

ZAMBIA

Case Study Series

Community-Based Information Systems

Background

Many community-based programs are providing services intended to mitigate the effects of HIV 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 data collectors; and how and by whom the data are managed, analyzed, used, and stored. MEASURE Evaluation, with funding from the United States Agency for International Development (USAID) and support and technical input from members of the President's Emergency Plan for AIDS Relief (PEPFAR) OVC Technical Working Group (TWG), conducted case studies in three countries to unpack the complexity of community-based M&E systems and to make recommendations.

This report presents the results of the case study from Zambia. Results from Tanzania and Kenya case studies are available in separate reports. Results from the case studies will be of interest to country governments, programs, and donors, both in and outside of Zambia. OVC programs' M&E systems were chosen as an area of community-based information systems to study because these programs that are at the forefront of AIDS-free generation efforts are often nested in local communities. Thus, results are relevant to community-based programs beyond OVC.

Programs for OVC in Zambia

For the case study, we selected the largest program in Zambia working to improve the lives of OVC and mitigate the effects of HIV for people affected by the virus: the Sustainability through Economic Strengthening, Prevention and Support for Orphans and Vulnerable Children and other Vulnerable Populations Project (STEPS OVC). STEPS OVC, a USAID Zambia-funded project, had a network of over 30,000 community caregivers providing care to over 300,000 OVC and 135,000 adults affected by HIV in all 72 districts as of September 2013.¹ In this report, we use the term “community caregivers” to distinguish volunteers providing services in the community from parent or guardian caregivers living in households caring for OVC.

STEPS OVC was a \$54 million project running from 2010 to 2013 with World Vision International (WVI) as the prime implementing partner. In October 2013, STEPS OVC entered into a 15-month project extension period with a corresponding budget increase to \$72 million. During the extension period, the project will provide at least one service to 398,122 OVC and 164,506 people living with HIV, equivalent to approximately 31 percent of all OVC and 10 percent of all people living with HIV in Zambia. A network of more than 40,000 community-based volunteers provides services.² The objectives of the extension

1) Price J, Moyo T, Topp S, et al. Motivations for Entering Volunteer Service and Factors Affecting Productivity: A Mixed Methods Survey of STEPS OVC Volunteer HIV Caregivers in Zambia. Lusaka, Zambia: USAID, 2013.

2) Source: STEPS OVC Program Documents, 2014.

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phase are to transition programs, community caregiver networks, and M&E systems to local partners; ensure a continuity of diverse care and support services at the household level; build capacity of the 13 partners to WVI to directly manage USAID funding and to sub-grant to others; and to transition the program from one of direct provision of goods to one of household economic strengthening.

In this transition period, the number of districts of operation was reduced from 72 to 43 to focus activities in geographic areas where the 90 percent of beneficiaries are located. In the extension, WVI remained as the prime USAID implementing partner subcontracting to 13 local Zambian partners (referred to as “partners” in this document). Those 13 partners are working with 185 community-based organizations (CBOs) and faith-based organizations (FBOs) (a number likely to increase) through sub-grants (we refer to these CBOs and FBOs as “sub-grantees” in this document).

The U.S. government has other OVC-funded projects in the country, though they are smaller in size than STEPS OVC, and some are in other sectors than health. A review of those activities are outside the scope of this case study. However, of note is that the USAID Mission recently awarded three separate projects to support the Government of the Republic of Zambia to improve the quality of OVC services with strengthened systems and policy framework for coordination, planning, implementation, and monitoring and evaluation. One of those programs is Data Rising (originally, Zambia Orphans and Vulnerable Children Management Information System [ZOMIS]). A local organization, Expanded Church Response (ECR), is implementing Data Rising (ECR is also a partner on STEPS OVC), and the two-year project is designed to support government efforts to establish an effective and sustainable national OVC M&E system. The other two projects, Zambia Rising, implemented by Save the Children and Community Rising, implemented by Luapula Foundation, are five-year projects designed to strengthen the national OVC response through systems strengthening at the central level; and to strengthen the efficiency and effectiveness of OVC services at the district and community levels, respectively.

Methods

We used a vertical case study design, meaning we focused on WVI’s STEPS OVC project and selected a subset of three of the thirteen partners. From the three partners, we then selected a subset of their sub-grantees (CBOs/FBOs) and caregivers. Table 1 (on page 3) summarizes the level, type, and number of respondents. Appendix 1 (on page 18) summarizes the case study design and flow.

The three WVI partners were selected in consultation with USAID Zambia and STEPS OVC staff to obtain variation in geographic location and M&E capacities (Figure 1). We also conducted one focus group discussion (FGD) with representatives from four other partner organizations, although we did not reach out to their sub-grantees. Thus, we have information from program managers and M&E officers from seven of the thirteen partners.

Figure 1—Map of Zambia and indications of the geographic areas of data collection for the case study



The partners, in consultation with STEPS OVC staff at headquarters in Lusaka, selected partner sub-grantees (CBOs/FBOs). The sub-grantees selected the caregivers to participate in the focus group discussions (FGD). For each partner or sub-grantee organization, we interviewed both the program manager (or similar

Table 1—Summary of type and number of respondents for case study data collection and method

Level	Respondents	Number
National	USAID Mission staff	2
	Government ministry staff (National HIV/AIDS/STI/TB Council [NAC] and Ministry of Gender and Child Development)	3
	STEPS OVC Headquarters Program Officer	1
	STEPS OVC Headquarters Operations Officer	1
	STEPS OVC Headquarters M&E Officer	1
Partner	Program managers/coordinators	4 (3 different partners)
	M&E officer	5 (3 different partners)
	Program manager and M&E Officer*	8 participants (representing 4 partners)
District	District AIDS Coordination Advisor (DACA)	3
	District Community Development Officer	2
	District AIDS Task Force Chairperson	1
	District Social Welfare Officer	1
Sub-grantee	Program managers/coordinators	8 (6 different CBOs/FBOs)
	M&E staff/data entry clerks	3 (5 different CBOs/FBOs)
Community	Caregivers*	7 FGDs with an average of 11 participants, range 5–25.

* The data collection method was a focus group discussion (FGD). All other data collection methods were in-depth interviews.

position) and the M&E officer (or similar position). We also conducted interviews with Zambian government officials, both at the national and district levels, whose departments dealt with issues and data collection related to OVC.

All interviews were in-depth interviews using an open-ended interview guide, with the exception that we conducted focus group discussions with caregivers and with one group of partner representatives. The study co-investigator or a consultant hired for the project collected data. Interviews were conducted in English and, where necessary, a third party provided translation. Detailed notes were taken. Interviews were recorded and the recordings used later to fill in note detail. All participants were informed of their rights through an informed consent process. The Futures Group Internal Research Review Committee reviewed the study and determined it to be exempt from review.

Brief Program Description

For STEPS OVC, the volunteer community caregiver is at the front line of care provision and data collection.

This person is from the community and regularly visits beneficiaries. Beneficiaries include both OVC and adult clients receiving basic care and support (BCS). The term BCS reflects an evolution in the health status of people affected by HIV. With the increasing availability of antiretroviral therapy (ART), clients are no longer bedridden and in need of palliative care; rather, they are ambulatory and looking to provide for their families. In recognition of this evolution, STEPS OVC has been shifting the emphasis from direct provision of goods (such as food and blankets) to economic strengthening programs including savings programs and community gardens. This emphasis continues in the program extension.

