

OVERVIEW

Case Study Series

Community-Based Information Systems

Background and Purpose

Many community-based programs provide services intended to mitigate the effects of HIV and AIDS, including HIV prevention, HIV care and treatment, and services for orphans and vulnerable children (OVC). These programs vary widely in terms of the data that are collected for monitoring and evaluation (M&E); the job function and skills of people who collect the data; and how and by whom the data are managed, analyzed, used, and stored.

MEASURE Evaluation, with support from the United States Agency for International Development (USAID), conducted case studies to understand and document how community-based information systems are designed, implemented, and used by program staff and government counterparts. Case studies in Kenya, Tanzania, and Zambia provide an opportunity to identify key lessons learned—including successes, challenges, and opportunities for improvement—that will inform community-based programs globally.

The case studies focus on OVC programs because such programs rely heavily on community workers and community-based organizations (CBOs) to implement activities and monitor program progress. However, case study findings are relevant to other community-based programs that support prevention efforts and ensure continuity of care through nutrition, home based care (HBC), and general community health programs that are at the forefront of AIDS-free generation efforts.

Case Study Approach

The case study team, with input from USAID, narrowed country selection to sub-Saharan Africa,¹ as 90 percent of children who have lost one or both parents due to AIDS live in sub-Saharan Africa. The team shortlisted 15 countries that have robust USAID-funded OVC programs. The team then considered the characteristics of PEPFAR OVC programs that would provide variation in findings to maximize the potential application of lessons to other programs, including:

- OVC programs and/or related M&E systems with more vs. less government oversight;
- stand-alone OVC programs vs. OVC programs embedded/integrated into other programs;
- single vs. multiple PEPFAR-funded OVC programs in a country; and
- PEPFAR funded OVC programs with vs. without electronic reporting systems.

Based on this, we identified three countries that would be suitable for the case studies: Kenya, Tanzania, and Zambia. Table 1 provides detailed information regarding the OVC context in each of the countries selected for case studies, including the number of adults and children living with HIV; the number of OVC; the name of the primary OVC government partner in country; the national OVC guidance that exists in each country; and whether there is a national OVC M&E system.

1) Tenth Annual Report to Congress on PEPFAR (2014). <http://www.pepfar.gov/press/c61873.htm>. Accessed June 2014.

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Table 1—Country and Government Context for HIV and OVC

Country	# of adults and children living with HIV*	# of OVC*	Primary OVC Government Partner	National Guidance	Existence of national OVC M&E system
Kenya	1.5 million	1.2 million	Ministry of Labour, Social Security and Services, Department of Children's Services	Minimum Service Standards for OVC	No
Tanzania	1.4 million	1.3 million	Ministry of Health and Social Welfare (MOHSW), Department of Social Welfare (DSW); Prime Minister's Office of Regional Administration and Local Government (PMORLAG)	National Costed Plan of Action II	Currently being developed
Zambia	980,000	690,000	Ministry of Gender and Child Development, Ministry of Community Development Mother and Child Health (MCDMCH), and other ministries such as education	National Child Policy	No

* UNAIDS, *Report on the global AIDS epidemic, 2010*.

In each country, we consulted the USAID Mission to understand the PEPFAR OVC program landscape. Where there was more than one prime partner, we selected two projects based on geographic variation and areas of interest to the Missions. Zambia had one primary OVC project and lead organization: STEPS OVC. Kenya and Tanzania had one project with several different lead organizations: APHIAplus in Kenya and Pamoja Tuwalee in Tanzania.

Table 2 presents information regarding each of the USAID-funded programs selected for case studies, including: the name and type of program; the number of lead projects in the country; and for those projects selected, the geographic location and whether the project has an electronic database.

Table 2—OVC Program Information by Country

Country	PEPFAR Program Name	Program Type	# of Lead Projects in Country	# of Projects Selected	Geographic Location	Server or Internet Database
Kenya	APHIAplus	Integrated clinical and community-based services, including OVC	5	2	Nakuru Kisumu	Yes No*
Tanzania	Pamoja Tuwalee	Community-based OVC	4	2	Morogoro Dodoma	Yes** Yes
Zambia	STEPS OVC	Community-based OVC and HBC	1	1	Livingstone Chipata	Yes

*The database was just starting at the time of the case study visit.

