available to support the SRH intervention (i.e., social worker, facilitator, outreach workers, M&E officer)?
- Are staff trained in adolescent-friendly facilitation and counselling techniques?

Box 2. Guiding principles for women and girls' safe spaces (WGSS)

- *Leadership and empowerment of women and girls:* Women and girls should be included in project planning, implementation and M&E to ensure relevance and ownership.
- *Client/survivor-centred:* The safe space should be open to all women and girls and their wishes, choices, rights and dignity should be respected. Safe spaces should prioritize safety and confidentiality.
- *Safe and accessible:* The safe space should be located in an area that is conveniently accessible to women and girls, assuring their safety and privacy.
- *Community involvement:* Safe spaces must understand the perspectives of husbands, parents and community leaders and must mobilize community support so that women and girls are able to safely participate in all activities.
- *Coordinated and multi-sectoral:* Activities and services should take into consideration the varying needs and experiences of women and girls and should deliver services that respond to their life cycle, including issues related to GBV prevention and response.
- *Tailored:* Safe spaces should maintain a balance between structured activities, services and time to socialize, with culturally and age-appropriate activities and approaches. They should take into consideration the special needs of women and girls living with disabilities.

Source: United Nations Populations Fund, *Women & Girls Safe Spaces: A Guidance Note based on Lessons Learned from the Syria Crisis*, 2015. Available from: <https://www.unfpa.org/resources/women-girls-safe-spaces-guidance-note-based-lessons-learned-syrian-crisis>

Figure 1. Overview of monitoring and evaluation (M&E toolkit)



2. Principles of monitoring and evaluation

Note: This chapter serves as an overview of monitoring and evaluation (M&E). For programme staff who have never been trained on M&E, the principles and terminology presented here may take time to learn. Programme staff whose primary role is to conduct M&E will likely be very familiar with this information. Ideally, M&E staff will work with field staff to help them understand these principles and relate the principles to the ongoing work of the safe space.

What is monitoring and evaluation?

Regular M&E provides the information necessary to assess programme quality and make recommendations on how best to improve programming for a greater impact. *Monitoring* refers to the routine collection of relevant programme information, analysing this information and using it to measure a programme's ongoing performance. *Evaluation* describes the process of assessing whether or not the programme was successful in bringing about its desired changes. A good monitoring system can help with an evaluation, but collecting additional information is usually necessary. Decisions related to M&E should be made as early as possible, ideally during the design phase of the intervention.

Why conduct monitoring and evaluation?

Being able to demonstrate results has numerous advantages. A robust M&E system shows us if and how our intervention is working and can be used to strengthen various aspects of programming. M&E results can also contribute more broadly to a global evidence base of what does and does not work and can inform similar interventions elsewhere. M&E can help greatly with funding, as donors are more inclined to initiate or renew funding for an intervention

that has proven effectiveness. Last, but not least, M&E has the potential to mobilize communities to support interventions and can empower beneficiaries to inform programming to best respond to their needs and priorities.

We can think of building an M&E system as answering the following key questions:

- What does the intervention seek to change?
- How will the intervention achieve the desired change?
- What are the specific objectives related to these changes?
- How will we measure these objectives?
- How will data be collected and analysed?
- How will what we learn help to improve our intervention?

Theory of change

To answer these questions, we start by creating what is known as a *theory of change*. A theory of change explains how activities produce results that contribute to achieving the final intended impact. It

helps us to consider the desired impact of the intervention, understand the necessary steps to get there and design indicators to measure whether or not the intervention is working. While it may seem difficult or counter-intuitive to embark on this process before designing the intervention itself, the theory of change will in fact help determine the topics to include in our intervention, the duration of the intervention and what type of information we should collect on an ongoing basis.

The theory of change can be understood as five main components:

- *Desired impact:* The major health change we wish to see in our area of work; the ultimate reason for implementing the ASRH intervention.
- *Outcomes:* The changes in knowledge and behaviours that we hope to see as a result of our ASRH intervention.
- *Outputs:* Services or products that must be in place for the desired outcomes to be achieved.
- *Activities:* The technical and support tasks required to produce the outputs.
- *Inputs:* Resources required to support the activities.

When thinking about our theory of change, we work backwards, starting with the desired impact and then thinking through the steps that are necessary to achieve it.

This process helps us think through what we wish to achieve at each stage and whether

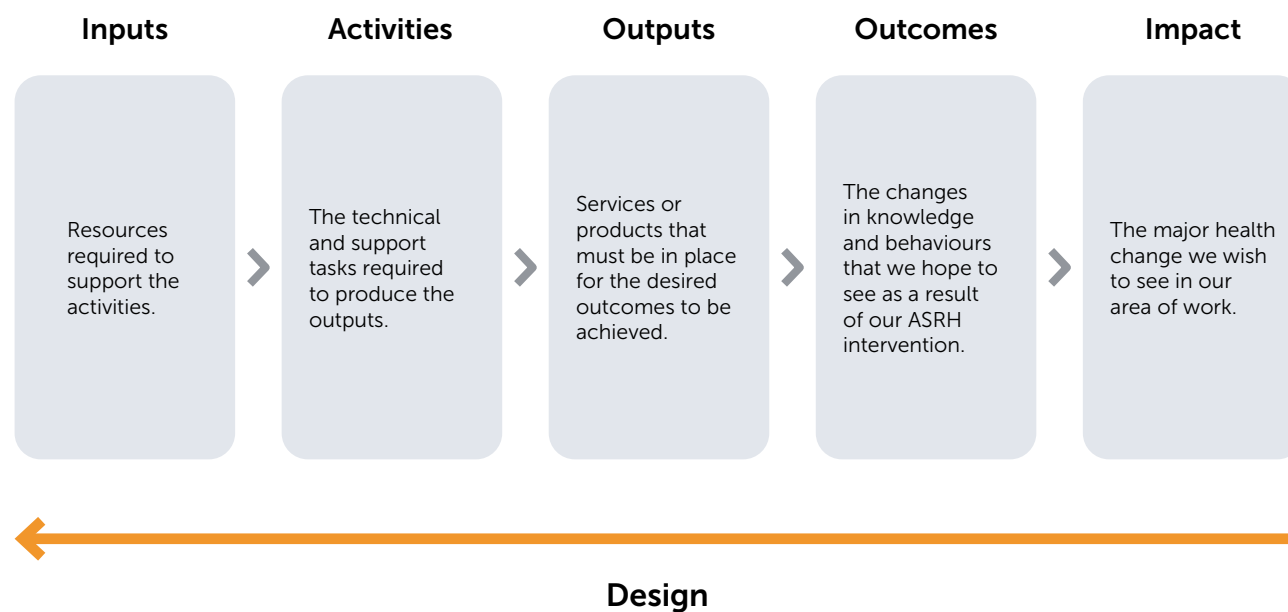
or not it is reasonable to assume that each stage will result in the next. It can be helpful to frame our theory of change as follows: "This set of *inputs* and *activities* will result in these services [*outputs*], which will facilitate these changes in the population [*outcomes*], which will contribute to the desired *impact*."

A theory of change for an SRH intervention for adolescent girls in safe spaces may be: "The intervention in this safe space will provide weekly sessions for adolescent girls on SRH-related topics and provide referrals to adolescent-friendly SRH services. These activities will result in an increased number of adolescent girls attending SRH information sessions, which will facilitate changes in SRH-related knowledge, attitudes and behaviours among adolescent girls. These changes will contribute to an improvement in ASRH in this camp."

As we will see later in this guide, in order to design, implement, monitor and evaluate an intervention successfully, each stage of the theory of change should be as clearly defined as possible. In other words, we must specify what we mean by improving ASRH, what type of knowledge, attitudes and behaviours we wish to change, and what the activities of the intervention will entail. We also must decide how each of these stages will be measured and how we can use the information we collect to better serve adolescent girls.

The next chapters will detail how to determine what it is we wish to accomplish at each stage of the theory of change, how to measure these objectives and how to use information collected to improve interventions.

Figure 2. Theory of change process



3. Establishing an adolescent girl-driven monitoring and evaluation system

Note: The concept of participatory programming or participatory M&E may be familiar to both field and M&E staff. However, ensuring that the M&E process is truly participatory can be challenging and may entail some trial and error to see how best it can be accomplished in a given context. By raising awareness on the potential benefits of participatory M&E, safe spaces can begin to adopt a culture of participation and start making small changes to ensure that adolescent girls are involved in the design, implementation, monitoring and evaluation of interventions.

Importance of participatory monitoring and evaluation

Involving adolescent girls in the design, implementation, monitoring and evaluation of an intervention falls within the fundamental right to participation enshrined in the Convention on the Rights of the Child.⁶ Not only does their involvement help an intervention better respond to girls' needs, but it also empowers girls to actively inform change. Adolescents have a unique capacity to identify approaches or solutions that will best respond to their personal circumstances and needs. Further, they are able to engage in activities outside their immediate environment as they develop a sense of individual and collective identity. Providing adolescent girls with safe and productive opportunities to express their needs and develop their identities helps prevent unsafe or risky behaviours, while encouraging them to develop critical consciousness and leadership abilities.⁷

Participatory approaches are beneficial in many ways, but only if participation is ethical, feasible and useful. The benefits of participation are neither automatic nor guaranteed. Participation should not be a

one-off event; instead, it must be thought of as a process that includes the design, monitoring and evaluation of an intervention. Participatory approaches must also involve a capacity-building component in order for adolescents to build their skills while feeling empowered to make a significant contribution to programming.

This chapter will provide a general overview of how to involve adolescents in a meaningful way. Each chapter of this toolkit contains more specific guidance on adolescent participation at the respective design, monitoring and evaluation stages of the intervention.

As a minimum, all ASRH interventions should have in place the following features:

- Adolescent girls decide which topics they would like to include as part of the SRH intervention
- Adolescent girls help determine the intervention's objectives and appropriate indicators.
- Adolescent girls provide their views on the intervention.

⁶ United Nations General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3.

⁷ E.J. Ozer and A.A. Piatt. "Adolescent participation in research: Innovation, rationale and next steps," *Innocenti Research Brief*, 2017–07, *Methods: Conducting Research with Adolescents in Low- and Middle-Income Countries*, no. 5, UNICEF Office of Research (2017).

- Adolescent girls give feedback on M&E results and the implications for future similar projects.

Beyond these minimal means of engagement, we suggest that adolescent girls are given the opportunity to build skills in programme design, implementation, monitoring and evaluation by being consulted and engaged throughout the intervention. All participants should be briefed on what M&E means and why it is being carried out for the said intervention. Participants who are interested in being more actively engaged can be part of an adolescent M&E team who are given more concrete tasks and responsibilities at different stages of the intervention. Key steps to involving adolescents in the M&E process are provided in box 3.

Principles of participatory monitoring and evaluation

Observing ethical standards is necessary whenever adolescents are participating in programme design, monitoring or evaluation. This is particularly true when working with vulnerable adolescent girls who rely on certain services provided by the safe space. The following ethical principles must be followed at every stage of adolescents' participation in the M&E cycle:⁸

- Clearly explain to all participants what the implications of their participation are. Make sure you do not build unrealistic expectations and always keep in mind potential risks of participating.
- Clarify the purpose of the intervention and the potential impacts of participation in terms of any costs, harm or benefits.

- Ensure that participation benefits the participants in some way, whether through the provision of information and services, or through building skills that can be used in the future.
- Obtain agreement to participate and ensure that everyone is fully informed, understands the conditions of agreement and has the ability to withdraw at any time.
- Ensure that participation does not reinforce patterns of exclusion or exploitation.
- Put in place additional safeguards for those who are most vulnerable.
- Ensure that any adults working with adolescents have the appropriate skills and are adequately supervised.

Additional ethical considerations must be made when data or information is being collected from adolescents. This is covered in more detail in chapter 7.

In addition to ethical considerations, involving adolescents in the M&E process should be guided by certain principles of meaningful engagement. Table 1 outlines the principles for engaging adolescents in the M&E process, with questions to consider for each principle.

The questions should be discussed prior to recruiting adolescent girls to participate in M&E and should be revisited throughout the intervention to ensure that the M&E process is meaningful and truly driven by adolescent girls themselves.

⁸ I. Guijt. "Participatory Approaches," *Methodological Briefs: Impact Evaluation* No. 5, UNICEF Office of Research, Florence (2014).

Table 1. Principles of adolescent-driven M&E^{9, 10}

Participation is...	Questions
Transparent and informative	<ul style="list-style-type: none"> Do adolescent M&E focal points have enough information about the project to make an informed decision about whether they may participate and how? Is information shared in a language they can understand? Are the rules and responsibilities of everyone involved clearly explained and understood?
Voluntary	<ul style="list-style-type: none"> Have adolescent M&E focal points been given enough information and time to make a decision about whether they wish to participate? Can focal points stop participating at any time they wish, without suffering from negative consequences as a result of their withdrawal?
Respectful	<ul style="list-style-type: none"> Do the ways of working with the adolescent M&E focal points consider and build upon local cultural practices? Has support from key adults been gained to ensure respect for the focal points' participation?
Relevant	<ul style="list-style-type: none"> Are the issues being discussed and addressed of real relevance to participants' lives? Do adolescent M&E focal points feel any pressure from adults to participate in activities or assignments that are not relevant to them?
Adolescent-friendly	<ul style="list-style-type: none"> Are staff trained in adolescent-friendly approaches and methods? Do the ways of working build the self-confidence of adolescents of different ages and abilities? Are adolescent-friendly meeting places used? Are such places accessible to all adolescents, including those with disabilities?
Inclusive	<ul style="list-style-type: none"> Are adolescents of different ages and backgrounds given opportunities to participate as adolescent M&E focal points? Are focal points encouraged to address discrimination through their participation?

9 UNICEF. *Adolescent and Youth Engagement Strategic Framework*, 2017, www.unicefemergencies.com/downloads/eresource/docs/Adolescents/63792683.pdf.

