Community-Level Program Information Reporting for HIV/AIDS Programs

Introduction

MEASURE Evaluation is a MEASURE program project funded by the U.S. Agency for International Development (USAID) through Cooperative Agreement GHA-A-00-08-00003-00 and is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in partnership with Futures Group, ICF Macro, John Snow, Inc., Management Sciences for Health, and Tulane University. The authors' views expressed in this publication do not necessarily reflect the views of USAID or the United States government.

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Acknowledgments

CLPIR is presented as a "beta" version, a work in progress that continues to evolve based upon users' experiences. The current version has been shaped by stakeholder input and field testing in several countries and is a culmination of lessons learned from the review of community-level HIV programs and information systems from several countries.

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List of Acronyms

ART	antiretroviral therapy
BCC	behavior change communication
CBO	community-based organization
CLPIR	Community-Level Program Information Reporting for HIV/AIDS Programs
FBO	faith-based organization
HBC	home-based care
HMIS	health management information systems
M&E	monitoring and evaluation
MERG	Monitoring and Evaluation Reference Group
NGO	nongovernmental organization
OVC	orphans and vulnerable children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLWHA	people living with HIV/AIDS
STD	sexually transmitted disease
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	U.S. Agency for International Development

Background

The increased availability of funds, through programs such as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), has resulted in many community-level activities and programs that aim to prevent and mitigate the impact of HIV/AIDS in affected communities. Many of these activities, such as those that care for orphans and vulnerable children (OVC), promote preventive behaviors, and provide home-based care (HBC) to people living with HIV/AIDS (PLWHA) and their families, occur outside of health facilities, and often even outside of the health sector. As a result, facility-based health management information systems (HMIS) are usually not designed to capture information from these types of programs.

There is an urgent need to improve the quality of information and the information systems that generate data from community-level HIV/AIDS programs. Community-Level Program Information Reporting for HIV/AIDS Programs (CLPIR) was developed to address this need. The objective of CLPIR is to support harmonized monitoring and reporting systems that capture indicator data from community-level programs; systems that are essential for effective program management and decision-making, and that facilitate the reporting of high-quality program performance data to host country governments and donors.

A number of stakeholders involved in community-level HIV/AIDS programs in Kenya, Nigeria, Tanzania, Zambia, and the United States were consulted during the development of CLPIR. Early during the development process, field visits to community-level programs in Nigeria, Tanzania, and Zambia were conducted to talk to direct-service providers, to determine what information they considered useful in managing their programs. During this process, hundreds of existing indicators from service delivery programs, host country governments, and donor agencies were collected and reviewed. The indicators were then refined, consolidated into a manageable set, and reviewed by experts from a number of U.S.-based organizations. This body of information serves as the building block for CLPIR.

Intended Users

CLPIR contains a variety of resources to help engage country stakeholders at multiple levels (national, sub-national, service delivery) to address gaps in community-level HIV/AIDS information and to build harmonized monitoring and reporting systems:

- For ***community-level organizations***, the CLPIR tool kit contains indicators, indicator reference sheets, sample data collection forms, aggregation and reporting tools, and a curriculum for adapting these resources to design and implement a program monitoring system.
- For users at the ***national or sub-national level***, CLPIR contains tools and guidelines to conduct a rapid assessment of existing systems and harmonize community-level indicators.

- The tool kit also contains participatory process guides that help ***stakeholders at each level*** make use of the information, resource materials and tools to ultimately help improve data quality, foster ownership, and secure long-term sustainability for a harmonized monitoring and reporting systems. CLPIR is useful to host country governments, donors, multilateral organizations, and implementing organizations, including nongovernmental organizations (NGOs), faith-based organizations (FBOs), and community-based organizations (CBOs).

Some of the terms used in this tool kit need further clarification. Community-level HIV/AIDS programs are implemented in a variety of ways by implementing organizations that vary widely in their organizational, financial, and technical capacity. In this document, we use the term ***implementing partner*** to refer to organizations that have a comparatively high level of organizational, financial, and technical capacity to implement community-level HIV/AIDS programs. They may be providing services to communities directly or partnering with or managing grants to NGOs, FBOs, or CBOs to provide services to communities. We use the terms ***NGOs***, ***FBOs***, and ***CBOs*** to refer to local organizations that have less experience than "implementing partners" and a comparatively lower level of organizational, financial, and technical capacity. They may be funded directly by a donor, receiving donor funds through an implementing partner, managed by an implementing partner, or partnering with an implementing partner to deliver services to communities.