Community caregivers reported providing a wide variety of services on many topics: They monitor school enrollment/attendance; counsel on food and nutrition and HIV prevention; counsel to get HIV testing (and some caregivers can do HIV tests); link beneficiaries with legal and social support; encourage participation in economic strengthening programs; encourage bed net use; refer for other clinical assessment and care; provide anti-retroviral therapy (ART) adherence counseling; and assess shelter.

The number of clients that volunteer caregivers were responsible for varied widely. Caregivers in this study reported responsibilities for six to fifteen OVC per caregiver and three to ten BCS per caregiver. This is consistent with what was found in another study of STEPS OVC caregivers: Price et al. found that caregivers were responsible for an average of 9–10 OVC beneficiaries (range 1–55) and 5–6 BCS beneficiaries (range 1–50), but visited 80–84 percent of those clients in a typical month.³ Typically households have more than one beneficiary (OVC and/or BCS) enrolled in the program, but this is an increase over the initial five households caregivers were assigned.

Community caregivers visited households one time per month or possibly more often if someone was sick. The length of a visit was typically about 30 minutes, but a visit could be longer depending on the needs of the beneficiaries. On the other hand, sometimes a “visit” could be as simple as running into a client in the street and asking after his/her welfare. The distance community caregivers had to travel also varied. Many caregivers lived in the same community as their beneficiaries, and it could take about 15–20 minutes to walk to the beneficiaries’ home. In the most extreme cases, travel time could take up to one hour. In total, the trip and the visit could take up to three hours. These outliers were rare and seemed to be correlated with clients who had moved away but the caregiver continued to visit.

Respondents considered the STEPS OVC program as “integrated” because it included five to six key OVC interventions, which could be psychosocial counseling, education, health, health economic strengthening, and shelter. The program is also integrated in the sense that caregivers addressed the needs of both children and adults, focusing on the family unit.

STEPS OVC does not currently enroll new beneficiaries on a continuous basis. From 2010 to 2013, beneficiaries were enrolled based on eligibility criteria and to ensure STEPS OVC met their program targets. By the end of

2013, the program had 627,526 beneficiaries enrolled, of which 562,628 will continue to receive support in the extension (the decrease is largely a result of a reduction in the number of districts). Over time, some beneficiaries have dropped out due to death or relocation. Some OVC have “graduated” in that they have turned 18 and thus are no longer considered OVC, though they may now be BCS clients.

Relationship with Government Systems

At the national level, no one ministry is responsible for data or planning related to OVC. The National Child Policy informs many issues related to children, including orphans and vulnerable children. Responsibilities for OVC are spread across the Ministry of Gender and Child Development, Ministry of Community Development, Mother and Child Health (MCDMCH), and other ministries such as education. An inter-ministerial national steering committee on OVC convenes as needed to assess certain issues.

The role of the National HIV/AIDS/STI/TB Council (NAC) is largely coordination, although it is a primary source of information about OVC and HIV programs, donor resources, and implementing partners. NAC collects this information through the stakeholder activity reporting form (SARF) at the district level on a quarterly basis. Partners (such as STEPS OVC) submit hard copies of the SARF to the District AIDS Coordination Advisor (DACA), and from there the SARF data are reported up to the NAC. The NAC systems face challenges when partners (typically non-STEPS OVC partners) do not report to them.

At the district level, the SARF is also shared with the District Development Coordination Committee (DDCC). The head of the DDCC is the District Commissioner (DC), and s/he is also the head of the government at the district level. On a quarterly basis, the DDCC submits a report to the provincial and national level of activities and resource needs for the district. Feeding into that report, in addition to the NAC data, is information that comes from the District Welfare Assistance Committee (DWAC) and the

3) Price J, Moyo T, Topp S, et al. *Motivations for Entering Volunteer Service and Factors Affecting Productivity: A Mixed Methods Survey of STEPS OVC Volunteer HIV Caregivers in Zambia*. Lusaka, Zambia: USAID, 2013.

District AIDS Task Force (DATF), among other groups. When resources come to the district from the national level, the DDCC uses this report to identify institutions and vulnerable groups to support. For example, there could be a decision to increase funding to the Social Welfare Department for cash transfers or food packs, or to increase funds to for school fees.

The district representative for the Community Development and Social Welfare offices chairs the District Welfare Assistance Committee (DWAC); the committee is best placed to know about what is happening with OVC from the district government perspective. The committee's perspective is not limited to HIV, however. HIV is mainstreamed into government social services, so people living with HIV and OVC are treated like any other person who needs social welfare assistance for education support, agriculture support, etc.

District AIDS Task Force (DATF) focuses on HIV and OVC and organizations, and on ministries working on HIV and with OVC. The DATF includes representatives from a number of different line ministries and NGOs, such as MCDMCH, District Social Welfare and Community Development offices, District Health office, Ministry of Agriculture, and Ministry of Education through the District Education Boards. They hold monthly stakeholder meetings to present work plans and to promote collaboration and avoid duplication. As mentioned above, the DATF submits a monthly situation report on HIV and OVC to the DDCC.

STEPS OVC M&E Systems

The STEPS OVC M&E system is decentralized, with data collection and entry occurring at the sub-grantee or sometimes partner level. Data are managed through a database housed at a server in Lusaka at the STEPS OVC Program Management Unit (PMU) offices. The current M&E system has grown out of several years of development and evolution that began under the predecessor project, The Reaching HIV/AIDS Affected People with Integrated Development and Support

(or RAPIDS project, 2004–2009). RAPIDS had 29 different data collection and reporting forms and an Excel-based data entry and management program.

Under STEPS OVC, the overall number of forms was reduced to 13. The main data collection form, the caregiver visitation form (Appendix 2 on page 19), was consolidated into a single form. The visitation form was revised to focus on events occurring during a single visit, rather than on multiple services (which required multiple forms). The electronic database, the Community-based Prevention Information System (CoPIS), was introduced in 2011 and, after three months of testing, was rolled out for project use.

The STEPS OVC M&E hierarchy can be described as decentralized. The STEPS OVC PMU M&E staff organize M&E trainings and supervise M&E staff at the partner level. Partners organize M&E trainings and supervise M&E staff at the sub-grantee level. While some sub-grantees have M&E staff or a data entry clerk, others do not and rely on the partner for that service.

Demand for M&E Data

Demand for M&E data comes from a number of sources, but these four are the most frequently mentioned:

1. USAID: STEPS OVC is required to submit reports to USAID Zambia on a semi-annual and annual basis, although USAID can also make ad hoc information requests. They are required to report on 17 PEPFAR indicators, 3 NAC indicators, although STEPS OVC tracks 39 indicators. The additional indicators are helpful to explain the 17 required indicators. For example, the number of beneficiaries that report improved well-being is not required, but it is collected because it is helpful to explain program outcomes.