10 UNICEF Middle East and North Africa Regional Office, *Toolkit for Adolescent and Youth Engagement*, 2018, www.nolostgeneration.org/sites/default/files/webform/contribute_a_resource_to_nlg/481/aye_mena-toolkit.pdf.

3. Establishing an adolescent girl-driven monitoring and evaluation system

Participation is...	Questions
Supported by training	<ul style="list-style-type: none"> • Are staff trained in adolescent-friendly participation? • Do staff members have the confidence and skills to facilitate the participation of the adolescent M&E focal points? • Do staff members have opportunities to improve their capacity in working with adolescents?
Safe and sensitive to risks	<ul style="list-style-type: none"> • Are adolescent M&E focal points aware of the impact or potential consequences of participation? • Do focal points feel safe when they participate? • Have you identified risks and ways to keep focal points safe? • Do focal points know where to go for help if they feel unsafe while participating?
Accountable	<ul style="list-style-type: none"> • Do adults take adolescent M&E focal points' views and suggestions seriously and act upon them, or offer adequate justification for why they cannot be actioned? • Are focal points given feedback about any of their requests and follow-up?

Potential challenges to meaningful adolescent participation

Even with the best intentions to meaningfully involve adolescents in the M&E process, there are numerous barriers that may

prevent them from fully participating in one or all of the stages of programming. The following table presents potential challenges encountered when involving adolescents in the M&E process, as well as potential solutions for meaningful engagement.

Table 2. Potential challenges and solutions to ensuring an adolescent-driven M&E process

Potential challenge	Potential solutions
Inadequate understanding of the local context and cultural norms of participation	Prior to involving adolescents, meet with families and community members to understand cultural norms surrounding participation and any risks that may be posed by engaging adolescent girls in the M&E process.
Shortcuts taken in participatory processes, with no clear benefits to the intervention or participants	Be clear about the purpose of adolescent participation and what the intended benefits are, for both the intervention and the participants. Make a clear plan showing how participants will be involved at each stage of the M&E cycle.
Adolescents are hesitant to give their input, or their input is not valued or taken into consideration.	Pay attention to potential power dynamics. Ensure that all facilitators working with adolescents on M&E are receptive to the process and trained on the basics of adolescent participation and engagement.
Few adolescents are interested in, or able to participate in, the M&E process.	Clearly explain the possible benefits of adolescent participation in the M&E process. Consider offering small material incentives (e.g. pens, notebooks, snacks) for participation, if appropriate.
Attention given to participation during data collection only, and not the other steps of design, implementation, monitoring and evaluation	Clearly plan how participants will be involved at each stage of the M&E cycle. Hold programme staff accountable to the participation plan and get feedback from adolescents as to how engaged they have been at each stage.

Box 3. Key steps to begin an adolescent-driven monitoring and evaluation process

- Ensure that the principles of adolescent-driven M&E and ethical principles have been thoroughly reviewed with any staff who will be involved in the intervention and the M&E process.
- Create a terms of reference (ToR) for adolescent M&E focal points. Think about what will be required of adolescent M&E focal points throughout the intervention. Responsibilities may differ for older versus younger adolescents. See box 6.
- When girls register for the intervention, inform them that there is an opportunity to be involved in the delivery of the program. Ask if they would be interested in participating and indicate their interest on their registration form.
- Hold an initial meeting for all girls who expressed an interest in participating as an M&E focal point. Explain to the group why you have gathered them and what will be expected from them if they choose to participate. Explain the principles of engagement and make sure the girls understand fully the terms of their commitment and that they are aware that they may choose to stop participating as an M&E focal point at any time.
- For girls who remain interested in participating, obtain their assent and parent/caregiver's consent (for girls under 18 years old). For girls aged 18 years and older, obtain their consent to participate. See chapter 7 for more information on informed assent and consent.
- Set up a preliminary schedule of meetings for the adolescent M&E focal points. Eventually, focal points may opt to meet for 15 minutes either before or after attending the intervention.
- Ensure that other girls are given the chance to join as an M&E focal point if they were unable to attend the initial meeting, or if they become interested at a later stage.

Determining the sexual and reproductive health-related needs and priorities of adolescent girls

One of the very first ways to involve adolescent girls in the design, monitoring and evaluation of the intervention is to ensure that their needs and priorities are taken into account from the outset. Before setting objectives and identifying indicators, and prior to the launch of the intervention itself, it is critical to determine what it is that girls hope to achieve through the SRH intervention. Not only does this allow us to design a more relevant intervention, but it also helps determine what information we should be collecting throughout the M&E process. The assessment can be integrated as part of a baseline assessment, which will be explained further when we discuss evaluation design (see chapter 6).

Determining the needs and priorities of adolescent girls, or conducting a needs assessment, may seek to answer the following questions:

- What are the main SRH-related concerns of adolescent girls?

- How do girls prioritize information needs on SRH topics such as puberty, sexual anatomy, menstruation, pregnancy and childbirth, family planning, STIs and where to access SRH services?
- What SRH-related information do girls wish to learn in *safe spaces*?
- What SRH-related information is best delivered in ways other than through a safe space?
- Which SRH services do girls need, or wish to learn more about?
- Which community members should be involved in aspects of the SRH intervention?

It is also critical to consult with adolescent girls' parents and caregivers, as well as any community members who may make decisions regarding adolescent girls' access to information or services. This also provides an opportunity to share information on the importance of the intervention, as well as other services available at the safe space.

A. Tools for adolescent participation

- Free listing
- Participatory Ranking Methodology (PRM)
- Intervention design planning

4. Setting objectives and identifying indicators

Note: There may already be a set of objectives associated with your safe space programming and corresponding reporting requirements. Creating separate objectives and indicators for an ASRH intervention ensures that meaningful data is collected throughout the programme cycle and that the ASRH intervention stays on track. Stand-alone objectives and indicators should be developed in conjunction with M&E staff to ensure alignment with safe space programming.

Importance of objectives and indicators

M&E helps us understand how successful an intervention has been in achieving what it set out to do. Before we attempt to determine the success of our SRH intervention, we must first define what our intervention is seeking to achieve and how its achievements will be measured. An intervention's *objectives* should clearly define what we aim to achieve, while its *indicators* should tell us exactly how we will measure results. Deciding which indicators to measure determines the type of evaluation we should conduct, which is discussed in greater detail in chapter 6.

An overarching objective of ASRH interventions in safe spaces is to increase access to SRH information and services for adolescent girls. Beyond this, objectives should be set at different levels of the theory of change. Generally, objectives should include targets detailing what the intervention hopes to achieve. Targets can be a useful way of creating accountability and provide a more concrete measure of whether or not the intervention has succeeded. It may be necessary to complete a baseline assessment prior to the setting of objectives, particularly when the objective states a desired percentage increase in a certain outcome.

It is crucial that the objectives of the intervention are not decided upon by project staff alone—active engagement with adolescent girls is especially critical at this stage of programme design. They can greatly inform what it means to increase access to knowledge and services: the type of knowledge they wish to have, the type of services they wish to access and how the success of the intervention should be defined. This process should be informed by the needs assessment, after which adolescent girls can further shape objectives and indicators.

Potential indicators for adolescent sexual and reproductive health interventions

Each objective must include one or more indicators to clarify *how it will be measured*. Indicators will serve as your guide when conducting M&E, as they determine the data and information that need to be collected. Thinking through how objectives will be measured is a key part of the M&E process. The following are some suggested indicators that should be expanded or adapted as needed.

Process indicators measure the use of inputs and resources, or the implementation of activities. Examples of *process indicators* include:

- number of SRH sessions delivered to adolescent girls
- number of safe spaces implementing SRH sessions with adolescent girls
- money spent on the intervention
- number of hours of staff time contributed to the intervention

Output indicators measure the services provided by the intervention and the quality of these services. They focus on delivering a particular service, rather than what you expect to happen as a result of the service. Examples of *output indicators* include:

- number of adolescent girls who attended at least 80 per cent of SRH sessions
- number of referrals to SRH services made to adolescent girls participating in the intervention
- percentage of adolescent girls living in camp who have attended at least two SRH sessions at the safe space
- percentage of adolescent girls who attended at least 80 per cent of SRH sessions and rank the quality of the sessions as 'good' or 'excellent'

Outcome indicators measure the knowledge, attitudes, skills, intentions and behaviours of the target population. These indicators will likely be the most commonly used in an evaluation of an ASRH intervention. Some examples of *outcome indicators* include:

Knowledge

- average score on a knowledge assessment (administered before the

intervention and one month after the completion of the intervention)

- percentage of girls who score at least 80 per cent on a knowledge assessment (administered before the intervention and one month after the completion of the intervention)
- percentage of girls who can correctly identify at least three sources of family planning (asked at baseline and one month after the completion of the intervention)

Attitudes

- percentage of girls who report favourable attitudes towards family planning (test administered before the intervention and one month after the completion of the intervention)
- percentage of parents and caregivers who believe adolescent girls should have access to SRH information and services (test administered before the intervention and one month after the completion of the intervention)

Behaviours

- percentage of participants who report adequate menstrual hygiene practices in the past two months
- number of participants who attend a one-on-one counselling session with a facilitator in the three months following the start of the intervention

Impact indicators include higher-level measures of health or well-being in the wider community that the intervention is serving. As it can be difficult to conduct an impact evaluation of an ASRH intervention in a safe space, looking at impact indicators in

the wider community can be helpful. Some examples of *impact indicators* include:

- adolescent birth rate
- contraceptive prevalence rate among adolescents
- percentage of community members who have favourable attitudes towards the provision of SRH information and services to adolescent girls

Measuring impact indicators requires a great deal of resources—financial, time and staff capacity. Further, such changes often take time to occur, so they may not be the best indicators for measuring the success or failure of a single intervention. Nevertheless, it can be useful to think of impact-level indicators to better frame our intervention and to create subsequent objectives and indicators.

Some impact-level indicators may be easier to measure than others and may be more directly related to the objectives of an intervention. For example, perhaps the intervention ultimately aims to change

community attitudes towards providing SRH information and services to adolescent girls. We could measure this through a household survey supplemented by key informant interviews with health care providers. This would be far easier than, say, measuring the adolescent birth rate before and after our intervention.

Further considerations for objectives and indicators:

- Objectives and indicators should be SMART: Specific, Measurable, Attainable, Relevant and Time-Bound. See box 4 for more information.
- Objectives and indicators should be disaggregated whenever possible. For example, if separate sessions are held for 10–14-year-olds and 15–19-year-olds, there should be separate objectives and indicators for each group.
- Indicators should be clearly linked to objectives, which should be clearly linked to one step in the causal pathway.

Box 4. The SMART method

'SMART' is a common acronym used to guide the setting of objectives and the creation of indicators. In summary, objectives and indicators should be:

- | | |
|---|---|
| S | Specific: The objective/indicator should be narrow and focus on the 'who' and 'what' of the intervention. |
| M | Measurable: The objective/indicator should have the capacity to be counted, observed, analysed, or tested. |
| A | Attainable: The objective/indicator should be realistic to achieve as a result of the intervention. |
| R | Relevant: The objective/indicator should be a valid measure of the objective and should relate to the desired impact of the intervention. |
| T | Time-bound: The objective/indicator should be attached to a time frame. |

Creating a monitoring and evaluation framework

Once we have decided upon our objectives and how we will measure them, an essential task is to create an M&E framework. The framework should provide information on what our objectives are, how each objective

will be measured, where we will obtain the information to measure it, how often we will collect information and who is responsible for collecting the information. Ensure that information is included for each indicator, as there may be more than one indicator per objective.

Table 3. Monitoring and evaluation framework template

Level	Objective	Indicator	Measure	Means of verification	Frequency of data collection	Person(s) responsible
Example: Output	Increase the number of girls attending SRH sessions	Number of adolescent girls who attended at least 80 per cent of SRH sessions	Total number	Attendance records	Attendance taken at every session; total number calculated at end of intervention	Session facilitator

B. Tools for setting objectives and identifying indicators

- Problem tree
- Focus group discussion guide for parents and caregivers
- Creating a monitoring and evaluation framework

5. Setting up a quality monitoring system

Note: Collecting monitoring data may be very familiar to field staff. Understanding why this data is collected, and how best it can be used, is essential to ensuring that it is of high quality. This chapter provides an introduction to monitoring systems, with an emphasis on why monitoring is so important. Applying the principles of adolescent participation to the creation and implementation of a monitoring system is often the first step towards providing adolescent participants with an opportunity to inform programming.

What does a monitoring system measure?

Monitoring refers to a routine and continuous process of collecting programme information, analysing this information and comparing actual results to expected results in order to measure a programme's performance. It is important to ensure that implementation is on track, and monitoring allows us to make ongoing adjustments to improve the quality of our intervention.

Information collected from ongoing monitoring can also feed into a more comprehensive evaluation of an intervention. It can assess the extent to which the intervention was implemented as planned and explain possible reasons why the intervention did or did not work, as well as reasons for any unanticipated effects. Thinking back to the theory of change, we can understand monitoring as the collection of information on *inputs*, *activities* and *outputs*. Monitoring can help us answer the following questions:

- *What resources are being used to implement this intervention?:* How much money is being spent? How much time is being dedicated to the intervention? Which programme staff are contributing to the intervention?
- *What activities are taking place?:* What is the content of SRH sessions? How many SRH sessions are being carried out each week?
- *Were the activities carried out as planned?:* How many girls did the SRH intervention reach? Were the SRH sessions of good quality?

Collecting information on inputs, activities and outputs is sometimes referred to as a *process evaluation*. While the routine monitoring of programme data can indeed inform programme implementation, we generally need to know more to assess whether or not our intervention is effective. In the next chapter, we provide guidance on designing an *outcome or impact evaluation*.