Strengthening National M&E Systems

The chronic nature of the HIV/AIDS epidemic and the magnitude and scale at which it has devastated countries has driven home the point that there are no quick fixes to this problem. It is now widely accepted by the HIV/AIDS community that long-term, sustainable solutions need

Three Ones: Principles for the Coordination of National AIDS Response

On 25 April 2004, the Joint United Nations Programme on HIV/AIDS, the United Kingdom, and the United States co-hosted a high-level meeting at which key donors reaffirmed their commitment to strengthening national AIDS responses led by the affected countries themselves.

They endorsed the "Three Ones" principles, to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management:

- One agreed-upon HIV/AIDS action framework that provides the basis for coordinating the work of all partners.
- One national AIDS coordinating authority, with a broad-based multisectoral mandate.
- One agreed-upon country-level monitoring and evaluation system.

to be implemented. This recognition led national governments, civil society, and development partners in 2004 to pledge to follow the principles of the "Three Ones" (described below) to support the coordinated planning, implementation, and monitoring and evaluation of one national response to the HIV/AIDS epidemic.

Part and parcel to strengthening a national response is strengthening the systems that monitor the national response. To do this, there has to be an agreed-upon vision for what constitutes a functional monitoring and evaluation (M&E) system, as well as an implementation strategy that works across multiple sectors, different service delivery areas, and multiple but interdependent levels of the health system. This is no doubt a complex process, but is essential for establishing sustainable solutions. In 2008, the Joint United Nations Programme on HIV/AIDS (UNAIDS) Monitoring and Evaluation Reference Group (MERG) endorsed an organizing framework for a functional national HIV/AIDS M&E system to help countries and development partners arrive at a common understanding of what constitutes such a system. The organizing framework presents 12 components of a national system, one of which is routine HIV program monitoring. The framework specifically acknowledges the challenge of establishing routine data collection and reporting from community-based HIV/AIDS services, but states that this information is essential for countries to coordinate service delivery and monitor the HIV response comprehensively. CLPIR addresses this challenge by providing the information, tools, and resources that countries need to collect routine program-monitoring data from community-level programs by supporting harmonized monitoring and reporting systems.

CLIPR Adaptability and Use at Various Levels and in Other Contexts

Although we make reference to building and supporting harmonized information systems for community-level HIV/AIDS programs throughout the CLPIR tool kit, we want to acknowledge that it is not always feasible to work at a national level and want to point out that the CLPIR can be equally useful in other contexts. With appropriate adaptation, the tool kit can be useful to sub-national and program-level users. For example, although the indicator harmonization component of CLIPR references harmonizing a national set of community-level HIV/AIDS indicators, the same process can also be applied to harmonize indicators at the sub-national (e.g., provincial) level or even within the context of a specific program. As another example, even though the CLPIR recommended indicators, indicator reference sheets, and generic data collection forms are part of the rollout component of the tool kit, these resources can also be utilized in a less structured way by community groups that want to improve the way they gather information and make informed decisions about their activities. Furthermore, the materials can be used by individual service providers who want to learn how to set up program performance targets and monitor their progress over time. As illustrated by these examples, CLPIR is adaptable to a number of contexts and can be applied outside the context of supporting a national system. Likewise, although the current version of CLPIR focuses on community-level HIV/AIDS programs, the overall processes detailed in the tool kit can be adapted and applied to other community-level health programs, such as maternal and child health, family planning, malaria, and tuberculosis programs.

Community-Level HIV/AIDS Programs

The CLPIR tools focus on the following program areas:

- prevention, including abstinence and be faithful and condom promotion;
- home-based care, including palliative care; and
- orphans and vulnerable children.

The definitions of these program areas (detailed in this document) correspond to PEPFAR definitions.