2. National HIV/AIDS/STI/TB Council (NAC): The data that caregivers collect are also used to fill in the quarterly NAC Stakeholder Activity Reporting Form (SARF) form. The data from STEPS OVC maps to six required indicators on the SARF. Partners simply copy the information from what they have collected for STEPS OVC to the SARF; no special data collection

is needed. STEPS OVC partners give information to the District AIDS Task Force (DATF), and the District AIDS Coordination Advisor (DACA) reports to the Provincial AIDS Coordination Advisor (PACA). The PACA reports to NAC. The NAC has an online system for reporting at www.zambianacmisonline.org. The M&E directorate at NAC compiles national reports from the database.

3. STEPS OVC Program Management Unit (PMU):

Partners provide quarterly, semi-annual, and annual reports to STEPS OVC PMU, including analysis of indicators and narrative reports which contain success stories and lessons learned. Narrative reports inform partner reports, which sub-grantees submit monthly, together with the data collected by caregivers.

4. Organizational planning use: Partners, although not so much sub-grantees, reported that data collected under STEPS OVC was also useful for the organization in preparing their organization's own annual reports, reporting success stories via their Web sites, or when seeking other funding:

[We use] the information that the CBOs report to us in decision making, advocacy, and sometimes ... issues specific to certain areas where they are working. When we see it come out we can use it to advocate. For example, if they report OVC data and it shows that the majority of OVC in that area don't have birth certificates, then we start advocating at government department that are responsible for such activities to get birth certificates.

—(M&E Officer, partner level)

M&E Plan

The STEPS OVC Performance Monitoring Plan (PMP) describes the program's goal to "strengthen the capacity of Zambian Communities to provide sustainable HIV and AIDS prevention, care and support services in a harmonized manner to priority geographic areas, target populations and stakeholder communities." The PMP was finalized in 2010, but an annex was added in 2013 for the 15-month extension project. The PMP describes 39 indicators designed to demonstrate achievement toward the nine results areas. The annex for the project extension period describes 22 indicators, 19 of which

are from the original PMP. Three indicators are new for the extension period and represent the program areas of emphasis for the extension, namely economic strengthening support and increased capacity and ownership of local organizations.

Each of the partners produces a PMP as well. The PMP format and content are standardized across the partners, and they receive technical assistance from the STEPS OVC PMU to develop the PMP. The partners and sub-grantees all have the same project results and use the same indicators for the STEPS OVC program. The main difference across the PMPs is the targets for each indicator. Some sub-grantees have PMPs, but sub-grantees having their own PMP has not been an emphasis of the STEPS OVC program.

M&E Forms

1. Visitation Form (Annex 2): STEPS OVC has 13 M&E forms (Table 2 on page 7). While many of the forms depend on the caregiver to fill them out, the visitation form is filled out most frequently. The form records all the services provided for a single client. The same form can be used for a child or adult beneficiary. The visitation form is in English and was designed to

be filled out after every visit and submitted monthly; however, most caregivers and program staff reported that it is filled out monthly before they are required to submit it. The visitation form has a provision for information to be entered on the same form for up to three visits. The blank forms



M&E Officer holding copies of the books of visitation forms and the Profile Update Forming

are in a large booklet; the width and height are A3 paper size—11.7" x 16.5" or 297cm x 420cm. However, the size allows for all fields to be visible on a single sheet. A duplicate sheet stays in the booklet so that the caregiver has a copy. (In the past, photocopies of the forms had

Table 2—Summary of data collection forms

Data collection form	Who fills it out	Frequency of collection	Unit of collection
Visitation form	Caregiver	Monthly	Beneficiary
Referral form	Caregiver	As needed	Beneficiary
Caregiver Registration Form	Site Coordinator	One time, at enrollment into STEPS OVC program	Caregiver
BCS Registration Form	Caregiver	One time, at enrollment into STEPS OVC program	BCS Beneficiary
OVC Registration Form	Caregiver	One time, at enrollment into STEPS OVC program	OVC Beneficiary
Profile update form	Caregiver	One time, currently ongoing to update information	Beneficiary
Child Status Index	Caregiver	Every 3–6 months to check status	OVC Beneficiary
Community Outreach form	Caregiver, Program Manager	As conducted	Numbers reached by service
Distribution form	Caregiver, Program Manager	As distributed	Numbers commodity distributed (e.g., gifts in kind)
Caregiver Registration form	Program Manager	At enrollment into STEPS OVC program	Caregiver
Training or Workshop Reporting form	Program Manager	As conducted	Number trainees by type of training
Organization Capacity Building Assessment Reporting form	Partner	Initial assessment with new sub-grantees and re-applied to assess growth over time	CBO/sub-grantee
Public Private Partnership reporting form	Partner	As agreements with private partners are made (documented in Memorandum of Understanding)	Private sector partner

to be made.) Monthly, the top sheet is torn off and given to the site coordinator, who then submits it to a proximate data entry point for entry. For some sites that are far from a data entry point, staff agree to meet the site coordinator and collect the forms. Copies of the top sheet are stored at the point of data entry, which can be the sub-grantee office or partner office.

There are two main reasons why most caregivers do not carry the booklet. One is that some caregivers have to travel long distances to meet up with clients, and caregivers report that carrying the booklet can be unwieldy (though this could be remedied by providing them a bag for carrying the booklet). The second, and primary reason that they do not carry the booklet is because of the negative reaction it often provokes from beneficiaries and the community. Many respondents noted that the beneficiaries complained that “all they [the caregivers] do is talk,” and they don’t bring any tangible items, like food or soap, as they used to in

the past. Some caregivers reported that some clients complained that if the project has resources to buy these books, they should have resources to give them tangible items. The booklet also could put the clients at risk of being known in the community as HIV-positive.

Instead, caregivers carry small notebook in which they write down beneficiaries they have visited and what services they provided. Then, back at home, they transfer this information to the booklet. Respondents reported transferring the data to the booklets once per month, although some did report doing it more frequently or right after the visit. Filling in the forms was not very time consuming; most respondents reported spending 3–5 minutes filling in the form. Some caregivers spent more time writing, due to slow writing speeds, or because they needed help filling in the report. Many caregivers are English illiterate; STEPS OVC records show that 26 percent of caregivers cannot read or write in English. All caregivers we spoke with

reported getting or giving help to fill in the forms. They had another opportunity to get help filling in visitation form through regular monthly or weekly meetings with the site coordinators.

2. Referral form: STEPS OVC has a form that caregivers fill out when they need to refer their beneficiaries for other services, both clinical and social, not offered by the caregiver. We heard a wide range of reports about the use of the referral form; many caregivers reported that they rarely or had never used the referral form, or did not have it. On the other hand, we heard from two sub-grantee organization representatives that they had no problem with the referral forms. The caregivers who also volunteered at the health facilities reported more successes with referrals and the referral forms because they were known at the facility and could also access the registers to find out what services the beneficiaries received.

Among those caregivers who report low or no use, the main reason was related to the fact that the referral health facilities did not accept the STEPS OVC referral form because the government clinics have their own referral form. Similarly, there were reports that the referral form did not bring any advantages to the clients who reached the health facility; they were treated just like any other client, including having to wait for services or re-submit to procedures, e.g., HIV test, that they had already received from the caregiver.