Components of a quality monitoring system

There are six key components that all programmes should monitor:

- **Recruitment:** How participants were selected and registered for the intervention.
- **Reach:** Proportion of the intended audience that participated in the intervention.
- **Dose delivered:** Amount or number of intended units of the intervention delivered.
- **Dose received:** Extent to which participants are satisfied with the intervention.
- **Fidelity:** Extent to which the intervention was implemented as planned.
- **Context:** Things beyond the intervention that may influence implementation or outcomes.

Table 4 provides additional information on each component, including its definition, what it seeks to measure, potential challenges and suggested tools and approaches.

Recruitment and reach

Undoubtedly, one objective of the intervention is to reach more girls with SRH information and referrals to services through safe spaces, in particular the most vulnerable or isolated girls within communities. You may have concrete objectives related to how many girls you wish to enrol in the intervention, or certain sociodemographic characteristics that should be represented

among participants. It is important to track the number and sociodemographic characteristics of girls who are recruited, of those who register for the intervention and of those who attend each session. This information will help to design better outreach strategies and to understand trends regarding girls' attendance at sessions.

Dose delivered and received

Participants should be able to attend as many sessions as possible. Infrequent attendance would make the desired changes in knowledge, attitudes or behaviours more difficult to achieve. With poor attendance, or poor monitoring of attendance, it would also be much more difficult to evaluate whether or not any changes were in fact a result of the intervention. The frequency and duration of the SRH intervention will depend on the available resources, including staff capacity, as well as participants' preferences. Consultations with adolescent girls and their parents and caregivers should be carried out at the earliest opportunity to determine their preferences. Determining the frequency and duration of the intervention will also guide the selection of topics. Many curricula have condensed versions that are designed specifically for situations with time constraints.

Of equal importance is assessing participants' satisfaction with the intervention and their absorption of information provided in the SRH sessions. Allowing girls to provide ongoing feedback, and to have an active say in how information delivery could be improved, is essential. Check-ins at the start of sessions to assess what girls recall from the previous session can help ensure that girls are retaining the information provided in the short term. Assessing the competency of facilitators is a critical component in understanding the quality of the intervention and should be done

as a routine part of monitoring. Observing facilitators also provides an opportunity to offer them capacity-building.

Fidelity and context

Once you have determined the appropriate duration and frequency of the intervention, it is time to select the actual content of the SRH sessions. Information collected from the needs assessment can feed into the selection of modules, and girls should be consulted on an ongoing basis to ensure that your intervention is not leaving out any key topics. Monitoring fidelity must be done in tandem with understanding the context in which the intervention is implemented.

If, for example, a major event occurs that is outside the control of the safe space and prevents girls from attending sessions as planned, programme staff may be better prepared for contingency planning in the future. It is also important to understand situations that might enhance changes in participants' knowledge, attitudes or behaviours. For example, perhaps girls are attending similar programming at another location in the camp. Knowing this will allow a better understanding of the extent to which your intervention has resulted in the desired outcomes.

Sources of data for monitoring

It is possible that a safe space already has a monitoring system in place that tracks attendance, referrals to services and other key indicators. It should therefore be relatively straightforward to integrate monitoring of the ASRH intervention into the existing system. Key sources of data for monitoring include:

- participant registers (*used to record sociodemographic characteristics of participants, which will enable us to ensure that the intervention is not excluding any group*)
- attendance lists (*used to monitor attendance to ensure that registered participants are in fact participating in the intervention*)
- activity records (*used to keep track of the content of SRH sessions and the number of sessions being carried out*)
- session feedback (*used to measure the relevance and quality of the SRH sessions in order to make improvements for future programming*)
- observation tools and checklists (*used to monitor the capacity of programme staff to deliver the sessions and the quality of sessions in order to make improvements for future programming*)

C. Tools for setting up a quality monitoring system:

- Participant register
- Attendance register
- Lesson planning
- Satisfaction survey
- Facilitator evaluation
- Fidelity tracker

Table 4. Ensuring successful high-quality monitoring systems

Component	Definition	What it might measure	Common challenges	Tools (solutions)
Recruitment	How participants were selected and registered for the intervention	How many adolescent girls were recruited or registered for the intervention? Did they represent desired age groups and other sociodemographic characteristics? Add staff.	Not recruiting enough adolescent girls for the intervention, or only recruiting girls of a certain demographic (in school, unmarried, living in close proximity to the safe space). Add staff example.	Participant register Outreach and recruitment guidance
Reach	Proportion of the intended audience that participated in the intervention	How many adolescent girls participated in SRH sessions out of the entire target population?	Poor outreach strategies that don't recruit the most vulnerable, isolated adolescents.	Participant register Attendance register
Dose delivered	Amount or number of intended units of the intervention delivered	How many SRH sessions were carried out? How many SRH-related topics were covered?	Limited number of topics covered. Evaluation/assessments cover topics not included in the intervention.	Lesson plans Fidelity tracker
Dose received	Extent to which participants are satisfied with the intervention	How did girls rate the quality of the SRH sessions? Did the facilitator deliver the information in a satisfactory manner?	Content is not relevant or of interest to girls. Facilitator is not properly trained to deliver services.	Satisfaction survey Facilitator assessment
Fidelity	Extent to which the intervention was implemented as planned	Were the SRH sessions delivered according to guidance in the curriculum? Were other elements of the intervention, such as referrals to services, implemented as planned? What was the quality of the intervention?	Deviations from planned activities due to external factors. Insufficient training to carry out activities.	Fidelity tracker Pre- and post-surveys
Context	Things outside the intervention that may influence its implementation or the outcomes	Were sessions cancelled or delayed for any reason? Did a major event occur that prevented girls from attending as planned? Are other similar interventions under way where girls are getting additional information?	Interruption in intervention due to external factors. Similar interventions competing with intervention in WGSS.	Contextual analysis

6. Designing an evaluation

Note: This chapter presents the basics of designing a programme evaluation. While it is unlikely that an evaluation will be designed and conducted by field staff, knowing why evaluations are important and what type of data to collect is essential for everyone working on programme implementation. Field staff should also be consulted on evaluation design, as it relates to the objectives of the ASRH intervention itself.

What do evaluations measure?

Evaluations assess whether the changes that the intervention aimed to bring about have happened as intended. They typically take place at pre-specified points before, during and/or after the intervention and require the collection of additional information beyond routine monitoring data. Depending on the complexity of the evaluation, it may require additional resources to be allocated and additional staff who are dedicated to the collection, analysis and reporting of information to be hired.

Evaluations are typically conducted to measure *outcomes* or *impacts* (or both). They can help us answer the following questions:

- Did the intervention achieve its intended objectives?
- Were there any unintended consequences of our intervention?
- Were changes the result of our intervention?
- How can the intervention be improved to better achieve its intended objectives?

Selecting an evaluation design

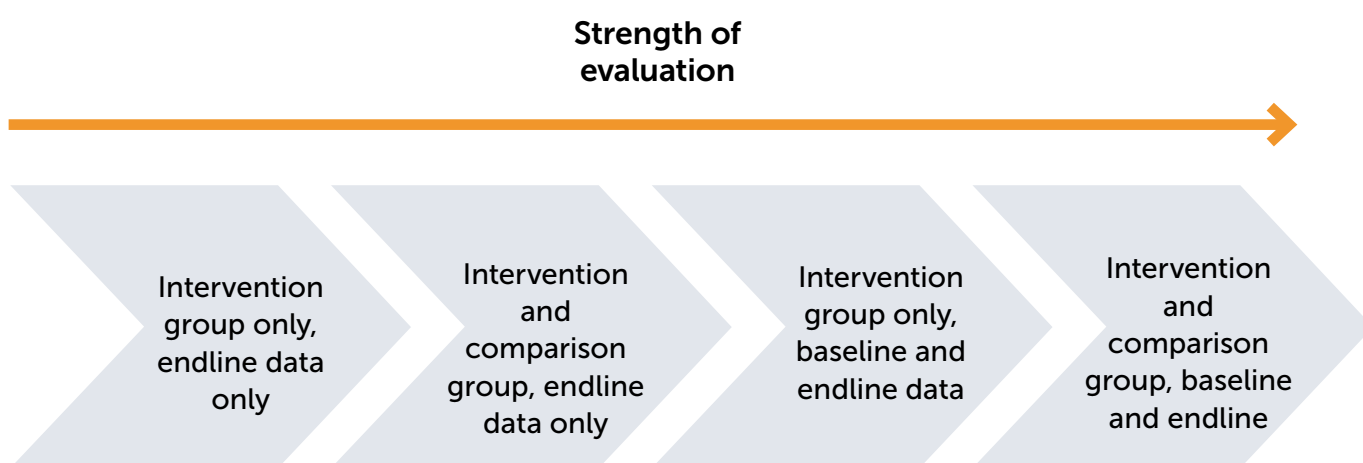
Evaluation design should be considered as early as possible and take into account two major considerations: *when* to collect data and *from whom* to collect data. These decisions will influence our ability to say whether or not our intervention caused certain changes. Say, for example, that data is only collected at the end of an intervention from the adolescent girls who attended the SRH sessions. We may be able to accurately assess the group's SRH-related knowledge, attitudes and behaviours at the time, but we would not know if there had been any changes between the time before the intervention and the time we collected our data, and whether any changes were a result of participating in the intervention.

There are two ways of better assessing whether or not changes are the result of our intervention:

- collecting data from participants before the start of our intervention (*baseline*) and at the end of our intervention (*endline*)
- collecting data from a similar group of individuals who have not participated in our intervention (a *control* or *comparison group*)

Combining these two approaches generally provides us with the greatest certainty as to whether or not any observed changes are the result of our intervention. This means collecting relevant data at the start of our intervention and at various points during and after our intervention, and assessing those who participate in the intervention and those who do not. Of course, the costs of this type of evaluation can be high and

sufficient time is required between baseline and endline assessments to be able to see change in behaviours. The evaluation must be carefully planned to ensure that data collection is completed for the intervention group before the intervention begins and that a suitable comparison group has been identified to collect data from at the end of the intervention.



Ideally, the comparison group should go on to receive the intervention as well, in order to avoid an ethical dilemma of only providing information and services to one group. Programme staff should therefore ensure that there is the capacity to continue programming if a comparison group is to firstly be used for an evaluation.

Strengthening an outcome evaluation

In reality, an evaluation design is often not as strong as we would hope. Perhaps the evaluation was planned once the intervention was already under way, so there is no way to collect baseline data, or perhaps certain restraints mean it is not possible to collect data from a comparison group. While not ideal, there are ways to strengthen an

evaluation in these cases. If no baseline data was collected from the intervention group, it is possible to ask participants whether any of their knowledge, attitudes or behaviours have changed as a result of the intervention. This is particularly useful with qualitative methodologies, as participants can provide more detailed explanations as to how the intervention affected them. If there is no comparison group, it may be possible to compare those who participated in the intervention with existing data on adolescent girls in the community. Another simple approach is to use the baseline data from a new group of participants as the comparison data for the group that has completed the intervention.

A note on impact evaluations

Ultimately, the goal of our interventions is to have a lasting, positive impact on the health and well-being of adolescent girls.

Often, what is referred to as an impact evaluation is in fact one that evaluates outcomes. By our definition, an impact evaluation would assess whether or not our intervention resulted in any changes in the SRH of adolescent girls. As we will see in the following chapter, measuring

changes at this level can be incredibly complex and requires a great deal of time and resources. It may be difficult to tie our specific intervention to health outcomes, as other similar programmes may be ongoing in the same community, resulting in general improvements in various health indicators among adolescent girls. Impact evaluations may be most useful if an intervention is in place for a long period of time and if collecting data from the community it serves does not pose any major challenges.

D. Tools for evaluation:

- Evaluation checklist
- Body mapping
- Community mapping
- Survey to measure knowledge, attitudes and behaviours
- Most-significant-change method

7. Collecting data

Note: Often tasked with collecting data directly from adolescents, field staff must understand the principles of ethical data collection. Field staff may also provide input and oversight when more robust data collection takes place as part of an evaluation. This chapter introduces key principles and concepts related to data collection and should be an integral part of capacity-building for field staff.

Data collection methodologies

Choosing the methodology and tools for data collection should be informed by the type of evaluation we are conducting and what our objectives and indicators are. Drawing from our M&E framework, we will have a good idea of the type of information we need. This will help us select or design the tools to measure the chosen outcomes.

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

Quantitative methods focus on telling you 'how much', 'how many' and 'to what extent'. Information is usually presented in numbers and/or percentages. Modes of quantitative data collection include surveys and questionnaires, project records, registers, service statistics and observation checklists. Meanwhile, **qualitative methods** provide insights into experiences, perceptions and beliefs. The most common modes of qualitative data collection include focus group discussions and in-depth interviews.

Most of the indicators we have presented in this guide are measured quantitatively. While this is the nature of indicators, we strongly suggest that quantitative data be supplemented by qualitative data, since evaluations are conducted not only to find out whether the work has taken place, but also to understand how and why changes have come about.

Combining quantitative and qualitative data collection allows us to do just this. It provides us with more detailed accounts of the successes and limitations of our intervention and can better inform adjustments for future programming.

Collecting data from adolescents

Soliciting information from adolescents requires special considerations, particularly when asking about sensitive topics related to SRH. Prior to collecting any data from adolescents, careful consideration must be given to ethical issues, including consent, assent, anonymity, confidentiality and data storage.

Consent refers to giving permission for something to occur. In research, informed consent is the formal process for obtaining permission before a person can participate in research. In most settings, children (defined as those who have not reached the age of legal majority) lack the capacity to decide to participate in research and cannot provide legally valid, autonomous consent. Instead, consent from a parent or guardian is necessary for the child's participation in research.

Assent refers to "the willingness to participate in research, evaluations or data collection by persons who are by legal definition too young to give informed consent ... but who are old enough to understand the proposed research in general, its expected risks and

possible benefits, and the activities expected of them as subjects.”¹¹ Assent gives children, including minor adolescents, the ability to take ownership of their participation and make their own decision as to whether or not they want to participate.