Prevention

Abstinence programs include those intended to delay the onset of sexual activity, as well as secondary abstinence, fidelity, partner reduction, and related social and community norms. Activities include:

- disseminating information about HIV transmission through mass media;
- creating adolescent awareness about abstinence until marriage;
- promoting abstinence and fidelity among youth and married men;
- training community leaders and peer educators on HIV prevention;
- promoting community norms advocating marital fidelity and partner reduction; and
- promoting community norms denouncing forced sexual activity.

Condom promotion and other types of prevention activities aim to reduce HIV transmission by promoting correct and consistent condom use, improving knowledge about sexually transmitted diseases (STDs), and producing messages aimed at reducing injection drug use and other high-risk behaviors.

Activities at the community level include:

- disseminating information about HIV transmission through mass media;
- distributing condoms and promoting their use, particularly among those at high risk for HIV infection;
- empowering women to negotiate condom use with their partners;
- encouraging injecting drug users to discontinue use;
- training community leaders and peer educators on HIV prevention; and
- working with local institutions to spread HIV/AIDS prevention messages.

Home-Based Care

Home-based care (HBC) includes home-based and community-based activities supporting HIV-infected adults or children, and their families, aimed at optimizing quality of life throughout the continuum of illness. Activities include symptom diagnosis and relief, psychological and spiritual support, and culturally appropriate end-of-life care.

Activities at the community level include:

- ❒ providing clients with nutrition, legal aid, and housing;
- ❒ helping those who are on antiretroviral therapy (ART) to adhere to regimens;
- ❒ training individuals to provide home-based care to HIV infected members of the community;
- ❒ conducting community mobilization meetings;
- ❒ training community leaders;
- ❒ monitoring medicine stocks;
- ❒ providing psychological and spiritual support services for HIV-infected individuals and their caregivers; and
- ❒ providing economic and social support for HIV-infected individuals and their families.

Orphans and Vulnerable Children

OVC activities aim to improve the lives of orphans and children made vulnerable by HIV/AIDS and their families. The PEPFAR definition of OVC applies to children 17 years of age or younger who are either orphaned (have lost one or both parents to HIV/AIDS) or are made more vulnerable because of HIV/AIDS. Children are more vulnerable if they:

- ❒ are HIV-positive;
- ❒ live without adequate adult support (e.g., in a household with chronically ill parents, a household that has experienced a recent death from chronic illness, a household headed by a grandparent, or a household headed by a child);
- ❒ lack family care (e.g., live in residential care or on the streets); or
- ❒ are marginalized, stigmatized, or discriminated against.

OVC programs aim to strengthen communities and families, and so help meet health, nutrition, education, income and psychosocial needs. Often, these needs are met by providing support to caregivers, helping children and adolescents meet their own needs, and creating a supportive social and policy environment through community engagement. Examples of OVC activities at the community level include:

- ❒ providing targeted food and nutrition support;

- providing shelter and protection;
- providing health care services;
- providing psychological support services for OVC;
- improving access to education for OVC;
- improving access to legal services for women and children;
- training caregivers at the individual and household level;
- training and supporting community leaders to promote care and support for OVC; and
- providing behavior change communication (BCC) materials to communities.

Integrated or Family-Centered Programs

While some programs are specialized to provide a particular type of service, other community-level programs provide a package of several services. Increasingly, programs are trying to provide integrated or family-centered services and care at the household level. This model of service delivery views the entire household as the target beneficiary, not just an individual client, and seeks to provide a holistic package of services to the household. If services are delivered through an integrated or family-centered model, program monitoring and evaluation also needs to reflect the integrated nature of the program. CLPIR contains some examples of integrated/family-centered data collection tools that are useful to programs that are delivering integrated services.