**This Web-based database was not yet fully functioning at the time of the case study visit.

In each country we used a vertical case study design, meaning that we collected information from the national to community levels, and at the government level where appropriate. Case study methodology included qualitative data collection methods, including in-depth interviews and focus group discussions, document review (e.g., review of M&E plans, data collection forms and summary forms, guidelines or protocols for data capture), and observation of filing and storage systems. Our study design was reviewed by Futures' Group Internal Research Review Committee who determined it to be exempt from full ethical review.

Key Successes

M&E systems are comprehensive and robust: The community-based projects we studied have developed comprehensive M&E systems with clear roles and responsibilities related to M&E; designated M&E responsibilities from the national to the CBO level; performance monitoring plans or M&E plans; clearly articulated indicators, forms, guidelines, and procedures for data collection and reporting; and often, have guidelines and processes in place for supportive supervision and data quality checks.²

Data aggregation is increasingly occurring at the CBO level: The case study sites have evolved to place the task of data aggregation on the CBO rather than volunteers, primarily through the use of databases. This has reduced both the burden on volunteers and data transcription error.

Strategies are in place to build the capacity of local CBOs: A main focus of the sites visited is building the capacity of CBOs in both technical and M&E competencies. Project staff provide support to CBO staff in collecting information and accessing data through standardized reports. In some cases, CBOs are able to query databases to answer other questions of interest. This approach empowers CBOs to make decisions based on their data without having to wait for feedback from the program.

Evidence of strategic information use: There is increased emphasis on use of information for decision making, particularly at the program and CBO levels. Many of the projects discussed data use as an important goal of the M&E systems, though standardized activities to promote data use are still being developed. Some of the information collected is indeed collected for a useful purpose such as for programmatic monitoring - measuring performance against targets, determining coverage, and making adjustments in staffing or service delivery. Further, some of the tools used help facilitate casework management, for instance by helping volunteers determine what support to provide to individual children and their families.

In many cases, projects are building the capacity of the local government structures to effectively coordinate and plan the response for OVC. Projects also are providing project information to government agencies to help with coordination, planning, and resource allocation.

Projects are moving to harmonize information system: In countries with multiple projects implemented by different consortia, each project traditionally has its own M&E plan and supporting data management system. In one of the countries, USAID has initiated a process to streamline the reporting systems across all of the implementing partners. This will ensure similar indicators and reporting across partners, ensuring standardized data are available at the country level.

Key Challenges

M&E systems mainly capture outputs related to services delivered: Most of the routine reporting focuses on outputs, or services delivered to individual children in the areas of health and nutrition; education; psychosocial support; and child, legal, and social protection. Extensive data are collected, yet not always prioritized, making it a challenge to identify service delivery priorities. Projects are trying to identify ways to assess outcomes on a more routine basis by developing new instruments and tools, such as tools to assess economic strengthening and household vulnerability. However, these tools are nascent and not routinely or systematically used.

Referral systems and monitoring referrals are weak: Programs did not often use referral forms. When they did, data on referrals made and completed were lacking. In many cases, indicators related to referrals were not clear, particularly for non-health related referrals.

Some M&E practices impede data flow: The way M&E systems are designed can facilitate or impede data flow. The number of forms and amount of information collected on a form, including approval signatures, can impede timely and accurate submission of data.

2) The quality of these processes was not verified in this assessment.

The act of collecting data affects the relationship between the caregiver and the volunteer service provider³:

Caregivers are often the primary source of data collected through the M&E system. At registration, and again at routine monthly visits, caregivers are asked many questions. At times questions are repetitive (e.g., date of birth of child, HIV status, priority needs, education status) and are unchangeable by the program either ever or within the reporting period. Over time, this repetition can cause a strain between volunteers and caregivers, and volunteers may end up not reporting data. In other cases, volunteers do not like to ask the questions that imply that services or goods will be offered, such as questions about the availability of soap or blankets.