Although your M&E activities may not be formal research, obtaining consent and assent is still crucial. Not only does it provide participants and their parents and guardians with the ability to understand the purpose of the research, but it also allows them to take agency and consider any potential risks and benefits of participation. Consent should be obtained from parents or caregivers, followed by assent from the participant (if they are under 18 years old). Both consent and assent must be obtained **before any data collection begins**. Whether consent or assent are obtained verbally or in writing depends on the population’s level of literacy. See the [consent form builder](#) in section E for guidance on how to create a consent and assent form.

Protecting **anonymity and confidentiality** is another critical component of ethical data collection. Providing anonymity means that there will not be any identifying information of individual subjects (name, place of residence, etc.). Maintaining confidentiality means that only certain people involved in data collection can identify the responses of individual subjects; there must also be efforts to prevent anyone outside from connecting individuals with their responses.

Generally, for the purposes of monitoring and evaluating of ASRH interventions in safe spaces, data collection should provide both anonymity and confidentiality. Any data collection that includes a girl’s personal information (such as the registration form) should be kept separate and have no clear

links to other data. **Data storage** should ensure that no one else may access the data. For data stored on computers, make sure that the folder and files are password protected. For paper-based data, keep files in a locked drawer or cabinet.

Forming a data collection team

Collecting data for a robust evaluation is no small task. It requires sufficient resources and may very likely require hiring additional staff to collect data. The success of an evaluation relies heavily on the selection, training and supervision of a data collection team. The following are some key considerations when selecting data collectors:

- **Age:** Depending on the context, adolescent girls may feel more comfortable discussing personal information with someone close to their age. If data is to be collected from parents, caregivers or key community stakeholders, you will have to consider whether it is more appropriate to have a slightly older data collector for this task.
- **Gender:** If collecting data from adolescent girls themselves, the data collection team should be female. If there is to be any data collection from males, such as fathers or male key informants, there may be a need to hire a male data collector.
- **Place of residence:** Ideally, the data collection team should be comprised of individuals residing in the community.

¹¹ UNICEF, *Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis*, New York: United Nations Children’s Fund, 2015, https://www.unicef.org/supply/files/ATTACHMENT_IV-UNICEF_Procedure_for_Ethical_Standards.PDF.

Box 5. Example job description for data collection team

Purpose: To conduct research activities to determine the effects of an ASRH intervention on adolescent girls.

Major responsibilities

- Conduct interviews with parents, caregivers and other community members
- Lead participatory research activities with adolescent girls
- Actively participate in all aspects of training and data collection
- Abide by ethical guidelines in the collection and storage of data
- Perform other duties as assigned

Qualifications

- Spoken and written fluency in English and local language
- Basic knowledge of and commitment to improving adolescent sexual and reproductive health
- Comfortable working with adolescents
- Strong communication and facilitation skills
- Comfortable using technology (typing and word processing, entering data on a mobile phone)
- Holds a degree in social science or teaching (preferable)

Box 6. Sampling

A sample is a subset of a population that aims to be representative of the entire population. Sampling can reduce the amount of time and resources required for an evaluation by allowing you to select information from a representative subset of participants of an intervention, rather than having to collect data from all or most of them.

The sampling process varies greatly, depending on whether you are using quantitative or qualitative methods. For quantitative methods, we must ensure that everyone has an equal chance of being selected for the sample. Generally, we need to calculate the number of participants needed based on the total population size. Once a sample size has been determined, there are various approaches to selecting participants. One of the best ways to guarantee a representative sample is to conduct *random sampling*. This requires selecting at random from a list of all participants. For the purposes of evaluating an ASRH intervention in a safe space, it is unlikely you will use complex sampling approaches. Conducting a simple random sample to obtain participants for a comparison group should be sufficient.

For qualitative methods, the numerical methods of deciding on sample size are not used. Instead, we focus on the concept of saturation. This means collecting data until further data collection adds little to the big picture that has already been observed. It is hard to know in advance how quickly this will happen. A good rule of thumb is to conduct around 20 research activities, whether that is individual interviews or group discussions. Methods used to select participants are equally important for qualitative methods. Often, participants are selected to fulfill a quota defined by a particular set of characteristics, for example, young adolescent girls, older adolescent girls, adolescent girls in school, mothers/female caregivers, fathers/male caregivers, etc.

Additional guidance on sampling approaches can be found here:

https://betterevaluation.org/en/rainbow_framework/describe/sample

E. Tools for collecting data:

- [Consent form builder](#)
- [Data analysis plan](#)

8. Analysing data and reporting findings

Steps of data analysis

Collecting data is of no value unless it is analysed and subsequently informs changes to an intervention. There are five major steps in analysing information collected during an evaluation:

1. Developing a data analysis plan
2. Collating or organizing information
3. Data analysis
4. Triangulation
5. Interpretation

These steps apply to analysis of both quantitative and qualitative data and to various types of evaluations. This chapter will discuss each step in turn.

Developing a data analysis plan

The data analysis plan expands on the data collection by describing in detail how data and information is organized and analysed. The plan should also provide the purpose of data collection and analysis and indicate the intended use of the information collected. The template in annex E.2 outlines the information that should form part of the analysis plan. In developing a data analysis plan, it is essential to account for the length of time necessary for proper data analysis. A good rule of thumb for qualitative data is that for every hour of recording, transcription and analysis will take three hours.

Quantitative data analysis may not be quite as time-intensive, but making sense of findings and linking them to qualitative data takes a considerable amount of effort.

Collating or organizing information

An evaluation may generate a lot of information that can seem overwhelming to analyse, making it important to organize materials so that analysis can proceed in a clear and structured manner. For quantitative data, collation can be carried out using a simple spreadsheet with software such as Excel, or, for more complex data, data can be entered into data processing software such as CSPro. It is then important to clean the data, which means checking over the spreadsheet or data entries carefully against original documents to verify entries as necessary.

Collating qualitative data can be a bit more challenging. All notes should be typed up; if research activities were audio recorded, and if there is the time and capacity, it is best to transcribe the audio-recordings. The team should then make sure that notes of sessions and/or transcriptions are each assigned a code, such as FGD 1. A table should be created that provides all necessary information for each transcript (date, location, group characteristics, facilitator, etc.). This also helps keep the group's identifying information separate from the transcription itself. When we begin analysis, we can use this table to track which transcriptions have been reviewed.

Data analysis

Data analysis is performed to identify trends or patterns in information that was collected for the evaluation. We are mostly interested in looking at changes or differences: either changes from before the intervention to after, or differences between those who attended the intervention and those in a comparison group (or both).

One of the simplest ways of doing this is to compare indicators to see whether there are any notable differences. With quantitative data, it may be helpful to create simple bar graphs and compare results across time and/or between groups to see whether they differ.

There are more advanced statistical techniques that allow us to see whether the differences observed are due simply to chance, or whether they are a result of our intervention. Doing so requires some advanced skills in data analysis and should be planned for during the design phase so that enough time and resources are allocated. It is likely that you may have to identify an individual skilled in advanced data analysis to conduct what is commonly referred to as 'hypothesis testing'.

Qualitative data analysis typically focuses on identifying patterns and trends. This involves finding themes or issues that recur across a number of participants or a number of groups. As conducting qualitative analysis can be quite time-consuming, teams should account for this prior to data collection. Beware of not simply conducting a superficial analysis of qualitative data, such as selecting a few good quotes or only identifying themes that confirm what you expected. If there will not be enough time for proper qualitative analysis, it may be best to use methods that are easier to analyse, such as participatory ranking, body mapping or community mapping.

Further guidance on qualitative analysis can be found at: <http://learningstore.uwex.edu/assets/pdfs/g3658-12.pdf>

Triangulation

Triangulation refers to the comparison of data from different sources. Notably, triangulating quantitative and qualitative data can provide insight into why certain patterns were found and how they might be

connected in a broader context. Imagine, for example, your team finds that adolescent girls who participated in the intervention reported that they desire a smaller family size than their peers who did not participate in the intervention. Qualitative data would help to contextualize this finding and to understand why girls who participated in the intervention wish to have fewer children than those who did not participate.

Interpretation

Ultimately, we want to know whether the results of our analysis show that our intervention has achieved its objectives and whether or not—and to what extent—adolescent girls have benefited from the intervention. We should also have some information about what has helped or hindered our intervention and what we could improve for future programming. If we have planned carefully for the evaluation and created clear objectives and indicators, along with a sound monitoring system, this process should be relatively straightforward.

Often, however, there may be some discrepancies arising from our analysis. Perhaps we see that outcomes have improved for older adolescents, but not younger adolescents, or that only knowledge and attitudes have changed, but there are no changes in behaviours. The process of interpretation aims to make sense of these findings and tries to understand what dynamics may be at play.

It is also important to interpret any negative findings. If the intervention did not result in any changes, either from before the intervention to after, or between the intervention and control group, we need to explore why this is the case. These findings are just as important as those that show that our intervention works. Understanding which aspects of our intervention were unsuccessful can better inform future programming.

Reporting findings

The way in which you report the findings of your evaluation is critically important. It is likely that you will have to summarize your findings and recommendations for your organization, for which standard guidance may be provided. For example, many organizations have templates that describe how programme reporting should be conducted. Generally, the report should include a two to three page executive summary in addition to the full report. A standard outline may be as follows:

1. Background and introduction: What is the context of your intervention? How long has the safe space been in operation and which services does it provide?

2. The intervention: Why did you decide to implement an SRH intervention for adolescent girls? What was the intervention comprised of and how was it designed? How were adolescent girls recruited? What were the objectives of the intervention?

3. Methodology: What type of evaluation did you conduct? Was there a comparison group? Was baseline data collected? Which modes of data collection were used?

4. Participants: What are the characteristics of the adolescent girls who participated in the intervention? Were there any groups of girls who were not included? If so, why? If there is a comparison group for the evaluation, do their characteristics (age, education, residence, etc.) differ at all from those who participated in the intervention?

5. Findings: What were the main findings? You may wish to organize these by objectives of the intervention.

6. Analysis/interpretation: What do the findings mean for future programming? Were some components more successful than others? Why might this be the case?

7. Recommendations: What are four to five concrete recommendations for future programming and for other practitioners working on ASRH? Who is responsible for carrying out these recommendations?

Ideally, before finalizing and circulating reports, findings and analysis should be shared with the adolescent girls who participated in the intervention, as well as any other key stakeholders. In addition to contributing to the analysis, adolescent girls should have a say in whether or not the interpretation of findings is correct and if the recommendations reflect their needs and priorities. Adolescent girls may also participate in the sharing of findings with community members and other programme participants.

More in-depth reporting to adolescent girls and community members can also take place following the final report. Of course, reports should be translated into a local language, if possible, and alternative ways of sharing findings may be necessary in populations with low levels of literacy. Drama, song, drawings and storytelling are just a few of the ways that evaluation findings can be shared with community members.

E. Tools for analysing data:

- Introducing analysis to adolescents
- Codebook template

9. Resources

Monitoring and evaluation

United Nations Children's Fund (UNICEF). *Evaluation*. Available from: <https://www.unicef.org/evaluation/>.

UNICEF Office of Research (2014). *Impact Evaluation Series*. Available from: <https://www.unicef-irc.org/KM/IE/impact.php>.

Adolescent participation

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Safe spaces for women and girls

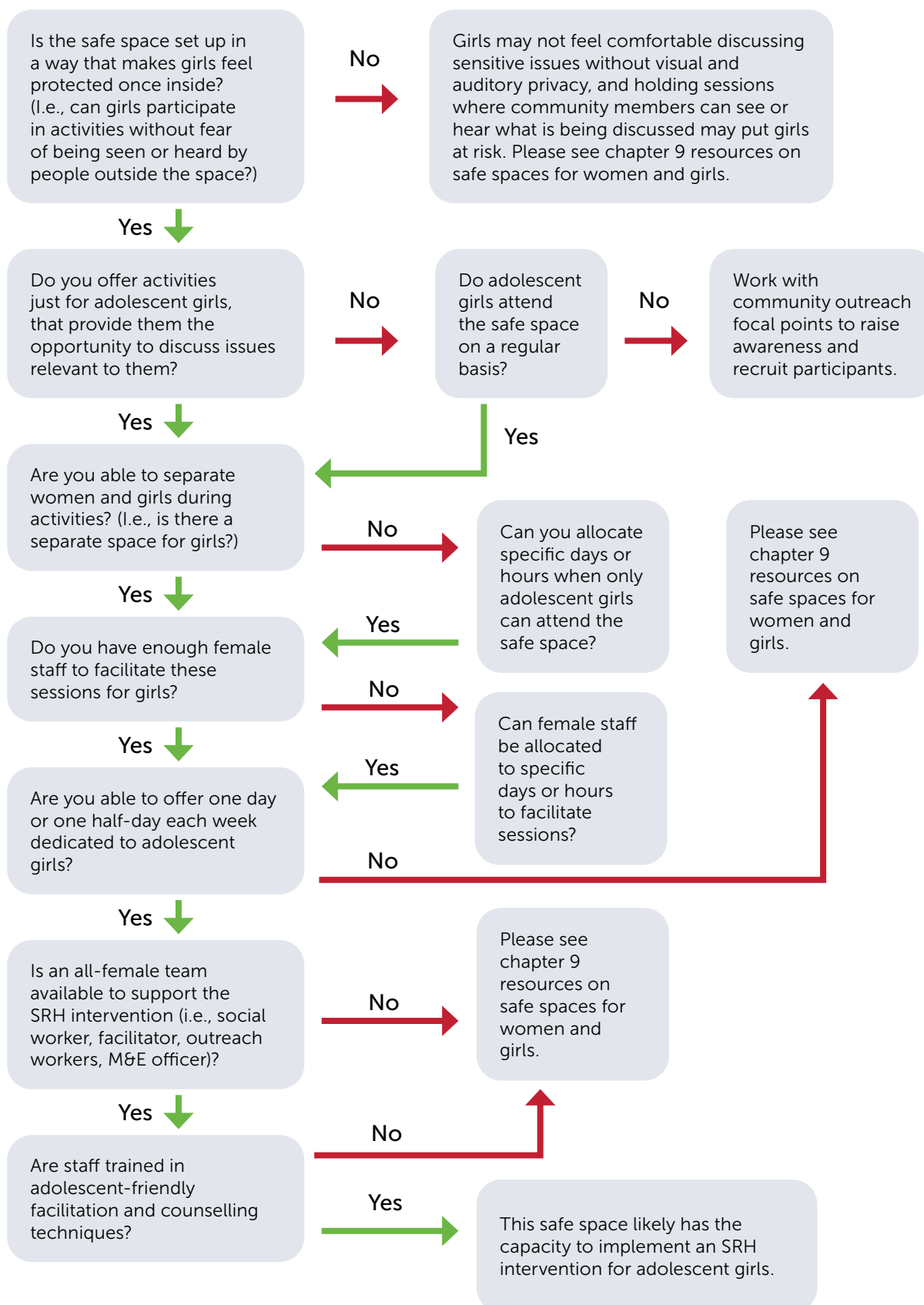
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10. Tools