The CLPIR Tool Kit

Information is essential for program planning, management, and monitoring. When systems are able to collect high quality data on a timely basis, the increased availability of data facilitates the use of data and creates a demand for more data. This is true for systems that support data collection from community-level HIV/AIDS programs. While host-country governments and donors may require community-level programs to collect and report on certain indicators that are tracked at the national level, the majority of data that are collected should be directly useful to the program. Frontline service providers work at the level where data are generated and collected. The data they collect must represent information that they value and must also be useful to stakeholders at higher levels. How do you determine what information is useful to different levels? How will it be collected and by whom? Which indicators will be reported? Who will the data be reported to and how frequently? How will the information be used by different levels? How will feedback be provided to the service-delivery level to help improve data collection, data quality, information use, and program performance? To supporting systems that produce high quality community-level HIV/AIDS data, these questions need to be addressed in a participatory but structured manner, to arrive at agreed-upon, implementable, and sustainable solutions.

As described in the subsequent sections, CLPIR is designed to support stakeholders to identify their information needs, support their systems for collecting information, and facilitate data utilization to improve program management and program performance. One result that we expect to see when monitoring and reporting systems are supported is an improvement in the quality of reported data. Figure 1 illustrates how supporting a harmonized community-level information system can help meet the information needs of programs and the reporting needs of host country governments and donors with high quality data.

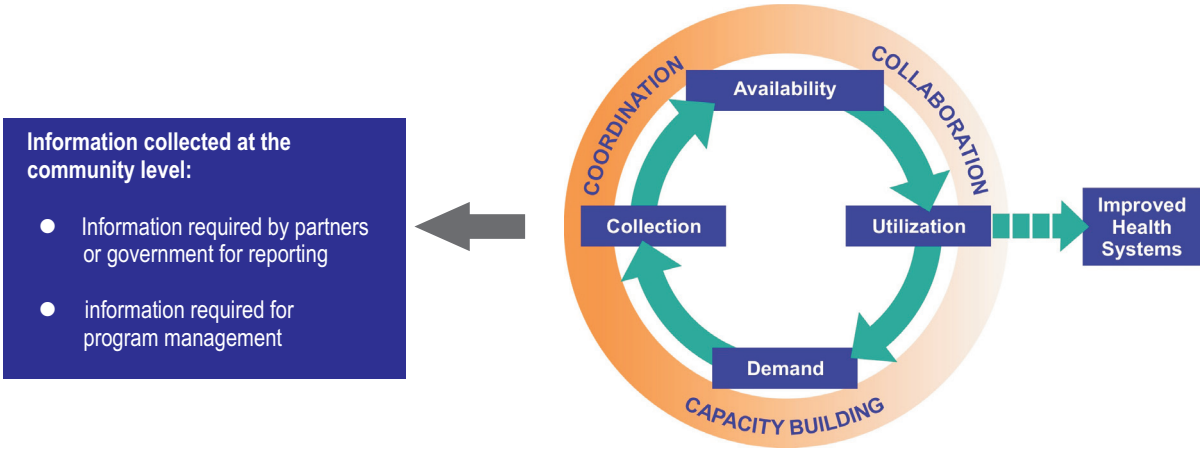

Figure 1. CLPIR supports a data demand and use cycle that strengthens community-level HIV/AIDS information systems.

Tool Kit Organization: Overview of Tools and Processes

Tools

The CLPIR tool kit contains both tools and process guidelines. The tools are the heart of CLPIR and include illustrative program indicators; indicator reference sheets; generic data collection forms for prevention, home-based care, and OVC programs; and user guides for the forms. The set of illustrative program indicators (and indicator reference sheets) include indicators that are required for PEPFAR reporting in the following program areas: abstinence and being faithful, condoms and other prevention, OVC, and palliative care/HBC.* These indicators also capture information most commonly required by other donors, and by host-country governments. As mentioned earlier, the illustrative program indicators and generic data collection forms were developed by reviewing hundreds of HIV/AIDS program indicators and data collection tools being used in the field by community-level programs in Tanzania, Nigeria, and Zambia, and conducting key informant interviews with service providers from these programs.

Processes

The processes through which the tools and resources are introduced to different stakeholders, adapted to meet specific needs, and utilized by country users are equally important to the implementation process. The tool kit contains guides and curricula to facilitate three processes that are part of the implementation — the rapid assessment, indicator harmonization, and rollout. These processes are described below.