For caregivers who used the referral form, this would count in the M&E system as a “referral made.” The referral form must be returned to STEPS OVC for the referral to be counted as a “referral completed.” We heard that even when the referral form was used, it rarely was returned to be counted. There is likely major underreporting of referrals and services received in the STEPS OVC program.

In some cases, referral form use was more successful following sensitization activities at the health facility. For example, one organization raised the issue of health care centers not accepting the referral form at the district stakeholders meeting. After this, clinic health workers started accepting their clients. In another

instance, one sub-grantee reported asking STEPS OVC to write a letter to take to the clinics in their area to facilitate referrals from the STEPS OVC caregivers. One partner reported that when they raised the lack of use of the STEPS OVC form up at the District Development Coordination Committee (DDCC) meeting, they had a positive response from the government. However, the government official still wanted them to use the government form. This respondent noted the need to harmonize the two forms to “we all get what we need.”

Q: What has worked well [with the referral form]?

A: The form helps to guide the caregiver to refer their clients to other institutions/partners to get services they need that STEPS OVC is not able to provide.

Q: What has not worked well?

A: Government health centers have their own referral system and forms. They refuse to use and sign on our form because it is not their form they say.

Q: How this is being addressed?

A: We have brought this up in District Development Coordination Committees where all district government, NGOs and other development partners meet to discuss and plan for district activities. And we have had good response from the government since they track what we are doing through the SARF reports ... But they want us all to be using the government referral forms ... we have brought this up to the attention of PMU.

Another respondent noted that in another province, a large project implementing HIV programs had successfully negotiated with the provincial government official to modify the referral form to meet the needs of both the government and implementing partner. The main differences between the government and STEPS OVC referral forms is that the government form does not have a counter referral option and is limited in the details about why the client is referred (leaving it to the client to explain).

Reports, however, suggest that referrals may work better with other non-health facility referral points. Several organizations reported being able to use the referral form with the Department of Social Welfare, and

that they would get the referral form back. The DSW provides services such as school fees and uniforms. There were also reports of successful referrals to the Community Development Department for farming inputs such as fertilizer and the District Education Board for education support.

On the other hand, there were several reports from caregivers that they did not know about any referral points or resources or some referral points are slow (e.g., government) or full (“we have our own clients”). Finally, referral for certain situations, such as child abuse, was challenging because people were often unwilling to come forward to provide evidence of the problem.

3. Other STEPS OVC forms: At the beginning of the STEPS OVC project, community caregivers filled out a registration form to enroll clients in the program. That form is no longer used. However, after several years of providing services, there is a need to update the beneficiaries’ information. The visitation form does not regularly collect information on certain variables, such as household income or existence of birth registration. STEPS OVC recently introduced a Profile Update Form to obtain and update beneficiary information. Caregivers will also collect these data, although the form had not been fully rolled out to the caregiver level at the time of the study. This information will also be entered directly into the CoPIS database.

There were also reports of the Child Status Index form, but implementation was not systematic across respondents, as its use requires training. Those who used it reported administering it once or twice a year to get information on the child’s well-being and to understand what services the child needs. There were reports that the CSI had been rolled out by other HIV implementing partners (e.g., FHI 360), and that technical assistance in the use of the CSI had been provided to government agencies such as the Ministry of Gender.

4. Forms external to the STEPS OVC program: There were few non-STEPS OVC data reporting forms; the exception is that partners filled out the SARF (described above). Organizations, particularly at the partner level and above, received funding from other donors for

other programs. However, within the organizations, those programs were implemented vertically. In other words, a particular organization dedicated its staff to the STEPS OVC M&E, program, and finance activities. Those staff did not work on projects outside of STEPS OVC and therefore did not have additional reporting responsibilities or forms to complete. For organizational-specific reporting requirements (e.g., annual reports or narratives), they relied on the data collected by the STEPS OVC program.

Some sub-grantees asked caregivers to fill out timesheets to track their donated time. This information would be used for the sub-grantee internal purposes, external from STEPS OVC.

We did not find that caregivers worked on other projects, with the exception of some also volunteered at the health facility. According to one caregiver:

I am a trained PMTCT [prevention of mother to child transmission] lay counselor and HBC [home-based care] at same time. I do make follow ups in community, and there are those that are enrolled under [CBO] and those mothers that I follow in the community for [name] clinic, those breastfeeding moms ... For HBC I follow those enrolled to make sure they don't miss appointments at the clinic and to make sure there is not a problem with adherence. I am a volunteer at [clinic]. I don't work for other organizations. I am a caregiver with [CBO]. I provide care for other clients who are not PMTCT clients.

Advantages and disadvantages of the forms

There are reports of some aspects of data collection forms being confusing for community caregivers and of some inconsistencies with how caregivers report information. Reports focus on the visitation form because it is the most frequently used by caregivers. We have summarized those issues in this section.

Inaccurate reports from beneficiaries: Respondents reported that beneficiaries do not want to disclose how much money they spend annually or they hold back on reporting how much money they make because they think they will not be able to get support from STEPS OVC. (*Registration and Profile update forms*)

[The challenge with the profile update form is] the [HIV] status is withheld and clients are not willing to disclose how much money they spend annually and sometimes the caregivers are not able to calculate this accurately. Clients think if they portray a true picture of their household income they will not be able to receive tangible support from our project, which is not the mandate for STEPS OVC. For instance, clients who own cattle do not declare them. They instead tell the caregivers that they have nothing.” (M&E Officer, Partner level).

In general, some community caregivers reported that it was hard to get information from OVC because they do not “open up,” which affected both completing the forms and providing services. Caregivers wanted training in counseling techniques for this reason.

Lack of understanding of form concepts or structure:

Several examples of this were reported:

- There were reports of some caregivers who do not understand the “single” or “double” orphan concept. (*Registration and Profile update forms*)
- On the visitation form, the words “paralegal” and “household dialogue” could be misunderstood.
- Caregivers reported confusion with having OVC and BCS on the same form. For example, why have an element about “review of under-5 card” if it doesn’t apply for adults? Similarly, “couples counseling” does not apply to children.
- There is an element that asks whether the caregiver referred the beneficiary to a kids club or post-test club, if needed. Caregivers wanted more explanation about what to do if there were no clubs to refer to.
- “Other protection/legal service” is too vague.
- One item requires caregivers to report the response disaggregated by age (10–14 years vs. 15 years and older), and some caregivers found this confusing and could not disaggregate.

Inconsistencies with what is reported/counted:

Respondents reported instances where caregivers understood visitation form items to mean different things. For example, the form provides space to tick on nutritional counseling. There were reports that some caregivers did not understand that counseling about where local food sources are is actually a nutrition

service and could be counted as such. Part of the challenge is that some of the counseling and services that community caregivers provide do not rise to the level of importance to be marked on the form (or they didn’t know where to mark it). For example, encouraging kids to go to school can be ticked under “school performance monitoring.” There was confusion about what gets counted in “Other Care and/or Shelter Service.” Some only interpreted construction of a house as “shelter” and did not count efforts to improve or renovate an existing shelter.