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Figure 4. Determining the capacity to implement an ASRH intervention in safe spaces



A. Tools for adolescent participation

A.1 Free listing

Objective	To identify the criteria by which adolescent girls understand 'reproductive health'.
Frequency and timing	<ul style="list-style-type: none"> The exercise should be completed before the start of the intervention. It can be conducted with multiple groups of girls to ensure that all understandings of 'reproductive health' are captured.
Time needed	30–40 minutes
Materials needed	Free-listing form

Steps:

1. Gather a group of 8–10 adolescent girls of a similar age (e.g. 10–12 years, 14–16, 17–19).
2. Inform the group that you are going to do an activity that will help design a project for girls attending the safe space.
3. Ask the girls to list all the characteristics or features of a girl their age who is healthy.
4. Write down each characteristic/feature on a flip-chart or piece of paper in the order they are stated. If a characteristic/feature is repeated, put a dot next to it on the list every time it is repeated.
5. Once this list is complete, tell the group that you are now interested in knowing about a specific type of health. Ask the girls to list all the things they associate with 'reproductive health'.
6. Write down each comment in the order they are stated. Again, indicate when something is said more than once.
7. Once the list is complete, read it back to the girls and ask if there is anything missing from the list.
8. You may also ask if there is anything on the list that does not belong. While everything should be kept on the list, this question could generate discussions to reveal what girls understand 'reproductive health' to entail.

Notes and tips:

- As with all activities and group discussions, it is essential that this exercise takes place in a location where the girls cannot be seen or heard by people outside.
- It may be useful to conduct icebreakers before this activity, particularly if this is your first time meeting with the girls.
- The girls may feel uncomfortable about saying certain words, or discussing certain issues related to reproductive health. It might be useful to set certain ground rules before the activity. Some key ground rules could include: Confidentiality (what is said during this activity will not be repeated to others) and respecting the opinions of other girls in the group.
- Remind the girls that there are no right or wrong answers and that this activity will help the safe space to design future activities.
- Do not lead the girls to mention certain ideas. If the girls do not list anything associated with 'reproductive health', this tells us valuable information as well.

A.2 Participatory Ranking Methodology (PRM)

Objective	To assess SRH-related concerns or learning priorities for adolescent girls.
Frequency and timing	<ul style="list-style-type: none"> Conduct before the start of the intervention. Sessions can be carried out with multiple groups of girls and results can be aggregated to assess the most pressing areas of concern or learning priorities.
Time needed	1 hour
Materials needed	<ul style="list-style-type: none"> PRM data collection form 10–12 different physical objects (for example, pen, piece of paper, rubber band, empty water bottle, twig, leaf)

Key steps:

1. Gather a group of 8–10 adolescent girls of a similar age (e.g. 10–12 years, 14–16, 17–19).
2. Ask the group, “What are girls your age most concerned about regarding their reproductive health?” Another option is to ask, “What would girls most like to learn regarding reproductive health?”
3. As the girls list issues, note them down and make sure that each is understood clearly by all the girls.
4. Once the list is complete, read it back to the group to make sure you did not miss anything.
5. Ask the girls to assign the physical objects to each issue.
6. Once each issue has a physical object associated with it, ask the girls to put the objects in order from the most important concern to least important concern. Or, from the topic they wish to learn about most, to the topics they are least interested in. You may have to remind the group what the physical items represent.
7. Once the line is complete, ask the girls if they wish to make any changes to the order. Note down any disagreements the girls have about the order. Allow the girls to make any final changes to the ordering of the objects and note down the final ranking.

Notes and tips:

- This method can be used to assess various research questions. For example, it could be used at the end of the intervention to understand which topics girls felt were most useful.
- Make sure that the issues listed are understood by all the girls to mean the same things. This may require clarifying what a girl means when she states the issue.
- If you have done the free-listing activity, you can refer to that definition of 'reproductive health'. If not, you may explain to the group that, by 'reproductive health', we mean changes that happen in the body as girls grow into adults and health issues specific to being a girl or woman, as well as marital relations, pregnancy and childbirth. You can ask them to add to the definition if necessary.

For more information, visit <http://www.cpcnetwork.org/research/methodology/participative-ranking-methodology/>.

PRM data collection form

Section 1: Demographic and background information <i>Please fill in the blanks.</i>	
Today's date (day/month/year)	
Facilitator's name	
Notetaker's name	
Location	
Number in group	
Group details (age range, marital status, participation in intervention, etc.)	
Section 2: Framing question (select one) What are the major SRH concerns of girls your age in this community? What would girls be most interested in learning about regarding SRH?	
Key issues identified Free list: <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	Rank order: <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
Notes: 	

A.3 Intervention design planning

Objective	To plan the number of sessions, frequency of sessions and duration of the intervention.
Frequency and timing	<ul style="list-style-type: none"> Consult with groups of 8–10 girls prior to the start of the intervention. Consult with groups of girls of different ages to determine the differing needs of younger versus older adolescents.
Time needed	60 minutes per group
Materials needed	Session planning form

Key steps:

1. Ask the girls the necessary questions to fill out the session planning form. Questions may include which days of the week they are generally available, what time works best for them, how often they prefer to meet, how long they can be away from home and until what date they will be able to attend programming in the safe space.
2. Fill in additional information regarding staff availability and the availability of physical space for the girls to meet.
3. Calculate the ideal number of sessions by multiplying the number of days per week that the girls are available by the number of weeks they are available.
4. Note which topics it is essential to cover, based on the findings of any needs assessment activities (e.g. free listing, PRM).
5. Use the session planning form to select a curriculum and to create a lesson plan.

Notes and tips:

- Ensure representation of various demographics when planning the frequency and duration of the intervention. This includes younger and older adolescent girls, in-school versus out-of-school girls, married and unmarried girls.
- While not all girls will be able to attend every session, the goal is to make sessions as accessible as possible and to not pose any risks to girls by keeping them long hours or past a certain time.

Session planning form

Name:	Date:	
Position/organization:	Location:	
Group demographics:		
Which days of the week are most girls available to meet? (Check all that apply.)		
Monday	Tuesday	Wednesday
Thursday	Friday	Saturday
Sunday		
What time of day are most girls available to meet? (Check all that apply.)		
Morning (8am–11am)	Early afternoon (11am–2pm)	Late afternoon (2pm–5pm)
Other: _____		
How many days per week would most girls prefer to meet?		
One	Two	Three or more
How long are most girls allowed to be away from home?		
Less than 2 hours	2–3 hours	More than 3 hours
How long are most girls able to commit to?		
Less than one month	One month	Two months
Three months	Four months or more	Other: _____
TO BE FILLED OUT BY SAFE SPACE STAFF		
When are staff available to conduct sessions with girls? (Specify all days and times.)		

Are there any days/times when other group activities take place in the safe space and there wouldn't be room for activities with adolescent girls? (Specify all days and times.)

What is the proposed number of sessions and why?

(Calculation: Number of days per week that girls are available x number of weeks)

Based on the preliminary needs assessment with the girls, what were the key topics arising from the group?

Based on discussions with the girls, did you notice any specific issues that should be addressed by the intervention?

Additional notes

B. Tools for setting objectives and identifying indicators

B.1 Problem tree

Objective	<ul style="list-style-type: none"> To identify root causes of SRH problems faced by adolescent girls and the effects of these problems. To identify solutions based on the causes and effects and create objectives based on these solutions.
Frequency and timing	Conduct the activity with several groups of girls prior to creating the M&E framework for the intervention.
Time needed	2 hours per group
Materials needed	Flip-chart, markers, sticky notes

Key steps (problem tree exercise):

1. Ask participants to list problems faced by adolescent girls in their community. You may wish to specify by asking about health-related problems, or problems related to the changes they go through when transitioning from childhood to adulthood. You can refer to the findings from the PRM exercise that was used to determine the greatest SRH-related challenge for adolescent girls.
2. Ask participants to select one or two issues to focus on. Make sure that these are problems that could be addressed through the intervention in the safe spaces.
3. Write the problem in the middle of a large sheet of paper or flip-chart. Explain that this problem is like the trunk of the tree and that we want to find out what the causes of the problem are (i.e. the roots) and what its effects are (i.e. the leaves).
4. To determine the root causes of the problem, ask participants, "Why does this problem exist?", or "What is the reason for this problem?"
5. Encourage participants to think about the 'causes of the causes'—for each cause they state, you may ask *why* that problem or issue exists. As causes are listed, write them on a sticky note and place them below the problem that they cause.
6. After participants finish listing causes, read back what they have shared. For example, "So, if I understand correctly, a problem faced by adolescent girls here is not having enough products during menstruation. This is caused by shyness to ask their parents for money to buy products and not having enough money to buy products. The shyness is because parents don't typically discuss puberty with their daughters and parents do not have enough money because there are limited opportunities for work here." Ask girls to rearrange, add or remove sticky notes in the trunk of the tree, as needed.
7. Ask participants what are some of the effects of the problem they identified, for example, "What happens as a result of this problem?" As with the causes, encourage

participants to think about the 'effects of the effects'—for each effect that they state, you may ask what the effects of that are. Write each effect on a sticky note and place them above their cause.

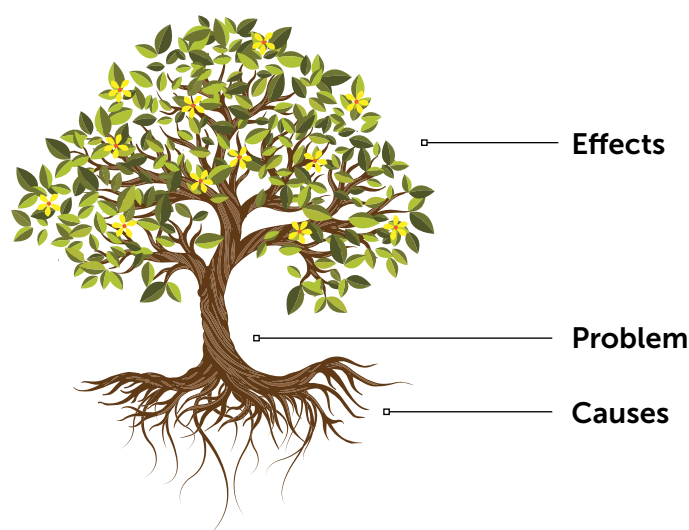
8. After participants finish listing the effects, read back what they have shared and look at it in relation to the causes. For example, "So, you are saying that not having enough products during menstruation means that girls must use unclean rags during their period, and this can cause an infection. If a girl gets an infection, she may not go to the health centre because she is too shy or embarrassed."

Key steps (translating causes and effects into objectives):

1. Once you have the list of causes, brainstorm ways in which an intervention can help address these. For example, if a cause of not having menstrual products is embarrassment to ask parents to purchase them, you may wish to have a session with mothers to discuss proper menstrual hygiene management.
2. For each cause and effect, determine whether you can design an objective and an indicator to measure progress.
3. Work with participants to think of ways they would measure each objective (i.e. to create indicators).

Notes and tips:

- Keep in mind the scope of the intervention when selecting objectives. Likewise, consider the capacity for M&E when designing indicators. It will not make sense to select difficult-to-measure impact-level objectives for a limited intervention, or when there is limited capacity to conduct an impact evaluation.
- Make sure that all participants in the intervention are aware of the issues identified in the problem tree exercise and ensure you consider their feedback as much as possible.



B.2 Focus group discussion guide for parents and caregivers

Objective	<ul style="list-style-type: none"> To assess the acceptability of implementing an ASRH intervention in safe spaces among parents and caregivers. To understand parent/caregivers' perceptions of the SRH needs of their adolescent daughters.
Frequency and timing	Consult with groups of 10–12 parents/caregivers before the start of the intervention.
Time needed	60 minutes per group
Materials needed	<ul style="list-style-type: none"> Focus group discussion guide

Key steps:

1. Obtain informed consent for participation in the focus group discussion (see Tool E.1 and adapt for adult participants).
2. Welcome participants to the meeting. Give a brief explanation of the project and the objectives. Go over some ethical ground rules for the discussion, including confidentiality. Emphasize that participants' names will never be used and that we want to know about adolescent girls in the community, in general; not necessarily about their daughters specifically.
3. Ask participants to introduce themselves with their name and the age of adolescents in their household.