Data collection systems do not support decision making for case management at the household level:

Data systems are organized for reporting and auditing purposes, limiting the use of information for case management. Volunteers do not maintain copies of forms in all projects (due to costs and confidentiality issues), and when they do, they are not able easily to track what happened for a child or household over time. In one country, child folders were stored at the CBO office, but volunteers did not necessarily have direct access to them.⁴ Further, much of the M&E supportive supervision described related to audits and accurate completion of forms rather than on actual program outcomes or information that would lead to improving program delivery. Volunteers rely on information external to the M&E systems to know how their clients are doing—such as whether a child is enrolled in school, how they are performing in school, the affect of a child, and how they are growing (from clinic cards).

Limited government ownership of M&E systems:

Government ownership of community-based OVC M&E systems have not been established or are not fully functioning. As a result, PEPFAR OVC programs that are proficient in M&E tend to drive information that is reported and used by government.

3) Each country refers to the cadre of volunteer service providers differently. They can be referred to as community volunteers, community home visitors, and community caregivers.

4) We did not assess the extent to which child files were updated in this assessment.

Discussion

The programs visited are mature programs that have tried various approaches for setting up M&E systems that address many stakeholder needs. Because they have had time to evolve and learn, these programs have developed systems that can adapt to changes needed due to new guidance and indicators, or other pressing information needs. Programs will always need to have the infrastructure, resources, and capacity to adapt systems accordingly, and this will require continued investment in M&E systems.

The majority of data collected are related to outputs and the number of services delivered. They do not provide information reflecting new priorities in programming to enhance the capacity of caregivers and communities to provide care and support for OVC or track actual improvements in child and family well-being. This focus on outputs reinforces the portrayal of programs as filling immediate material needs (e.g., providing mattresses, school fees, sanitary pads, etc.) rather than on building resiliency. M&E systems will need to continue to adapt to monitor how such resiliency is being built.

We did not find conclusive evidence that completing forms poses a burden to volunteers, though there were some examples of it, particularly for volunteers with lower literacy who sought help from others. This may be due to the fact that the projects have been working to address reported issues of volunteer burden. However, volunteers did discuss the reported burden on caregivers, calling into question how much information should be collected from households and how frequently. Further, CBOs indicate that data collection is time consuming, in person hours and opportunity costs. Many efforts have been made to address some of these concerns, such as reducing the number of forms or modifying the frequency of data collection. How these improvements change reports of caregiver burden is something to examine as new systems roll out.

Looking to the future, it is the CBOs that primarily provide community-based care. In that vein, PEPFAR and other donors have included capacity building of CBOs as a central component of their work. In the

future, OVC M&E—or any community-based M&E system—should develop systems and indicators that are relevant at the CBO level, regardless of funding source.

Information generated from such community based information systems ideally would link with the formal government information systems through the health, education, social welfare, or other relevant sectors. Much of these data could be useful for the government's own planning. With respect to information generated by these OVC programs, the link to government systems varied depending on existing government structures—but often information sharing involved providing copies of written reports. If government reporting structures were better established, and meaningful links to community information systems made, there could be better information for government decisions related to support and services.

Recommendations

This case study series serves as one of many inputs to a process that helps define the future of community-based information systems. Based on what was learned in this series, we provide these recommendations:

- Capture the strategic information needs of CBOs and local government structures in the design of M&E systems.
- Continue to invest in M&E systems that can adapt to new guidance, indicators, and pressing information needs.
- Continue to invest in and build capacity of CBOs to collect, analyze, and use information.
- Streamline data collection systems, collecting only information that is required for decision making.
- Develop other data collection methods for outcome monitoring that do not require volunteers to collect data.
- Develop other tools, outside of routine reporting, to facilitate case management.
- Strengthen referral systems and monitor referrals once such systems are strengthened.
- As M&E systems are developed, study the potential limitations of such systems and how they may affect data flow, data quality, and burden on caregivers, volunteers, and CBOs.
- As databases are developed, note the resources required and plan for how those will be maintained without donor support to establish sustainable systems.
- Facilitate volunteers' access to information by creating child files, or creating forms or innovations that allow volunteers to cross-check a child's status and services provided at last visit.
- Enhance use of information for case management; emphasize interpretation of data and the response during supportive supervision or data review meetings.