“We do not give them anything so it is hard to approach our clients and assess them on these questions”:

There are several instances of where the question asks about material goods, which caregivers do not provide or provide no longer. A history of provision of tangibles has left expectations. Community caregivers reported that this is very awkward with the clients. For example, there are two elements about nutrition counseling and services, and caregivers felt this implies that food should actually be given. Similarly, caregivers complained that there is nothing to give and did not think elements on the visitation form about provision of basic materials (e.g., blankets), education materials (e.g., uniforms, books), school fees, and soap should be included.

Data Flow

Caregivers submit forms monthly to the sub-grantee program officer or site coordinator. The program officer or site coordinator reviews forms and gives them to the M&E officer, who may or may not be onsite. STEPS OVC estimates that the average data entry clerk can enter up to 150 visitation forms per day, although not all data entry clerks are required to meet this target. The actual target for performance-based contracts is negotiated and the 150 per day serves as a benchmark. The M&E officer submits the forms to the data entry clerk or the M&E officer, and they enter data into CoPIS.

Most organizations, both partner and sub-grantees, reported weekly meetings between program and M&E staff to review the data, discuss what has been accomplished, and discuss what their upcoming plans

are. (Although caregivers submit forms monthly, data are continuously being entered in to CoPIS). The M&E officer is there to give updates on how well the program is meeting targets or what needs for training might be. Program staff then use this information to plan how to accelerate toward targets.

Less frequently, about monthly, the sub-grantee organizations and caregivers meet to discuss activities carried out compared with what is reported, and strategies to meet targets. This is also an opportunity for caregivers to ask questions about things they may not understand or discuss and get help on problems that they are facing.

Narrative reports are also prepared. Sub-grantees submit monthly narrative reports to partners. At the partner level, the M&E officer reports monthly and quarterly up to his/her organizational management. The partner M&E officer prepares a quarterly narrative report which is submitted to PMU.

Data Quality Mechanisms

An important aspect of quality control is capacity building and training. STEPS OVC offers a robust series of training, refresher trainings, and cascade trainings. Trainings are standardized using existing curricula. Trainings are reinforced by onsite mentoring and coaching activities.

Other quality control mechanisms start at the sub-grantee level with the site coordinator/program manager, who reviews the forms submitted by caregivers. Those not filled out properly are sent back to the caregiver. After the program managers signed off, they submit the forms to the data entry clerk, who also reviews them at his/her level before beginning data entry. The entered form is kept at the sub-grantee level for reference (or at the partner office, depending on where data entry takes place). After partners submit their reports, PMU provides feedback to partners on their reports. Additionally, PMU generates weekly performance reports for all partners that are discussed at PMU but also shared with the partners. Finally, STEPS

OVC M&E staff from PMU will visit sub-grantees to provide M&E assistance. Partners and PMU M&E staff conduct data quality assessments.

Routine data quality assessments (RDQA) and Community Trace and Verify (CTV), and sometimes just Trace and Verify (T&V), are all carried out to improve data quality. The site coordinator/program manager with the M&E/data entry person randomly selects clients from visitation reports and then conducts home-based monitoring. One partner reported going to the home without the caregiver to verify whether the services were actually provided. At the community level they verify the information on the visitation forms and the data in the database. If a minimum of six forms do not match the data in the database (reported by one partner), they go back to the hard copy forms and re-enter data. If the client information is not correct, then the data are discarded and they clarify with the caregiver. For T&V at the partner level, they assess the data entered by drawing 19 forms from each caregiver to check that the data are accurate.

Data Management and Analysis

Storage

Uploaded data are stored on a central server, but the system can be accessed from any computer with Internet access. Even when there is no Internet connection, data can be entered and uploaded to the server at a later time. After data are uploaded, the M&E officer or M&E assistant makes a back-up for the system and stores it on three media files: one on the computer, one on M&E officer's external hard drive, and one on M&E assistant's external hard drive.

Databases

The main database is the CoPIS system, and it archives the data from the caregiver visitation form and the 12 other forms. The system is prepopulated; one does not have to re-enter static information every time, such as the beneficiary's name. A prepopulated system reduces data entry burden, data entry errors, and double counting.

We had a data management and reporting system that was Excel-based. It had a lot of errors and we were not able to address double counting. But with CoPIS all these errors are gone. You cannot enter the same name or National Registration Card number, the system rejects this. It gives us specific codes that are unique, unique identifiers, that can't be tampered with.

—(M&E Officer, Partner level)

Those interviewed indicated that they have sufficient capacity to use CoPIS. The database entry is a mirror image of the form. Most data entry clerks have 12 years of schooling and can read and write. Where sub-grantees are not entering their own forms into the database, it is because they are new sub-grantees under the STEPS OVC extension, and they do not yet have the inputs in place (data entry clerk, computer, file room) to conduct data entry.

Since its implementation in 2011, the CoPIS system keeps evolving and improving. It is now on version 1.18. Respondents did not see the relatively frequent changes in versions as a problem. Respondents felt that changes and updates to the form and the database yielded improvements and efficiencies in the visitation form. Respondents reported timely and clear communication from PMU about changes, and they said that M&E staff at PMU are available and willing to help troubleshoot and provide assistance. One of the improved CoPIS features is the search function. In the past, each search related to a single caregiver had to be done one at a time from the home page. Now one can search by caregiver name, and all information for that caregiver comes up and can be stratified by type of client, BCS, or OVC. Another improvement is the expansion of the economic strengthening intervention field to reflect more intense programming in that area in response to the new OVC guidance issued by USAID in 2012.

Security and Confidentiality

Caregivers were clear and unanimous in their declaration that they did not share information about their clients with anyone. Caregivers gave examples of how they would not disclose their clients' information to anyone, not even another family member, unless they had the permission of the client. The only exception is



Variation in organization of file storage

the site coordinator and M&E assistant who review the forms the caregiver fill out: They see the clients' name associated with services. However, all staff sign a code of conduct promising to protect clients' confidentiality.

Visitation forms that have been entered into the database are stored in a folder in the partner or sub-grantee's M&E office. Some storage areas were more organized than others (photos).

The database is password protected, and only the M&E staff can access it and enter data and see data associated with a particular beneficiary or caregiver. Although all partners and sub-grantees are entering data into the same database, each individual sub-grantee can only access the data for his/her beneficiaries. At the partner level, an individual partner can access the data for all of his/her sub-grantees, but not other partners'. The only people who can access the entire database are the M&E staff at PMU.

The database is also set up to protect confidentiality during analysis. For example, one cannot run a cross tabulation between names and HIV status.

Analysis

The CoPIS database automates data analysis and reports. It is possible to conduct analysis from any computer with an Internet connection. Analyses are conducted to generate regular progress reports toward reaching target indicators and to track progress of data entry at the site level. CoPIS has preset indicator analyses; 50 customizable indicators can be analyzed at the data entry site level. It is also possible to conduct secondary analyses to answer questions that are not part of the automated analysis, even at the sub-grantee level.

It is the job of the data entry clerk to analyze the information. The data entry clerk analyzes the data and helps the organization know if they are making progress. We can have the report printed and we sit with the caregivers and those that have not done their work. For example, we find out how many clients have not been visited. So [we] receive the name and numbers and print out the report and give it to the caregiver to visit them.