Use the following questions to guide your discussion:

1. First, we'd like to discuss how people in this community define and think about 'young people' aged 10 to 19. In your view, is there a distinct phase between childhood and adulthood?
 - Do adults see 10–14-year-olds differently from 15–17-year-olds?
 - Which events determine the differences and transitions between these groups, e.g. marriage, menarche/menstruation, passing from one grade to another, a birthday?
 - Are the age groups for boys different to those for girls?
2. At present, what are the most significant influences on the behaviour and views of young people in this community?
 - Probes: Media? Parents? Schools? Peers?

3. Which family members or adults can adolescent girls go to for support and advice?
 - As girls get older, do their sources of support and advice change?
4. It can be difficult to discuss certain things with our children. What have been the most challenging things for you to discuss with your daughter as she transitions from being a young person to being an adult?
 - How have you managed to discuss sensitive issues, such as puberty? Menstruation? Sex and deciding when to have babies? At what age do you think your daughter should start to learn about such things?
5. What do you think are the best settings or who do you think are the best people from whom girls can learn about transitioning from being a young person to being an adult?
 - Who would be good people to talk with them about this?
 - Where is a good place for them to go to find out about this? Where do you feel comfortable letting your daughter go for information?
 - Is there anywhere that girls should NOT access services?
 - Would this be different if you were still back in your home setting?
6. At what age do you think young people are ready to have relationships?
 - Do you think these ages are appropriate?
7. At what age do young people in this community become aware of sexual relationships?
 - How do they become aware of sexual relationships? Where do they get information from and what do you think they are learning? Is there anything you wish they could learn that you do not feel comfortable discussing with them?
 - At what age do you see young people as being ready to have sexual relationships?
 - Do you think these ages are appropriate? At what age do you think they should become aware of, or ready for, sexual relationships?
8. How do you think young people define sexual relationships?
 - Are there different kinds of sexual relationships that they are aware of?
 - How do you think they differentiate between various types of sexual relationships?

9. Since being displaced, do you think there have been any changes in the way boys and girls have relationships?
 - How has this changed?
 - Has this changed for better or for worse?
10. What role do you feel you all, as mothers/fathers, have in young peoples' transition from adolescence to adulthood?
 - How would you want to be involved?
 - How would you want to see other adults involved?
 - Which adults might be the most influential in the transition of adolescents from being a young person to being an adult?
 - How is this similar to, or different from, roles that adults had before coming to this setting?
 - What role do you see yourself having in your daughter's life when she gets married? How would you discuss decisions related to having children?
11. How is this role different for parents versus other adults?
 - Is there any information you think it is best for girls not to have?
Any type of services?

Notes and tips:

- As much as possible, especially at the start of the focus group, ask questions in a general manner, i.e. make them about parents and caregivers of adolescent girls in the community, as opposed to about the participants themselves.
- Review questions for cultural context and make adaptations if necessary, especially for focus groups with fathers and male caregivers.

B.3 Creating a monitoring and evaluation framework

Objective	To have an overall picture of the intervention's objectives and indicators and how indicators will be measured.
Frequency and timing	To be decided after objectives and indicators have been identified, and prior to the start of the intervention.
Time needed	2 hours
Materials needed	<ul style="list-style-type: none"> • M&E framework template • Findings from needs assessment activities (free listing, PRM, problem tree)

Key steps:

1. Based on the needs assessment activities, draft a theory of change. Based on the theory of change, identify concrete objectives at each level (activities, outputs, outcomes and, if possible, impacts).
2. For each objective, identify several SMART indicators. For each indicator, determine how it will be measured, how often it will be measured and who will be responsible for data collection.
3. Fill in the table accordingly, using a separate row for each indicator.

Notes and tips:

- Following the creation of the M&E framework, ensure that all programme staff are aware of the objectives, indicators, measures and responsibilities.
- You may select a few indicators that are simple to measure for the adolescent M&E focal points to be responsible for.
- The M&E framework should remain constant throughout the intervention. However, if it becomes not possible to measure a certain indicator, or if you discover certain objectives to be irrelevant, make a note of this for future programming.

Example M&E framework:

Level	Objective	Indicator	Measure	Means of verification	Frequency of collection	Person(s) responsible
Example: Output	Increase number of girls attending SRH sessions	Number of girls who attended at least 80 per cent of SRH sessions	Total number	Attendance records	Attendance taken at every session; total number calculated at end of intervention	Session facilitator

C. Tools for monitoring

C.1 Participant register

Objectives	<ul style="list-style-type: none"> To track the number of girls recruited/enrolled to participate in the SRH intervention. To understand the demographic characteristics of girls enrolled to participate (e.g. age, education, marital status, disability status). To inform outreach activities and the recruitment of girls for the SRH intervention.
Frequency and timing	Once, at the beginning of the intervention
Time needed	Approximately 10 minutes for each girl at the time of enrolment
Materials needed	Registration form

Key steps:

1. Decide which sociodemographic characteristics you wish to track.
2. When registering each girl, assign her a registration number. Proceed to ask her about each of the characteristics you wish to collect.

Notes and tips:

- You may wish to add additional sociodemographic characteristics to track, as is appropriate in your given context.
- Input data into an Excel spreadsheet. For ease of input and analysis, you can code 'yes' as 1 and 'no' as 0.
- If more girls wish to register for the sessions than there are spots available, consider using a separate registration sheet to track girls who are waitlisted to participate.

Sample participant registration form

Registration number	Name	Age	Area of residence	Attending school?	Marital status	Number of children	Living with (both parents/one parent/neither)	Disability status

C.2 Attendance register

Objectives	<ul style="list-style-type: none"> To track the number of girls attending each session. To understand the demographic characteristics of girls who attend sessions.
Frequency and timing	Take attendance at the start of every session; combine attendance sheets at the end of the intervention to calculate cumulative attendance.
Time needed	Approximately 5 minutes at the start of every session
Materials needed	Attendance sheet

Key steps:

1. Create a list of all girls who are registered to participate in the intervention.
2. Take attendance at the start of each session and mark whether each girl is present.

Notes and tips:

- Input data into an Excel spreadsheet. For ease of input and analysis, you can code 'present' as 1 and 'not present' as 0. You can then calculate each girl's cumulative attendance and the percentage of girls who have attended a certain number of sessions.

Sample attendance sheet

	Location										
	Facilitator										
	Group number										
		Session number									
	Participant name	1	2	3	4	5	6	7	8	9	10
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											

✓ = present ✕ = absent

C.3 Lesson planning

Objective	<ul style="list-style-type: none"> To plan the number and frequency of sessions. To specify the topics to be covered in each session. To plan for any necessary materials or other preparation before each session.
Frequency and timing	Prepare lesson plan before the start of the intervention. It may be updated as necessary, but make sure to note reasons for any changes in the original plan.
Time needed	2 hours
Materials needed	<ul style="list-style-type: none"> Results of intervention planning activity Lesson planning template

Key steps:

1. Ask the girls the necessary questions to fill out the session planning form (see section A.3) and calculate the total number of sessions.
2. Note which topics it is essential to cover, based on the findings of any needs assessment activities (e.g. free listing, PRM).
3. Fill in the form with the modules, in order, to include the title of the modules and the included topics.
4. Assign a facilitator to the sessions. Ideally, the same facilitator will implement all sessions for a group.
5. Note any necessary materials, such as markers, flip-chart, stickers, handouts or post-its.
6. Use the lesson plan to inform the fidelity tracker (see section C.6).

Notes and tips:

- It may be necessary to update the lesson plan at some point during the intervention, either due to rescheduling or the need to include extra sessions. Make sure you note whenever you have updated the lesson plan, in order to inform the fidelity tracker.

Sample lesson planning template

Curriculum:				Age group:	Location:	
Session #	Date	Time	Module	Topics	Facilitator	Materials needed

C.4 Satisfaction survey

Objectives	<ul style="list-style-type: none"> To assess participants' satisfaction with SRH sessions. To understand how SRH sessions can be improved.
Frequency and timing	At the end of each SRH session throughout the intervention
Time needed	Approximately 10 minutes for girls to fill out the survey
Materials needed	Satisfaction survey form




Key steps:

1. Set aside 10 minutes at the end of every session to complete the survey. Determine the participants' level of literacy. If all participants are literate, you may use the sample survey form.
2. *For the survey form:* Distribute forms to participants and give them 5 minutes to complete it.
3. *Satisfaction survey for low literacy groups, option 1:* If appropriate, a participant can read the satisfaction survey out loud to any girls who have a low level of literacy and fill it in on their behalf.
4. *Satisfaction survey for low literacy groups, option 2:* If a significant number of participants have a low level of literacy, you may read the questions out loud to the entire group and ask them to raise their hand for each option (i.e. the session was great, the session was okay, the session was bad). You can then have a short discussion about what the girls liked the most, what they liked the least and what they would change for next time.

Notes and tips:

- Make sure that the girls understand the meaning of the smiley faces before use; this can be done during a needs assessment or initial consultation with the adolescent girls prior to beginning the ASRH intervention.

Sample satisfaction survey form, for groups with high literacy

Date:	Session:
<p><i>How did you feel about this session?</i></p> <div style="display: flex; justify-content: space-around; align-items: center;">    </div>	
<p><i>What did you like the most?</i></p>	
<p><i>What did you like the least?</i></p>	
<p><i>What would you like to change for next time?</i></p>	
<p><i>Any other comments?</i></p>	

C.5 Facilitator evaluation

Objectives	<ul style="list-style-type: none"> To assess the skills of facilitators. To identify areas for improvement and capacity-development needs.
Frequency and timing	Can be conducted in as many sessions as appropriate.
Time needed	Length of session
Materials needed	Assessment sheet

Key steps:

1. Review the facilitator assessment form with other staff members to ensure that you have a common understanding of each task.
2. Amend the facilitator assessment form, if necessary. You can add additional tasks, or remove certain tasks if they are not applicable.
3. Inform the facilitator that you will be observing a session and ask that she proceed in teaching as she normally would.
4. Join for the entirety of the given session. Sit in a place that will not interrupt the session or activities.
5. For each task, check or circle how the facilitator did. You may choose to write notes to clarify why you selected a certain number.
6. At the end, add up the total points to produce an overall idea of the facilitator's capacity.
7. Agree a time to meet with the facilitator to discuss the assessment, paying particular attention to tasks rated as excellent and those that need improvement.

Notes and tips:

- There should be sufficient training of facilitators, with an emphasis on certain benchmarks included in this assessment sheet.
- Providing feedback to facilitators should always take the form of encouragement for improvement. When providing feedback, frame things in a way that gives the facilitator an opportunity to see how she can improve, as opposed to simply criticizing her facilitation skills.
- Ensure the facilitator has appropriate resources at hand to build her capacity in areas in which she needs improvement. Be on hand to support facilitators to gain more skills.
- If you observe the facilitator doing something that puts girls at risk, provides them with incorrect and dangerous information, or discourages them from attending programming, take appropriate action as soon as the session is over.

Facilitator assessment form

Name of observer			Name of facilitator		
Date			Location		
Session topic(s)					
	Needs improvement		Good	Excellent	
Task	1	2	3	4	Points
Establishes a supportive physical learning environment	No changes to the room	Rearranges the room	Rearranges room but no movement around the room	Rearranges room and moves around the room	
Use of body language	No changes	Uses facial expressions	Uses facial expressions and changes posture	Uses facial expressions and hand gestures, changes posture and tone of voice	
Active listening	No active listening	Uses brief encouraging phrases	Uses brief encouraging phrases, reinstates and summarizes	Uses brief encouraging phrases, reinstates and summarizes, probes and validates	
Use of session guides	No session guide used, no materials prepared	Uses session guide and prepares some materials	Regularly uses session guide, prepares all materials, sometimes follows timelines	Regularly uses session guide, prepares all materials and always follows timelines	
Gives girls responsibility during session when relevant	Never	Only when specified in the session guide	Sometimes, to different girls	Regularly and equally distributed	
Provides appropriate examples and clarifications if needed	Never	Sometimes, when specified in the session guide	Sometimes, when they could sense girls were not following	Regularly, with or without prompts	
Emphasizes that there is no right or wrong answer (if relevant)	Never	Occasionally, when specified in the session guide	Sometimes, when they could sense girls were struggling	Regularly, including in preparation for a forthcoming discussion	
Provides girls with positive messages and encouragement	No positive messages or encouragement	Offers positive messages only as indicated in the guide	Sometimes provides encouragement to girls, even when not indicated in the guide	Regularly, emphasizes strengths of girls with empowering messages about their potential	
Uses general language (e.g. "What problems do girls like you face?") instead of direct questions	Consistent use of direct language	General language used only when specified in the guide	General language used sometimes, even when not specified in the guide	General language used regularly, as relevant	
Uses correct SRH terminology	Never	Uses correct terminology only when specified in guide	Uses correct terminology, even when answering questions or providing info not in guide	Regularly emphasizes importance of correct terminology and explains concepts in a way that girls understand	
Encourages feedback from participants	Never	Occasionally, when specified in the guide	Often, even when not specified in the guide	Regularly, and discusses feedback in the following session	
Total points					

Scoring

10–25 points: Needs improvement

26–34 points: Good

35–40 points: Excellent

C.6 Fidelity tracker

Objective	To summarize and track information about each session delivered.
Frequency and timing	To complete after each session has been completed.
Time needed	10–15 minutes per session
Materials needed	Session summary form

Key steps:

1. Upon completion of each session, enter relevant details in the first table.
2. For any session that did not take place, enter details in the second table.
3. Upon completion of the intervention, information should be aggregated for analysis.

Notes and tips:

- Ask multiple parties for reasons why a session did not take place, to provide a more complete picture of what could have been different.

