

Dear Data Use Net members,

We received a few thought provoking posts for Day 2. Thank you to those who took the time to submit and contribute to the discussion. We want to encourage more of you to participate in the discussion – while we ask for your name and organization, you are also welcome to submit your thoughts/ideas anonymously. Our main goal is to get a discussion going that addresses how best to increase data use at the CBO level. Whether you actually work for a CBO or provide grants/technical assistance to CBO's, we'd really like to hear your perspective.

### **Day 3 Discussion Question**

**The readings indicate that one of the main challenges of CBOs using data is insufficient demand for data. Why do you think demand for data is low among CBO's? What are ways to increase the demand? Do you have any specific examples where demand for information is high?**

### **Day 2 Discussion Summary**

Instead of responding to each individual post, we'll summarize our thoughts based on the contributions and pose a few questions back to all of you. These questions are underlined so you can see and respond to them. To see the full posts just scroll down below and you can see them in full.

Mark Spohr wrote in to talk more about how we define data use at the CBO level. He makes some excellent points about how M&E systems don't always take into account the questions that need to be answered for programs. He emphasizes that the process should involve starting with questions that need to be answered and then data systems and data collection are designed to answer those questions. He says, "It is unfortunate that 'monitoring and evaluation' does not emphasize the decisions that are made as a result of the data which is collected...but that really is the point... how well is this program functioning and how can it be improved?" Does anyone have experience working with a CBO where data are collected or reviewed based on a decision that needs to be made or a question that needs to be answered? Please provide an example of how this occurred.

Given the discussion so far, we thought we would include the MEASURE Evaluation definition of data use – what data use IS and what it IS NOT. Something is considered data use if data were reviewed to: monitor, create or revise a program or strategic plan, develop or revise a policy, advocate for a policy or program, and allocate resources. The review of the data could have led to an action (as stated above) or no action (no change was necessary). It is important to recognize that the review of data at dissemination meetings and scientific meetings and/or the reporting of data is NOT data use. These activities are critical to making data available but for data to be used the review must be linked to a specific decision-making process

Steven Wanyee from AfyaInfo in Kenya provides four facilitators for data use at the CBO level including, the technical capacity available at CBOs, culture of the CBO, demands made by partners and government, and CBO leadership. These are all excellent points and when present, such facilitators can lead to enhanced data use. The questions that remain are: what strategies have any of you used to increase technical capacity of CBO staff? How about strategies you have used to cultivate a culture of

data use? Or anything you have done to work with partners, government, and CBO leadership to demand evidenced based decision making from CBOs? [Humberto gave one example of this yesterday]

Lucy Steinitz from PACT presents a dilemma that many organizations face – how to fund evidence based decision making when donor funds are decreasing. She states, “given the decline of donor funding worldwide we have to figure out ways to gather and analyze that evidence without diverting resources that could, and should, be directed to interventions that support our target population.” She presents a low cost approach to conducting baseline assessments for children and families using the Ethiopia Child Support Index which was developed with local input and field tested in target communities. As Lucy points out, as well as Kim and Solomon, including community level workers and community members in development of tools and processes can lead to increased buy-in from these groups when using such information to make decisions at the local level. Does anyone have other examples of low cost strategies for data collection and use activities at the CBO level?

Kim Stover and Solomon Tesfaye from University Research Co., LLC (URC) provided three very useful considerations for facilitating data use at the CBO level: ensuring that data are relevant and useful (this gets back to Mark’s post about only collecting what you need!); at times using temporary indicators; and keeping data collection, aggregation, and analysis as simple as possible. They provide a wonderful example of how they were able to relate a challenging topic (health indicators) to a more familiar topic: “We found equating health indicators with agricultural examples of similar things they monitor, such as crop yield, helped the health indicators to be less intimidating.” This idea of keeping the data use strategies relevant and appropriate for the CBO level has been a theme for today.

In their response to the Day 1 question, Kim and Solomon provided a great example of how they have engaged community based workers in Ethiopia through the entire quality improvement process to determine ways for strengthening community processes for improved care during the critical 48-hour period after birth. What’s striking about this example is the extent to which a cross section of community members is involved – from creating necessary forms, to developing a process for data collection, and being involved in the review of findings. The extensive stakeholder involvement led to active engagement of the community based workers in making improvements to their work. Kim and Solomon write, “These are local solutions, based on local data, which will become more sustainable and create skills for improving other areas of care.” Do other people have examples of how they have engaged a wide group of stakeholders throughout the process that culminated in data use? Kim/Solomon, do you have a specific example of a change that was made by one of the community groups?