—(Data entry clerk, sub-grantee level)

The advantage of automated analyses is that it ensures that indicators are standardized across partners and reduces differences in measurement across partners. For example, the caregiver must touch on six elements to count that someone has been reached with prevention-with-positives (PWP) counseling. The CoPIS system will not allow PWP counseling to be counted as such unless all six elements have been entered.

CoPIS facilitates data analysis and reporting. For example, USAID requires 17 indicator results to be disaggregated by the ward level, and there are 1,006 wards. The system automatically generates an individual report for each indicator disaggregated by ward.

Because data entry clerks upload data at the sub-grantee or partner level on a daily basis, it is possible to have almost real-time information about beneficiaries reached and services provided. This allows for timely decisions in response to this information. For example, if a new strategy is being implemented, such as training a cadre of caregivers to counsel on PWP, supervisors can check to see if there are problems with rolling out the program element (e.g., trained caregivers not providing the new service to people living with HIV) or with reporting on it (e.g., ticking some, but not all, of the counseling elements). Because local sites control their own data, they can use the information to identify problems with program implementation and discuss with caregivers why they are not providing services they are trained in or why are they not providing referrals, and then they can look for solutions. Even at that level, they can make first-hand decisions about issues and response.

Data Use

The primary use of data is, of course, reporting to the donor, USAID. Within the project, however, there appears to be a strong data use cycle, although several sub-grantees reported never being formally trained to use the information generated by caregivers. One partner did report training sub-grantees on data use to help them to understand at what point the data can be used to help their caregiving.

Despite few reports of formal training, many respondents reported how the data that caregivers collected on the visitation forms helped caregivers do their jobs. Caregivers use the information to:

- identify clients that need to be visited,
- remember what services clients need,
- track beneficiaries' progress by month to know if s/he recovered if s/he was ill, and
- refer clients for additional care, such as hospital care for malnourished clients or to get a wheelchair from social welfare.

For example, one caregiver reported using the information obtained from the client, who was defaulting on medication, to refer the client to the health center for adherence counseling:

Some time we visit our clients you find someone he doesn't take meds at the right time or in one week he doesn't take meds. I encourage him and take him to the hospital. I have to see that he was given the medicine ... I go and stand for him and he is well treated thereafter.

In another situation, during a regular monthly meeting, caregivers were discussing data and the site coordinator learned that there was a malaria outbreak. The site coordinator reported this to the health center and to the water and sewerage company. They were able to get insecticide-treated bed nets from the health facility as a result of this report.

Data collected by the caregivers is used at higher levels to decide what trainings and interventions are needed. Caregivers cannot provide services in a particular area (and thus collect data on that area) until they are trained. Examples of how data are used to inform trainings include:

- Data suggested that many clients have not received prevention with positives counseling. In response, the partner or sub-grantee organized a training in PWP counseling so the caregivers would be able to provide this service.
- Data revealed that caregivers reported providing services in areas they hadn't been trained in, indicating a problem with completing the visitation form and/or misunderstanding on the part of the

caregivers. In response, the M&E officer conducted a supervision visit with caregivers to make corrections to completed forms and conduct a refresher on how to correctly complete the form.

- Data showed many beneficiaries with unknown HIV status. In response, the sub-grantee respondent organized a training for site coordinators and caregivers to do HIV counseling and testing.
- Data revealed many new malaria cases in the community. Caregivers were not trained in how to manage malaria, so a training was arranged to this end.
- Data revealed that many children were not protected in terms of shelter and that they needed educational support. The partner program coordinator worked to create linkages with outside services once they knew about these problems.

Partners also use the data to know how many beneficiaries have been visited and whether the sub-grantee is on track to meet targets. The data are used to identify clients who have not been visited and the program manager can make sure that a caregiver is assigned to visit the household. Assessing progress toward targets can also inform programming. Where organizations are underachieving in meeting their targets, they will revise their direction and strategy to meet the targets.

PMU and partners also use data to develop action plans, including informing resource allocation based on the number of beneficiaries or to support rollout of trainings and programs where gaps have been identified. In many instances, program and M&E staff report reviewing data together. For example, one sub-grantee documented a large alcohol abuse problem, so they informed the partner, made program plans to address the issue, and subsequently obtained funding to address alcohol abuse. In another example, one sub-grantee said knowing the number of beneficiaries helped the partner plan the budget for school fees.

Some organizations report being able to use the data they have collected from STEPS OVC to procure non-STEPS OVC funding for programs. Although more limited, there are reports of using data for advocacy

with the government. One example that was reported several times was how the data picked up a lack of birth registration among OVC beneficiaries. This information was used to successfully advocate with the government to decentralize the birth registration process from the capital, Lusaka, to those areas. Another example is that caregivers reported an outbreak of dysentery, then together lobbied the Society for Family Health to give chlorine to distribute to households.

Sub-grantees reported using aggregated data at the district level at a stakeholder meeting that included the District Health Officer (DHO), District AIDS Coordination Advisor (DACA), District Agriculture Coordinating Office (DACO), Social Welfare Department, and the District Commissioner. This allowed the sub-grantee to advocate for those partners to provide support where needed. One sub-grantee reported lobbying the DACO for food security inputs for small-scale farmer beneficiaries and the DHO for home-based care kits and supplies such as painkillers, vitamin supplements, and gloves.

Successes

The maturity of the program has brought with it clear channels of communication and responsibility, standardized M&E trainings, a functioning database, and common data collection forms. Training and technical assistance over time have resulted in strong capacity among partners to manage their own M&E systems and to roll out trainings to lower levels. Organizations have been able to use data to procure other funding, and data have been used for advocacy with government (e.g., civil registration).

There is an institutionalized data use cycle where M&E, programs, and finance staff are working together at all levels to make decisions. The available data help partners, sub-grantees, and caregivers know what beneficiaries need to be visited and what services are needed. Program managers and M&E staff know where more training is needed both in terms of implementing and documenting the program. M&E staff at the partner or PMU level can know almost in real time

where there are IT problems and where they need to intervene. Using data to identify programmatic weaknesses also informs where finances need to be moved to support programs.

District-level structures and committees appear to function well, facilitating communication between the STEPS OVC partners and sub-grantee organizations. Data from STEPS OVC is used to facilitate these interactions as well. There were documented reports of instances where data from STEPS OVC allowed the district committees to advocate for social support and health services, which they subsequently received. Similarly, relationships between the district government entities and the STEPS OVC organizations facilitated linkages to needed services for clients.

Challenges

There was much concern at the partner level and higher about the burden on community caregivers to collect data. However, caregivers themselves generally did not express this to be a burden. Their perception may be in part due to the effort that has taken place over time to reduce the number of data collection forms, to facilitate the ease of collection by just requiring a “tick” for service provided, and the routine training and orientation of caregivers. There are concerns from caregivers, however, about the time needed to help caregivers who were not English literate and with some fields on the visitation form. Also, it was clear that the referral form was very likely underreporting referrals made and received.