Fidelity tracker

Curriculum:				Age group:		Location:	
Session number and date	Title of session	Were all topics covered?	If not, which were not covered and why?	Number of participants	Number satisfied with session	Facilitator assessment score	Additional observations or setbacks for session

Did any sessions not take place at all? (If yes, fill in information below)					
Session number and planned date	Title of session	Reason(s) why session did not take place	Has session been rescheduled? If yes, to which date?	Were any topics covered in another session? If yes, in which session(s)?	Additional notes/follow-up actions

D. Tools for evaluations

D.1 Evaluation checklist

Objective	To determine whether your team is prepared to successfully monitor and evaluate the intervention.
Frequency and timing	Discuss before planning the intervention and refer back throughout.
Time needed	2 hours / ongoing throughout intervention and M&E process
Materials needed	Evaluation checklist

Note: Use the checklist to guide planning with staff members involved in the M&E process. Refer back to it at various stages to make sure you are covering every stage of the M&E process.

Evaluation checklist

Have you identified ways to involve adolescent girls in the M&E process?

- Are girls supported to meaningfully participate in all stages of programme design, implementation and evaluation?

Have you conducted a needs assessment?

- What are the key SRH-related challenges faced by adolescent girls in this community?

Have you identified realistic objectives for the intervention?

- Of the challenges identified in the needs assessment, what are realistic objectives to achieve as a result of the intervention?

Have you created an M&E framework?

- Do you have buy-in from participants and staff to carry out M&E tasks?

Do you have a monitoring system in place?

- Are there existing forms of monitoring for the safe space?
- Have you allocated sufficient time and resources to carry out monitoring activities?

Have you selected an evaluation design?

- Will you be able to collect baseline data? Data from a comparison group?
- Is it realistic to associate changes in outcomes to your intervention?

Have you assessed staff capacity to conduct M&E?

- Will you need to hire external support for any stages of monitoring or evaluation?

Have you created data-collection tools?

- Have you piloted tools to make sure they are contextually appropriate?
- Are the data-collection tools clearly linked to the intervention's objectives? Will they sufficiently measure the indicators?

D.2 Body mapping

Objective	To determine adolescent girls' knowledge of SRH-related topics.
Frequency and timing	<ul style="list-style-type: none"> Conduct before the start of the intervention and 3–4 weeks after its completion to observe changes in knowledge. Alternatively, the exercise can be done in its entirety before the start of the intervention. Once the intervention has been completed, you can use the body maps that the girls drew to guide a discussion about what girls learned from the SRH sessions.
Time needed	1 hour
Materials needed	<ul style="list-style-type: none"> Flip-chart paper (4–5 sheets per group) Markers Body mapping data collection form

Key steps:

1. Gather a group of 8–10 adolescent girls of a similar age (e.g. 10–12, 13–16, 17–19). Tell the girls that they will be drawing pictures to show how girls change as they grow into adults.
2. Explain that you will be dividing them into smaller groups and would like each group to draw three pictures: One picture of a young girl (age 8 or 9), one picture of a girl their age and one picture of an adult woman. The pictures should be detailed and show not only how girls look, but also how they think and feel and what they do. These drawings can show the changes that happen as girls grow into women. If the girls are able, they can label parts of the body and the changes that girls experience.
3. Remind the girls that there are no right or wrong answers and that you are just interested in knowing more about what type of changes girls their age experience.
4. Divide participants into three groups of 3–4 girls each. Give each group one flip-chart-sized piece of paper (or three regular-sized pieces of paper) and some markers. If there is enough room, make sure each small group is seated far enough apart from one another.
5. Give the girls around 15 minutes to draw the body maps. You may answer basic questions, but do not guide the girls too much in their drawing.
6. Circulate the room and ask the different groups to show their drawings and explain what they have drawn. Use the following to guide discussion in small groups:
 - Start small, with a less sensitive topic. For example: "Can you explain what the young girl is thinking? And what about the girl your age? Now the adult woman?"
 - Ask about certain changes the girls have illustrated. For example: "So I see you drew the girl your age with breasts. When does this change happen to girls? Do you know why it happens? How do girls in your community feel about this change?"

- Try to cover the following topics: breasts grow, hips widen, hair grows, body odour, menstruation. You can ask the girls about any topic they may have missed in the drawing by asking, "What about _____? Have you heard about that?" If the girls say yes, ask the above questions about the change (when it happens, why it happens, how girls in the community feel about this change).
7. IF the girls mention that once a girl gets her period she can become pregnant (or anything pregnancy-related), ask, "And do you know of any ways that she can prevent or delay pregnancy?"
 - If the girls say yes, probe further: "What methods have you heard of?"
 - Then, *for each method they mention*, ask, "Do you know anything about this method?"; "What are some good things about this method?"; and "What are some bad things about this method?"
 - *FOR MARRIED GIRLS ONLY*, ask, "Do you know where to find these methods?"
 8. If the girls do not mention anything related to pregnancy, ask, "What does it mean once a girl gets her period?" Then, only if pregnancy is mentioned, ask the follow-up questions above.
 9. Bring the girls back together into one large group. Use this list of questions to guide the conversation and use the drawings to facilitate their responses:
 - How did everyone feel drawing the body map? How did everyone feel sharing the body maps with other girls in this room?
 - What do we call it when certain changes happen to a girl's body? Which words do we use to describe this phase of a girl's life?
 - How do girls first learn about the changes that might happen during puberty?
 - *Probes: What do girls learn? How might a girl feel when she first learns this information? Is there anyone else who tells girls what might happen?*
 - How do girls feel when their bodies start to change?
 - *Probes: Is there anything or anyone who can help girls feel better about their bodies changing? Who?*
 - Is there anyone girls can go to with questions about changes happening to their bodies? Who?
 - *Probes: Anyone else? How might girls feel asking questions about the changes happening to their bodies? Is there anyone else girls in this community wish they could talk to?*
 - Are there any other changes that might happen to girls your age that we can't see from the pictures you drew?
 - *Probes (if these aspects were not already mentioned): What about non-physical changes? Are there changes that might happen with a girl's feelings or mood? What about changes in what girls like to do with their free time? Their interests and who they like to spend time with?*
 - How do families feel about the changes that girls go through?
 - *Probes: Are there any changes in how girls interact with their families? Are there any changes in what they are allowed or able to do? Are there any different rules or expectations from families as girls get older?*

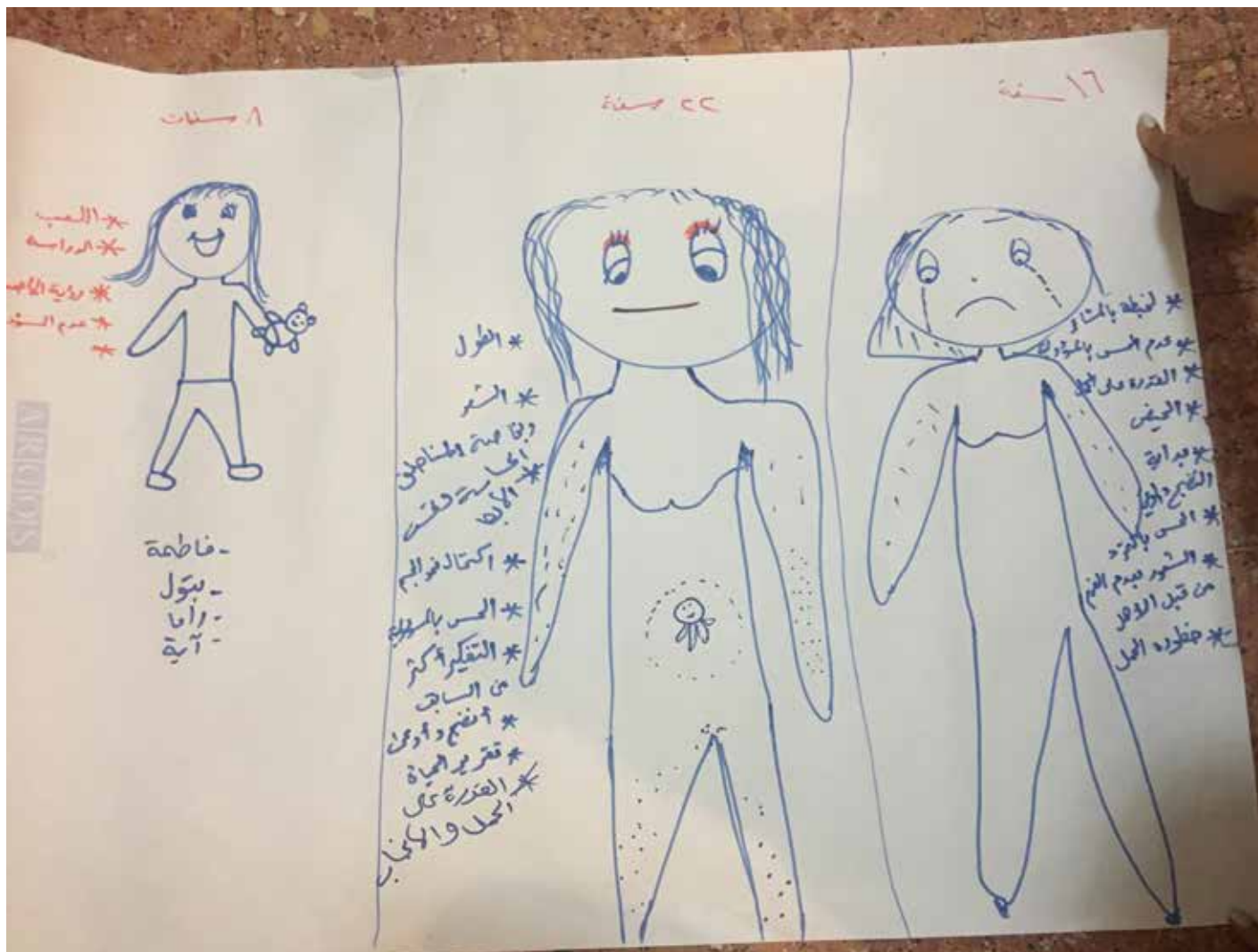


Photo of body mapping activity in Lebanon © WRC, 2018

Body mapping data collection form

Today's date (day/month/year)			
Facilitator's name			
Notetaker's name			
Location			
Number in group			
Group details (age range, marital status, participation in intervention, etc.)			
Grp	Characteristics of a young girl	Characteristics of an adolescent	Characteristics of an adult woman
a			
b			
c			

D.3 Community mapping

Objective	To understand where girls might go for SRH information and services, the quality of the information and services they obtain and any key barriers to obtaining services.
Frequency and timing	Can be done before the start of the intervention and after completion. It can also be used as an activity when discussing availability of SRH services.
Time needed	1 hour
Materials needed	<ul style="list-style-type: none"> At least three large sheets of paper and 10 markers Thirty small stickers of three different colours (10 of each colour)

Key steps:

1. Gather a group of 8–10 girls of a similar age (e.g. 10–12, 13–16, 17–19).
2. Tell the group that they will be drawing a map of their community. Explain that, by 'community', we mean the area around where they live. Tell them you want the drawing to include everything that exists in this area, including places and people. You may ask them to list some things that are in the area where they live.
3. Break the girls into smaller groups of 3–4 and give each group a large sheet of paper and markers.
4. Give the small groups 15–20 minutes to draw their maps. If any girls are stuck, you may suggest that they start by drawing the safe space and then draw everything that is around it. Remind the girls that they can also draw important people on their maps.
5. If the girls are able to write, ask them to label things on their maps. If there is no one in the small group who can write, you may label things for them when they have completed the drawing.
6. Once the maps are finished, give each participant 10 stickers of one colour. Ask them to put the stickers on places where girls their age spend their time. They can put more than one sticker on one place if girls spend a lot of time there. Collect the unused stickers.
7. Give each participant 10 stickers of the second colour. Ask them to put these stickers on places where girls can get information and services on reproductive health. They can put more than one sticker on one place if girls can get a lot of information or services there. If there is nowhere they can go, they do not have to place any stickers.
8. Give each participant 10 stickers of the third colour. Ask them to put these stickers on places where girls feel unsafe to go.

9. If there is time, ask each group to present their map to the others. Tell them to imagine that a new girl their age has just arrived in their community. What would they tell her about their map? What do they like most about their community and what do they like the least? Where can she go for SRH-related information and services? Which places are the best and why? Where shouldn't she go?

Notes and tips:

- Some girls may have trouble drawing their community. If girls are very unfamiliar with the concept, the facilitator may assist by asking girls to describe to her where things are and drawing the first few things on the map. Once the girls are more comfortable with the concept, they may continue to draw the map.

Community mapping data collection form

Today's date (day/month/year)		
Facilitator's name		
Notetaker's name		
Location		
Number in group		
Group details (age range, marital status, participation in intervention, etc.)		
Where adolescent girls spend most of their time		
Where adolescent girls can get SRH-related info and services		
Where adolescent girls are unable to go/do not feel safe to go		
What they like best about their community		
What they don't like about their community		
Additional notes		

D.4 Survey to measure knowledge, attitudes and behaviours

Objective	To assess SRH-related knowledge, attitudes and behaviours.
Frequency and timing	<ul style="list-style-type: none"> • Should be administered prior to the intervention and after its completion. • Ideally, wait at least three weeks after the completion of SRH sessions for a better measure of knowledge as opposed to memorization.
Time needed	Approximately 30 minutes per respondent
Materials needed	Survey template

Notes and tips:

- This provides an example of a survey, but it should be modified to reflect the indicators you wish to measure.
- Depending on the level of literacy, this survey can be self-administered, or administered by a facilitator.

Potential survey questions:

Demographics:

- Age
- Marital status
- Number of children
- Last grade of school completed
- Disability status

SRH knowledge, attitudes and utilization questions

- Is there a place in your community where young people are able to visit to talk and find out about relationships, sex, contraception, sexually transmitted infections, etc.?
- What kinds of SRH services are provided for adolescents?
- Have you visited a health facility or other place to get SRH services in the last six months?
- Do you have someone other than a friend whom you trust to give you information about your health?