Kim and Solomon from URC have submitted two documents to share: the MaNHEP newsletter and Time Series charts. Lucy from PACT submitted their Child Support Index tool that she refers to in her post. All of these materials are available on the Data Use Net discussion website: <https://www.cpc.unc.edu/measure/networks/datausenet/strategies-to-increase-data-use-by-community-based-organizations>

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## Day #2 Discuss Posts

Name: **Mark Spohr, MD**

Thank you for this interesting discussion. It is good to see the quality of thought that is going into this important area.

I have just one point to make on day one and that is regarding the definition of data use.

Data is used when you look at data and make a decision based on the data.

All of the other steps... data collection, analysis and presentation... are preparation for the use of data to make decisions.

When you are designing a data system, you should start at the top, end point of data use... the decision... and work back from there.

- What decisions do I need to make?

- What data do I need to make these decisions?

Use this to design your data system. Only collect data which will be used to make decisions. Anything else is just excess baggage which will cause an unnecessary burden on everyone.

Note that there are decisions at different levels and be sure to include them all. The manager in the field needs to make decisions on allocation of resources whereas planners and policy makers at higher levels need to make decisions on the design of programs. It is unfortunate that "monitoring and evaluation" does not emphasize the decisions that are made as a result of the data which is collected but that really is the point... how well is this program functioning and how can it be improved?

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Name: **Steven Wanyee**

Organization: **Afyainfo (USAID funded HMIS project)**

Country of residence: **Kenya**

Some of the factors are;

- Technical capacity available at the CBO - this is certainly not surprising and cuts across any institution or activity. CBOs with relatively high capacity in terms of skills sets of their staff, as well as well thought out support system in terms of their administration, management and leadership systems has noticeably better data utilization than those without.
- Culture at the CBO - this encompasses a bit of the previous point, but in addition, it also influenced a lot by development partners working with the CBO. A CBO which has over time worked with partners who have a high sense of data value and thus have "infected" the CBO, then it is noticeable that the CBO picks up that and cultivates a culture of injecting value into the data they collect entrenches that practice over time and therefore, their data use gets much more over time.
- Demands by partners/Gov - depending on who the CBO is working with, and again, this is closely related to the previous point, CBOs will have different practices of data use.
- CBO leadership - this is very evident in the varying data use practices and where a CBO has a leadership that has a strong bias for data, then that transcends to the staff of the CBO.

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Name: **Lucy Steinitz**

Organization: **Yekokeb Berhan (USAID funded program working with government, four international partners (Pact, UNICEF, FHI-360 and ChildFund) and 55 local Implementing Partners to serve highly vulnerable children and their families.**

Country of residence: **Ethiopia**

Evidence-based programming has become the mantra of the decade. Given the decline of donor funding worldwide we have to figure out ways to gather and analyze that evidence without diverting resources that could, and should, be directed to interventions that support our target population.

Low cost community- and individual (family) baseline assessments are critical to this process. They should be locally designed in order to reflect government standards, local priorities, and measurable outcomes. To remain manageable, the local community is advised to choose just a few questions rather than many, in a way that is clearly understood by all assessors. Our example is Ethiopia's Child Support Index that was adapted with community input from the original Child Status Index (USAID, 2007) and is being implemented nation-wide. To develop this assessment tool we designed the tool with the input of many local partner organizations, and then field-tested it in the community with grass-roots Community Committees and local households that were randomly selected for our pilot study.

### **The context**

Who are we? The "we" is Yekokeb Berhan, a relatively new USAID-funded program that works with government, four international partners (Pact, UNICEF, FHI-360 and ChildFund) and 55 local Implementing Partners in order to serve 500,000 highly vulnerable Ethiopian children and their families. To tailor training and support services in accordance with individual needs, Yekokeb Berhan's new version of the CSI assessment tool is: a) Pictorial, with sketches that reflect local culture and make the tool usable to low-literature groups; b) Measurable, with focus on government endorsed outcomes on 8 areas of service; and c) Includes one set of indicators for the caregiver as well as another set for each child in the household (20 questions, total).

### **Lessons learned:**

Input from government, local focus-groups and field-testing for reliability and validity in August and September 2011 by three local Implementing Partners (ISAPSO, Progynist and RATSON) refined the indicators, pictographs and wording in accordance with local culture and mores. Implementing Partners – many of which had worked with the original CSI -- now feel ownership of the new version and are pleased with the ability of a single tool to provide so much additional information with which to plan child-specific interventions, measure outcomes over time, and determine graduation from the program.

A copy of the CS tool is attached. In most cases, it is accompanied by a Follow-up Care Plan and case-management process.