Rapid Assessment — When supporting a harmonized monitoring and reporting system at the country level, a rapid situational assessment will help map the organizations working on community-level HIV/AIDS programs, to assess what the programs are doing, what kind of monitoring and evaluation systems they have in place, and if and how these programs relate to a national M&E framework. The rapid assessment also includes an action planning guide to help identify and plan the steps that need to be implemented in order to support the rollout of a national system.

Indicator Harmonization —In many countries, host country governments, donors, and service delivery organizations each have their own set of community-level indicators and reporting requirements. In the spirit of the third of the Three Ones (one national HIV/AIDS M&E system), the rapid assessment is followed by a harmonization process to harmonize and arrive at a core set of national indicators for community-level HIV/AIDS programs to help coordinate and streamline the collection, reporting, and use of community-level information. The key output of the harmonization process is a nationally agreed upon set of indicators for community-level HIV/AIDS programs.

Rollout — Community-level HIV/AIDS programs have multiple reporting requirements. However, if the data they collect focus only on reporting needs, and not on their own data and management needs, the quality and consistency of data may suffer and, over the long term, data

* These have not been updated to reflect PEPAR's Next Generation Indicators.

may not be used. The rollout component of CLPIR provides community-level organizations with the resources they need to support their program monitoring systems by helping them define their program's information needs; develop program-specific data collection forms, aggregation forms, and reporting tools by adapting the generic CLPIR tools (listed above); and train their service providers to use the adapted tools.

Tool Kit Organization: CLPIR Conceptual Model

Figure 2 illustrates how the tool kit can be applied to support a harmonized national (or sub-national) monitoring and reporting system. Module 1 (the top row) indicates that the CLPIR tools are used in conjunction with the other modules. The second row shows module 2-4, indicating the three CLPIR processes and the sequence in which they are applied. The blue ovals on the bottom row represent the expected outputs of each process and how the outputs of one process feeds into the subsequent process. The high-level result is that there is an overall improvement in coordination, reporting, data quality, data use, and program management. As previously discussed, CLPIR is adaptable and users are encouraged to modify the tool kit to fit their needs. For example, if a country does not have a national program for community-level HIV/AIDS activities, but a donor supports multiple organizations that provide community-level services, the tool kit can be adapted and used to harmonize monitoring and reporting among the programs that are supported by the donor.