- For the following statements, please say if you strongly agree, agree, disagree, or strongly disagree:
 - *I know how girls' bodies change during puberty.*
 - *I know how pregnancy can be prevented or delayed.*
 - *It can be harmful to a woman's body to have children when she is too young.*
 - *I am aware of at least three danger signs during pregnancy that would require me to go to the hospital.*
 - *I would feel confident to discuss when to get pregnant with my husband or partner.*
 - *I am able to safely access sanitary pads when I need them.*
 - *I would feel too shy or embarrassed to go to a clinic or health centre if I needed sexual and reproductive health information or services.*
 - *I know where to go for treatment for a sexually transmitted infection.*

Sample survey template

001 QUESTIONNAIRE IDENTIFICATION NUMBER |__|__|__|__|

002 DATE OF INTERVIEW ____ / ____ / ____
Day Month Year

003 LOCATION OF INTERVIEW _____

Section 1: Demographics			
No.	Question	Coding categories	Skip to
Q101	In what year were you born?	Year [__ __ __ __] Don't Know 8888 No Response 9999	
Q102	How old are you? [ESTIMATE BEST ANSWER, COMPARE AND CORRECT Q101 IF NEEDED]	Age in completed years [__ __] Don't Know 88 No Response 99	
Q103	Have you <u>ever</u> attended school?	Yes 1 No 0 No response 9	→Q106
Q104	Are you attending school now?	Yes 1 No 0 No response 9	
Q105	What is the highest level of school you have attended: primary, secondary or higher?	Primary 1 Secondary 2 Higher 3 Informal 4 No response 9	
Q106	Are you currently married?	Yes 1 No 0	→Q109
Q107	Have you ever been married?	Yes 1 No 0	
Q108	What is your marital status now: are you widowed, divorced or separated?	Widowed 1 Divorced 2 Separated 3	→Q109 →Q109 →Q109
Q109	Is your (husband/partner) living with you now, or is he staying elsewhere?	Living with her 1 Staying elsewhere 2	
Q110	How old were you when you first got married?	Age in years [__ __] Don't know 88 No Response 99	

D.5 Most significant change method

Objective	To understand how the intervention has changed adolescent girls' SRH-related knowledge, attitudes and/or behaviours.
Frequency and timing	Conduct upon completion of the intervention.
Time needed	30 minutes per interview
Materials needed	Audio-recorder

Key steps:

1. Identify girls to interview. This can be done by asking participants at the end of the intervention whether the intervention has resulted in any changes. Those who report that it has can be chosen for an interview.
2. Meet with interview participants one-on-one in a private/confidential location. Most-significant-change (MSC) interviewing could also take the form of a focus group discussion.
3. Inform participant(s) that you wish to learn whether or not the intervention has resulted in any changes in their lives.
4. Ask participant(s): "Looking back over the last [x number of] months, since the start of the intervention, what do you think has been the most significant change in the lives of adolescent girls in this community?"
5. As the participant(s) tell a story, you may take notes, but you should also be audio-recording (with participant consent) to ensure that you do not miss anything.
6. You may wish to use the following prompts to elicit more detail in a participant's story:
 - *Can you tell me a bit more about that?*
 - *Why do you think that happened?*
 - *What part of the intervention helped with that?*
 - *How do you think other girls felt about that?*
 - *How would it be different if you had not participated in this intervention?*
7. After collecting 5–10 stories, you can conduct analysis to identify common themes, or parts of the intervention that resulted in change.

Notes and tips:

- Make sure you give an opportunity for participant(s) to tell stories of negative change as well.
- If participants cannot identify ways in which the intervention caused a change, this is a finding as well.

For a complete guide to the MSC technique, see: <https://www.mande.co.uk/wp-content/uploads/2005/MSCGuide.pdf>

(Rick Davis and Jess Dart. *The 'Most Significant Change' (MSC) Technique: A Guide to Its Use*. 2005.)

E. Tools for data collection and analysis

E.1 Consent form builder

Objective	To obtain consent/assent for participation in M&E activities.
Frequency and timing	Obtain before set of M&E activities begins.
Time needed	5 to 10 minutes
Materials needed	Finalized consent/assent forms

Key steps:

1. Determine which activities require consent and assent (see chapter 7).
2. Insert the relevant information in the consent form builder.
3. Determine whether you require written or verbal consent/assent. If written consent/assent is necessary, create a line for signature.
4. Administer the consent form to parents of adolescent girls under 18 years old, followed by the assent form to these girls. Administer the consent form to adolescent girls aged 18 years and over.

Notes and tips:

- Ensure sufficient time is given to read the consent/assent forms and to explain any additional information to participants or parents/caregivers.
- Provide a copy of the form to the participant or parent/caregiver, if requested.

CONSENT FORM BUILDER FOR PARENTS/CAREGIVERS OF ADOLESCENTS AGED 10–17 YEARS

Hello, we are from _____. We want to tell you about a _____ we are doing. We are doing this research to learn more about _____. We are asking your _____ to take part in this research because she is between the ages of 10 and 19 and is _____.

Before agreeing to let your _____ participate, it is important that we explain to you why we are doing the _____ and what will happen to your _____ if she participates. You can ask questions at any time before, during or after our discussion. If you would like, you will also have time to read this form and then ask questions. At the end, we will ask you whether or not you agree for your _____ to participate. If you agree, we will then explain the research to your _____ and ask her if she agrees to participate.

In this research study, we want to learn more about _____. If you agree for your _____ to take part, she will participate in _____. We will also meet with other groups of girls living in nearby communities.

If your _____ participates, she will be asked to do the following:

The activities will take approximately _____. She will need to participate _____.

We will be taking notes during the activity [***if activity will be audio recorded: and we would like to tape record the conversations of the group. The recordings will be used to make sure we do not miss anything important that the girls say. The recordings will be stored in a password-protected computer and will be destroyed upon completion of the study***]. We will never write your _____ name in our notes [***if activity will be audio recorded: or when we write down notes from the tape recording***]. We will also use special codes for the location of the activity so no one will know the name of your community.

There is a chance that during the study your _____ could feel embarrassed when discussing certain topics, but she can choose not to answer any questions if they make her feel uncomfortable. She may also leave the activity at any time. There is someone at _____ who she can speak to if she feels upset or afraid about any of the topics discussed.

Neither you nor your _____ will receive any payment or other reward for taking part, but your participation may help design better programmes and services for adolescent girls in this community. You or your family will not have to pay anything to be in this study.

You do not have to allow your _____ to participate. We are asking you if you would like your _____ to participate but if you say no, there will not be any repercussions. You can also say yes now and if your _____ changes her mind later, she can leave the activities at any time. Your choice will not prevent you or any member of your family from participating in any activities provided by _____.

You may ask questions at any time. You can ask now or later. You may talk to the researcher or someone else. If you have any questions about this study, you can call _____ on _____. Or, you can visit the office of _____ and ask to speak with _____.

I have read this document so that you are clear about what our _____ involves. Do you agree to allow your _____ to participate?

- If *parent/caregiver consents* → Thank you. I would now like to ask your _____ for her agreement to participate. Would you like to keep a copy of this form for your records?
- If *parent/caregiver does not consent* → Thank you for your time.

ASSENT/CONSENT FORM BUILDER FOR ADOLESCENT PARTICIPANTS

Hello, we are from _____. We want to tell you about a _____ we are doing to learn more about the health needs and concerns of girls your age living in _____. We are asking you to participate because you are between the ages of 10 and 19 and _____.

[If participant is under 18 and consent has been obtained from parent/caregiver: We have already got permission from your parent/caregiver for you to participate]. You should only take part in this _____ if you want to. Before agreeing to participate, it is important that we explain to you why we are doing the _____ and what will happen to you if you participate. You can ask questions at any time before, during or after our discussion. If you would like, you will also have time to read this form and then ask questions. At the end, we will ask you whether or not you agree to participate.

In this _____, we want to learn more about _____. If you agree to take part, you will participate in _____. We will also meet with other groups of girls living in nearby communities.

If you decide to participate, you will be asked to do the following:

The activities will take approximately _____. You will need to participate _____.

We will be taking notes during the activity [***if activity will be audio recorded: and we would like to tape record the conversations of the group. The recordings will be used to make sure we do not miss anything important that the girls say. The recordings will be stored in a password-protected computer and will be destroyed upon completion of the study***]. We will never write your name in our notes [***if activity will be audio recorded: or when we write down notes from the tape recording***]. We will also use special codes for the location of the activity so no one will know the name of your community.

There is a chance that during the study you could feel embarrassed when discussing certain topics, but you can choose not to answer any questions if they make you feel uncomfortable. You may also leave the activity at any time. There is someone at _____ who you can speak to if you feel upset or afraid about any of the topics we discuss.

Neither you nor your family will receive any payment or other reward for taking part, but your participation may help design better programmes and services for adolescent girls in this community. You or your family will not have to pay anything to be in this study.

You do not have to participate. We are asking you if you would like to but if you say no, no one will be upset with you. You can also say yes now and if you change your mind later, you can leave the _____ at any time. Your choice will not prevent you or any member of your family from participating in any activities provided by _____.

You may ask questions at any time. You can ask now or later. You may talk to the researcher or someone else. If you have any questions about this study, you can call _____ on _____. Or, you can visit the office of _____ and ask to speak with _____.

Do you agree to participate?

- If adolescent consents/assents → Thank you. Would you like to keep a copy of this form for your records?
- If adolescent does not consent → Thank you for your time. Please let me know if you would like more information about the services provided by _____.

E.2 Data analysis plan

Objective	To ensure collected data is utilized and feeds into programming.
Frequency and timing	Create before data collection begins.
Time needed	2–3 hours
Materials needed	Data analysis plan template

Data analysis plan template

When will data analysis occur?	Will your team wait until all data has been collected to conduct analysis? Or will you analyse data at each stage (i.e. baseline, midline, endline)? What is the estimated timeline for analysis to be completed?
Which methods will be used for analysis?	What information will be analysed quantitatively versus qualitatively? How will the two types of analysis complement one another?
Does analysis require any specialized skills and/or equipment?	Is there the capacity to conduct analysis internally, or will you need to hire extra support? Do you need to download or purchase software for analysis?

Who will do the analysis?	<p>Which team members will be responsible for analysis? How will adolescent girls be involved in the analysis process?</p>
How and to whom will the findings be reported?	<p>What is the format of your organization's evaluation reports (if any)? Who is the audience for your report? Will you have to develop multiple reports for different audiences?</p>
Any additional considerations for the analysis process	

E.3 Introducing analysis to adolescents

Objective	To introduce the concept of data analysis to adolescents.
Frequency and timing	Conduct before data analysis begins.
Time needed	60 minutes
Materials needed	Around 20 objects

Key steps:

1. Collect different sized sticks, pens, leaves, plastic bottles, stickers, pencils, etc., and place them in a box or bowl. Make sure there are about 20 items in total.
2. Show the varied objects to participants. Explain that the variety of items represents the variety of information that we have collected (or will collect) from different individuals and groups of people during the evaluation. In order to make sense of the information, we need to sort it into meaningful categories and to understand more about the types of information we have gathered.
3. Ask participants to work together to sort the objects into four or five groups. They should discuss among each other why certain objects should be grouped together.
4. Once participants have agreed on groupings, ask them to explain why they chose to put certain objects together. Ask if there were any disagreements and how they settled them.
5. Explain that this is how we conduct data analysis: Each object represents different pieces of information and we want to sort them into larger ideas.
6. If participants are literate, the exercise may be repeated with words, quotes or concepts printed on pieces of paper. Groups with low literacy can assign themes to objects, similar to the PRM exercise, and then sort.

Notes and tips:

- If possible, allow adolescent M&E focal points to lead this activity (ensuring that they are trained on the activity beforehand).
- Emphasize the importance of different interpretations and how a group of researchers may work together to come to shared conclusions.

E.4 Codebook template

Objective	Identifying themes and patterns from qualitative information
Frequency and timing	Create after initial reading of transcripts. Can be revised following consultation with team members.
Time needed	2–3 hours
Materials needed	Transcriptions of audio-recordings from qualitative data collection

Key steps:

1. Clearly label all transcriptions of qualitative data with a code, such as *FGD 1*. A separate table should be created that provides all necessary information for each code (date, location, group characteristics, etc.).
2. Familiarize yourself with the data. Read through the notes and transcriptions of qualitative activities and discuss initial impressions with team members.
3. Reread several of the transcriptions and make notes in the margin on themes and ideas that emerge. For example, note whenever participants discuss menstruation, or whenever they mention specific things they learned from the intervention.
4. Translate these themes into codes. Codes are short phrases or single words that will be used whenever that same theme comes up. For example, 'menstruation' or 'safe space learning'.
5. For each code, create a clear definition of what it means and when it should be used, as well as when it *should not* be used. For example, 'menstruation' refers to any issues related to having a period, but it should not be used if a participant mentions a late or missed period. It is also useful to note what should be used *instead* in certain cases. For the aforementioned example, perhaps a code such as 'potential pregnancy' should be used. Finally, one or two example quotations can be selected for each code.
6. Once the draft codebook is complete, team members should code one or two selected transcripts and then meet to compare their coding. They should discuss any discrepancies and refine the codebook as needed.
7. Coding can be done in software such as NVivo or Dedoose and team members should meet periodically to discuss any issues that arise.

Notes and tips:

- The same codebook should be used for all transcripts of the same group (i.e. all focus group discussions with mothers/female caregivers should be coded using the same codebook). This allows you to identify themes and patterns across different groups.
- In-depth analysis of qualitative data takes a great deal of time. As a rule of thumb, every one hour of audio-recording may take three hours to transcribe and another one hour to code. So, for 10 hours of audio-recordings, you can expect to spend 40 hours transcribing and coding, and an additional amount of time for analysis.
- When there is not sufficient time or resources to conduct in-depth data analysis, consider other methods explained in chapter 8.

Example codebook template

Code	Definition and when to use	When not to use (and what to use instead)	Example quotation (transcript ID, page number)