Although caregivers were very committed to their clients, they faced several challenges to doing their jobs, including far distances to travel, lack of tangible items to offer clients, and lack of items to support their work such as bicycles or bags. These challenges are similar to those found by Price and colleagues.⁴ Further, with their clients being ambulatory, community caregivers’ previous palliative duties of cooking, cleaning, and

4) Price J, Moyo T, Topp S, et al. *Motivations for Entering Volunteer Service and Factors Affecting Productivity: A Mixed Methods Survey of STEPS OVC Volunteer HIV Caregivers in Zambia*. Lusaka, Zambia: USAID, 2013.

caring for the bedridden client were not needed. At times, caregivers did not ask about certain aspects that are on the visitation form if they felt that the questioning would imply that they provide a service (e.g., referral) or product (e.g., soap) that they did not have. We did hear more strongly than that what appears to be the case in Price and colleagues' work⁵ that caregivers felt that a major barrier to their ability collect and report data was their other life obligations. One respondent reported that caregiver visitation forms were late when the caregiver had to tend to his/her other responsibilities such as during harvest time. Because caregivers are volunteers, they have no financial incentive to return reports on time.

To some extent, the issues of misinterpretation of data fields and lack of timely or complete reporting will affect any data collection effort regardless of the simplicity or complexity of the form and the skills of the person collecting the data. Because of the qualitative nature of this study, it is not possible to quantify the problems related to data quality, timeliness, and accuracy.

The data collection forms do not collect information about the quality of the service provided, and this is not the intent of the current routine data collection system. Nonetheless, some respondents wanted more information about quality of the services. With the data that are collected, it is possible to know what services clients have received (coverage) and how often (intensity), but there is no information about the quality of services or counseling provided.

Because STEPS OVC is not currently enrolling new beneficiaries, many caregivers reported having to turn away other people who needed services but were not enrolled in STEPS OVC. Nonetheless, many caregivers reported that they provided services for non-STEPS OVC community members, made referrals, and generally used their skills to benefit members of the community who were not enrolled in the program.

Stop-gap measures are in place to deal with Internet outages, computer malfunctions, and software bugs. In the case of software glitches, the staff at PMU are notified to deal with the issue and software updates sent out. In the case of Internet outages, data can still be entered and uploaded at a later time.

Several partner-level and higher respondents were concerned about the report writing and data interpretation skills of their sub-grantee partners. They felt that the data and data infrastructure were in place, but some sub-grantee partners lack the skill to write the accompanying narrative reports. In fact, during organization capacity assessments conducted by STEPS OVC, M&E was identified as the most common area of weakness.

It was hard to understand who at the national level had ultimate authority for OVC M&E data. Although the NAC's SARF was widely known and used, the responsibility of the NAC at the national level was largely coordination. Responsibilities for OVC were spread across different ministries, with no clear lead. Within the U.S. government agencies, PEPFAR provided some coordination of programs, and there is a USG agencies' Care and Support Technical Working Group. National-level respondents were concerned about the lack of ownership for the program from the government side.

Considerations for Country Ownership

The STEPS OVC M&E system in Zambia is characterized by a strong technical lead at the central level. The coordination provided has resulted in standardized data collection forms, electronic data entry and analysis, indicators, trainings, communication mechanisms, and quality control checks. The approach is increasingly building capacity at more decentralized levels of service provision and M&E. While capacity among Zambians and by Zambian organizations is necessary for country ownership of the M&E systems, similarly strong leadership at the national level will be required.

⁵) However, it is difficult to rigorously compare the two works based on their very different study methodologies.

The coordination mechanisms are in place at the district level through the DATF and DDCC mechanisms to understand progress in reaching OVC and people living with HIV with services, what services they need, and to allocate resources and avoid duplication. It was outside the scope of this study to assess the extent to which these coordinating mechanisms (e.g., regular meetings, reports, work plans) function as intended; thus the strength and effectiveness of the system is not known. Certainly the effectiveness of the system is undermined if not all of the organizations are reporting into the system, which some respondents reported to be the case.

At the national level, the current challenge is that no one ministry has been identified as being responsible for OVC programming and M&E. Rather, responsibilities are spread across different ministries. While this may increase the likelihood of access to a wider range of social services, it will undermine planning and resource mobilization in the near term.

Conclusion

Community-based information systems are developed to ensure consistent monitoring of services provided by community based caregivers. Decentralized systems also offer an opportunity to build capacity at lower levels to collect and use data to guide programs and increase program reach. This case study suggests that information about which clients need any services, which clients need what services, and whether clients' well-being is improving over time tend to be the most useful for community caregivers, based on the data being collected.

Data collected from the decentralized STEPS OVC system are used at all levels, from the community caregiver to the sub-grantee to the partner and to PMU. Most of the data are used for program planning and to ensure that targets are being met. A routine monitoring

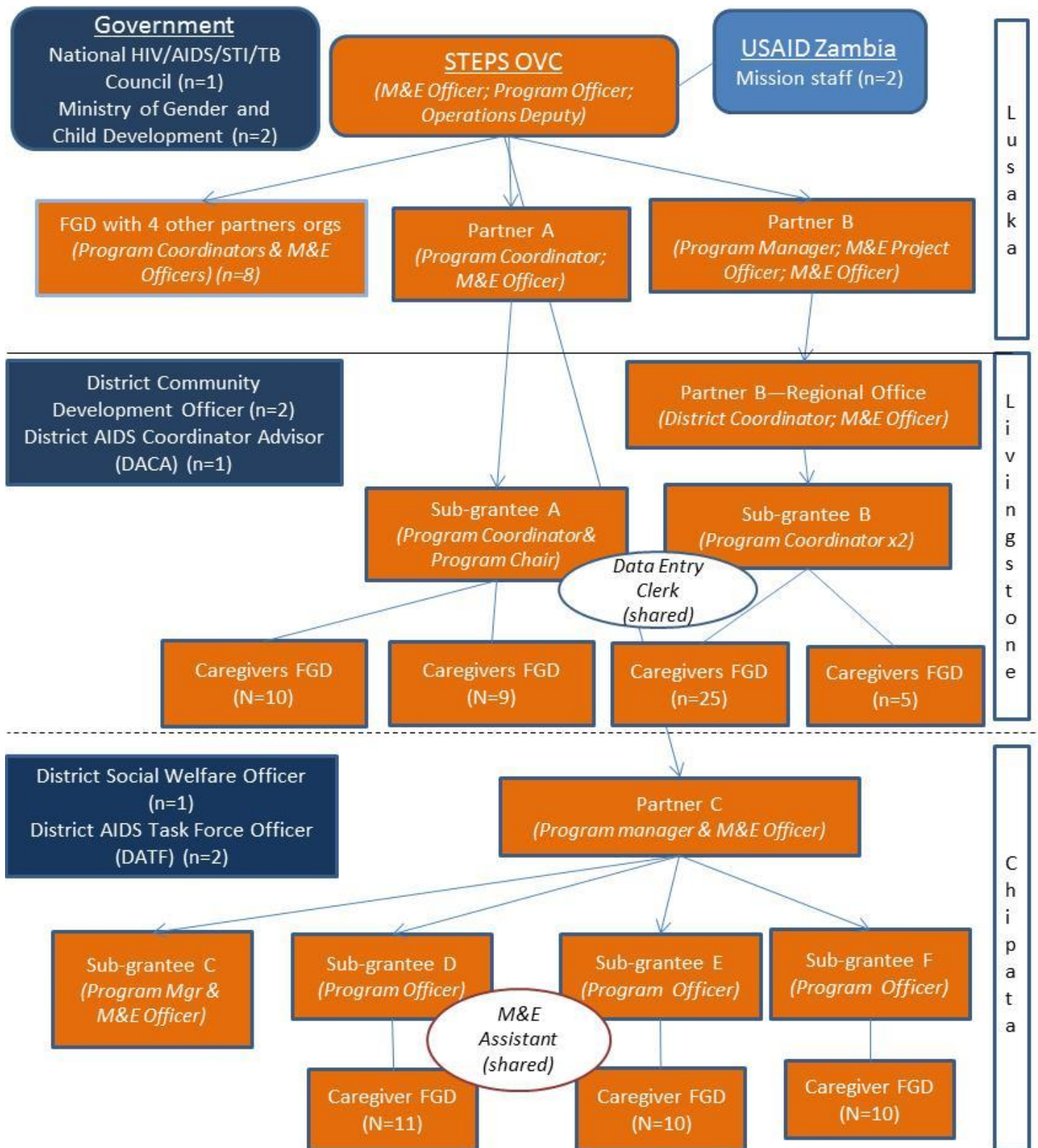
system is not the right data source to collect information about service quality, and currently information about service quality is missing.