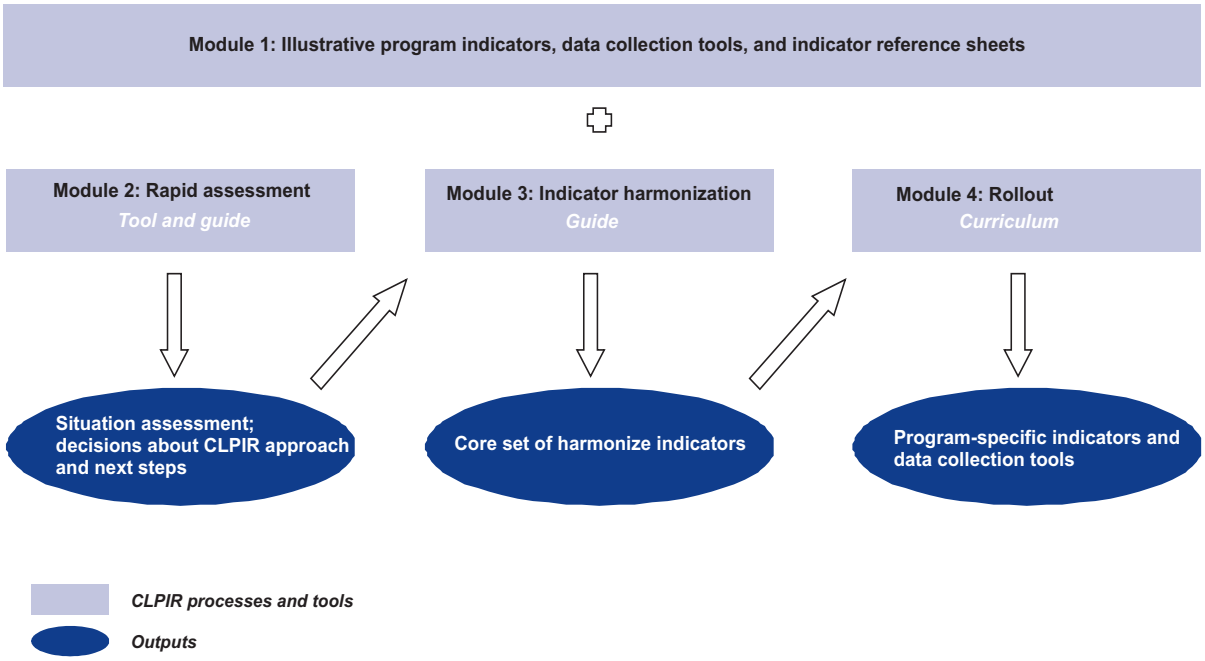

Figure 2. CLPIR supports a harmonized monitoring and reporting system, leading to improved national and donor coordination, reporting, data quality, and program management.

Tool Kit Organization: Modular Approach to Guide Selection and Use of Tools and Processes

CLPIR is a package of tools and processes that various stakeholders at different levels of the health system can adapt and use to support activities that strengthen the community-level HIV/AIDS information system. Different types of stakeholders will find different parts of the tool kit more useful than others. For example, national level stakeholders may find the rapid assessment and indicator harmonization most useful in supporting the development of harmonized systems, whereas program-level stakeholders may find the rollout process most useful in strengthening their program information systems.

When supporting a harmonized national system, the recommended order of implementation starts with the rapid assessment. This process brings together key stakeholders to map the different community-level HIV/AIDS programs, assess what types of services are being provided and to whom, determine what kind of monitoring and evaluation systems are in place, and assess if and how these programs are linked to the national M&E framework. If the result of the rapid assessment reveals that community-level indicators need to be harmonized, the indicator harmonization process can then be applied to develop a set of indicators that all community-level HIV/AIDS programs will routinely report on to the national level. After a consensus has been reached on a national set of indicators, each community-level program can then design data collection tools that capture the data elements that generate the indicators for their specific program while meeting the minimum reporting requirement of the country and donors. The CLPIR rollout process provides guidance on how to develop such indicators and data collection tools. At this stage, the illustrative CLPIR program indicators, data collection forms, and indicator reference sheets in module 1 can be adapted to help service delivery programs develop their program-specific indicators and data collection tools. This is the recommended order of implementation, especially in the context of supporting harmonized national systems; but as mentioned before, each of these processes can also be treated as stand alone and can be applied independently by stakeholders at different levels of the health system to support monitoring and reporting systems at their respective levels.

To make the tool kit user-friendly and accessible to different types of users, it is organized into five documents — a general introduction (this document) and separate documents for each of the four modules. ***Module 1*** contains illustrative program indicators, data collection tools with instructions on how to use them, and indicator reference sheets for prevention, HBC, and OVC programs. These are the "tools" in the CLPIR tool kit. ***Modules 2-4*** contain resource materials for carrying out the different processes through which the tools are implemented:

- ***Module 2*** is the rapid assessment process.
- ***Module 3*** provides guidelines for the indicator harmonization process.
- ***Module 4*** involves the rollout.

Depending on the context in which CLPIR is being applied, users can pick and choose the modules that are most relevant to them without having to go through the entire series of documents. Figure 3 illustrates all of the modules being used, while figure 4 indicates examples

in which only portions of the tool kit would typically be applied. Note that the style and tone of the modules varies on account of the different types of users that would most commonly use the module. Likewise, some information may be repeated in more than one module, taking into account that some users may pick and choose modules and not go through the entire series of documents.

Example 1: Supporting Harmonized National Monitoring and Reporting Systems

This application is the most comprehensive and entails the involvement of stakeholders from multiple levels (national, sub-national, and program) of the health system. In this context, all modules of the tool kit would be relevant and useful (as highlighted in figure 3). The expected users in this context are the CLPIR steering committee, host country national government, host country sub-national government, donors, implementing partners, NGOs, FBOs, and CBOs.