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Name: **Kim Ethier Stover, Senior Quality Improvement Advisor (Bethesda, MD) Solomon Tesfaye, Quality Improvement Advisor (Addis Ababa, Ethiopia)**  
Company: **University Research Co., LLC (URC)**

**Project: Maternal and Newborn Health in Ethiopia Partnership; (Funded by Bill and Melinda Gates Foundation; Emory University Prime; URC sub-awardee for QI; other partners include JSI and Addis Ababa University)**

- You have to show that the data is relevant and useful. In order to be useful, it is best to have fewer, targeted indicators that can provide quick feedback as to performance.
- At times, we may even have an indicator that is temporary, showing the community level teams that they have improved an intermediate step to a larger goal. Once they have achieved that goal, an overall indicator may be all that is necessary. (For instance, on our project, MaNHEP, community level teams are monitoring both labor/birth notification within 2 days and PNC within 2 days (home visit) to see whether notifications are happening and then whether postnatal care is happening. Once they have achieved their goal of PNC within 2 days for most (over 95%) women and babies, they can drop the labor/birth notification as it will be implicit in the PNC within 2 days indicator.)
- Data collection, aggregation, calculation and analysis should be as simple as possible so that it is not overwhelming. Especially at a community level, you find many people who are innumerate so data can be intimidating- the simpler, the better! We found equating health indicators with agricultural examples of similar things they monitor, such as crop yield, helped the health indicators to be less intimidating.

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**Day 1 Additional Post:**

**Name: Kim Ethier Stover, Senior Quality Improvement Advisor (Bethesda, MD) Solomon Tesfaye, Quality Improvement Advisor (Addis Ababa, Ethiopia)**

**Company: University Research Co., LLC (URC)**

**Project: Maternal and Newborn Health in Ethiopia Partnership; (Funded by Bill and Melinda Gates Foundation; Emory University Prime; URC sub-awardee for QI; other partners include JSI and Addis Ababa University)**

The Maternal and Newborn Health in Ethiopia Partnership (MaNHEP), under the leadership of the Ethiopian Federal Ministry of Health (MOH) is working to strengthen Ethiopia's Health Extension Program by building skills of frontline workers and community processes for improved care during the critical 48-hour period after birth. MaNHEP supports 51 communities in 6 districts located in Amhara and Oromiya regions in Ethiopia. The project uses a combination of a participatory training approach to get basic skills to the household level, a quality improvement (QI) approach at the community level to improve care process and BCC activities. The community processes for improvement included (but not limited to) pregnancy identification, registration in first antenatal care (ANC), coverage of household level training for all pregnant women, notification of birth to HEW, postnatal care (PNC) within 48 hours, and referrals to higher level. To being with, MaNHEP, district-level MOH officials, and health center staff visited communities to among other things assist them in setting up a QI team. Team members come from a cross-section of community members who have a direct role in the processes above or who had influence over the community. Teams include representatives from women's groups, family members, religious groups, community elders, community health workers, traditional birth attendants, Health Extension Workers (HEWs), and community (kebele) administration. QI teams then analyze themselves how well these processes are working, using process maps, existing data sources and other tools. Based

on the findings of the major problems, they then begin to develop changes (ideas they think will improve the process) and choose one or two to test. In order to know whether the changes they have tested are really improvement, they need to refer to data.

In the case of the community level, much of the data needed to monitor the processes above were either unavailable or missing. Most HEWs did not have official registers for ANC and PNC. A simple form for keeping track of key numbers needed (pregnant women identified, ANC, birth information, PNC information) was developed in order to monitor basic information related to the processes above. Before the QI teams could use the data to determine their progress, they first needed to clarify and develop processes for data collection, management and aggregation. They discussed who was responsible for which data and how and when they would pass this information on to the HEW who kept the aggregated data. QI teams used simple indicators and plotted the information monthly on a time series chart (see newsletter for example) which. By plotting their own data with graphs using plain paper and markers, the teams are able to monitor their progress and see quickly whether they have made improvement. Team members also say the outcome (graphs) of the information they were responsible for. Based on the data, they are able to determine if their changes worked well, needed modification or should be abandoned. Teams are brought together every 4 to 5 months to share their results – including their graphs- with their colleagues. The immediate visual representation of progress is motivational for QI team members who are proud to share their achievements with their peers. External coaches (MaNHEP, district MOH and health center staff) guide the teams through this process, but all of the ideas and analysis are generated locally. These are local solutions, based on local data, which will become more sustainable and create skills for improving other areas of care.

For more information on MaNHEP, please see: [www.manhep.org](http://www.manhep.org)

For more information on QI and time series charts, please see: [www.hciproject.org](http://www.hciproject.org)

I have attached two documents: the MaNHEP newsletter with graphs and additional information and a short explanation of time series charts.