With time, decentralized electronic data collection systems can be developed that will consistently collect and enter data with little delay, facilitating timely analysis and use of data. The largest responsibility for timely and accurate data, however, rests with the community caregiver who at times may not fill out forms correctly, underreport services provided, and turn in forms late (or not at all), depending on their other life circumstances.

In the Zambia case, data measuring service quality, referrals made, and referrals completed were lacking. A routine monitoring system is not the best source for quality of service data; thus, another source, such as periodic surveys, should be sought. To facilitate referrals, activities to improve coordination between partners is needed. One option is to map the organizational networks of partners working in a particular district, mapping where they work and what services to provide, and including social and other sectors in addition to health. Stakeholder meetings will be necessary to share this information and to identify mechanisms to strengthen linkages, as well as to reach agreement on forms that can be used to document referrals made and completed.

This case study from Zambia, when combined with other findings from Kenya and Tanzania, will yield insights into information systems for community-based programs. These findings will be available in a separate report and will discuss different models of community-based M&E systems; how they are developed; what indicators are the most useful at the community level; how data are used; successful strategies for collecting, storing, and analyzing data; strategies for building capacity for M&E; and the effect of changes, either externally or internally driven, to the system.

Appendix 1—Case Study Design and Flow Chart



Appendix 2—Caregiver Visitation Form

Caregiver Visitation Report

Instructions

1. Community Caregiver must complete a Caregiver Visitation Report at every home visit.
2. One Report must be completed for each beneficiary, even if Caregiver is visiting multiple beneficiaries in one household.
3. Fill in different dates of visit if more than one visit to a household is conducted before submitting the form to the site coordinator.

A. Basic information

1. District		2. Constituency			
3. Ward		4. Village/Compound			
5. Site/CCC		STEPS Partner		6. Caregiver Organisation	
7. Community Caregiver's Name [Surname in BLOCK LETTERS, first and middle name]					
8. Caregiver Code		9. Date of Visit (dd/mm/yyyy)	1 st Visit	2 nd Visit	3 rd Visit
10. Beneficiary's Name [Surname in BLOCK LETTERS, first and middle name]					
11. Beneficiary's Date of Birth (dd/mm/yyyy)		NRC of Head of Household			
12. Beneficiary Code:			Sex		

B. Functional status of beneficiary

Assess beneficiary's functional status on day of home visit and circle either "good", "fair" or "bad".

13. What is the functional status of the beneficiary today? Note: This field must be completed ALWAYS	
Good	Able to carry out normal activity and to work, no special care needed
Fair	Unable to work / play, able to live at home and care for most personal needs, some assistance needed
Bad	Unable to care for self, requires equivalent of institutional or hospital care, disease is progressing rapidly

C. Services provided to beneficiary

Tick all services provided to beneficiary on day of home visit. Where service are received from other organisation, please list them in the comments

Service		Tick if provided	Details / Comments
Health	14. Health assessment		
	15. *ART adherence assessment / counseling		
	16. Pain assessment Ask beneficiary to rate pain from 1-5. Circle response		Low pain----- High pain 1 2 3 4 5
	17. *Sexual activity assessment Provide risk reduction counseling, condoms, if needed		
	18. *Assessment for sexually transmitted infections Refer for STI treatment, if needed		
	19. *Assessment of HIV status of household members Provide/refer for testing, if needed		
	20. HIV prevention education		
	21. *Family planning needs assessment Refer for family planning services, if needed		
	22. Malaria prevention education		
	23. Other health or health education service		
Psychosocial	24. Psychosocial counseling and/or Spiritual support and/or prayer		
	25. *Needs assessment for community support Refer to kids club, or post-test-club, if needed		
	26. Other psychosocial service		

Site Coordinator Signature _____ Date _____ Data electronically entered by: _____ Date: _____

Food & Nutrition	27. Review of Under 5 card			
	28. Mid-upper arm circumference		5.5-12.4 cms [Red]	
			12.5-13.4 cms [Yellow]	
			13.5-25.5 cms [Green]	
29. Nutritional counseling				
30. Other food and/or nutrition service				
Care & Shelter	31. Provision of basic materials (blankets, etc.)			
	32. Other care and/or shelter service			
Education & Training	33. Provision of education materials (uniform, books)			
	34. School performance monitoring			
	35. Other Education/Vocational Training service			
Protection & Legal Support	36. Abuse assessment: child abuse, gender-based violence (Refer if needed)			
	37. Birth registration support			
	38. Paralegal support (wills, succession planning)			
	39. Other Protection/Legal service			
ES	40. Economic Strengthening service (any)	a. SILC		
		b. Selection Planning & Mgt.		
		c. Agriculture e.g. gardens, small livestock, market links		
		d. Others		
Other	41. Household dialogue	a) General		
		b) Prevention with Positives		
	42. Couples counselling			
	43. Alcohol counselling			
	44. Other: specify			

D. Services provided to household members of beneficiary

45. Did you provide any HIV prevention information to any household member during this visit?	Yes	No	46. If yes- How many people did you give HIV prevention information to during this visit?		10-14 yrs	15 yrs and older
				Males		
				Females		
47. Did you provide HIV testing and give the individual their results during this visit?	Yes	No	48. If yes - How many household members did you test for HIV this visit, who received their results?		Less than 15	15 yrs and older
				Males		
				Females		
E. Checklist				HIV Test Result	Positive	
					Negative	
				Yes	No	Unknown
49.	Client has attended a community support group in <u>past 1 month</u>					
50.	The HIV+ beneficiary has a follow-up appointment at an HIV clinic at the health facility.					
51.	The OVC beneficiary is <u>currently</u> enrolled in school.					
52.	The OVC beneficiary received school fees from STEPS in the last 3 months.					
53.	The beneficiary slept under an insecticide-treated mosquito net <u>last night</u> .					
54.	All household members know their HIV status, including infants, children and adolescents.					
55.	Household has soap.					
Any other remarks about the beneficiary or household						

Site Coordinator Signature _____ Date _____ Data electronically entered by: _____ Date: _____