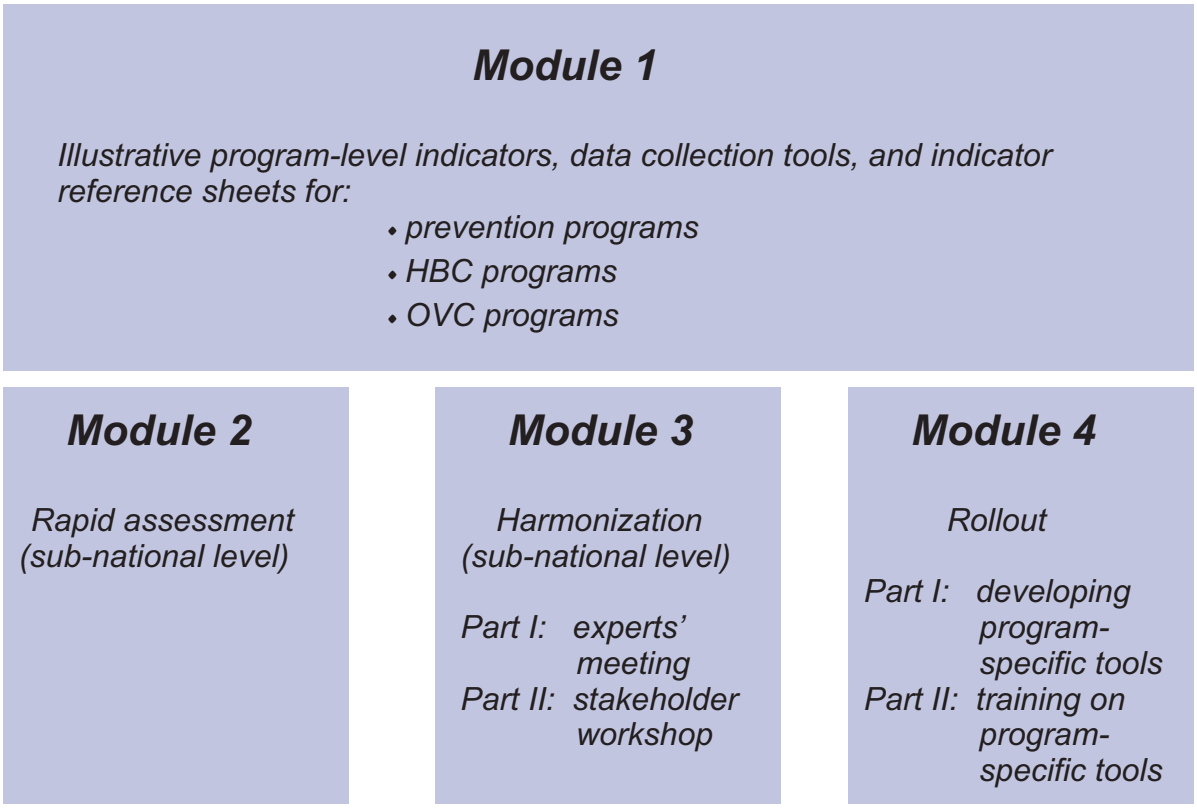

Figure 3. All CLPIR modules are relevant and useful for harmonizing national or sub-national monitoring and reporting systems.

Example 2: Supporting Harmonized Monitoring and Reporting Systems at the Sub-national Level

In certain countries, especially countries where the health system is decentralized, monitoring and reporting systems may not be centrally harmonized. In these countries, the sub-national level (for example, a provincial government) may be responsible for harmonizing systems within the province. This application of CLPIR would also be comprehensive and would entail the involvement of stakeholders at the sub-national and program levels. In this context as well, all modules of the toolkit will be relevant and useful (figure 3). The expected users in this context are the CLPIR steering committee, host country sub-national government, donors, implementing partners, NGOs, FBOs, and CBOs.

Example 3: Supporting Program-Specific Monitoring and Reporting Systems

In addition to supporting efforts to develop harmonized systems (either at the national or sub-national level), CLPIR is also useful for individual programs that want to strengthen their internal program monitoring and reporting systems. Depending on the type of program, module 4 and a program-specific component of module 1 would be most relevant and useful (figure 4 illustrates this for a prevention program). The anticipated users in this context are implementing partners, NGOs, FBOs, and CBOs.

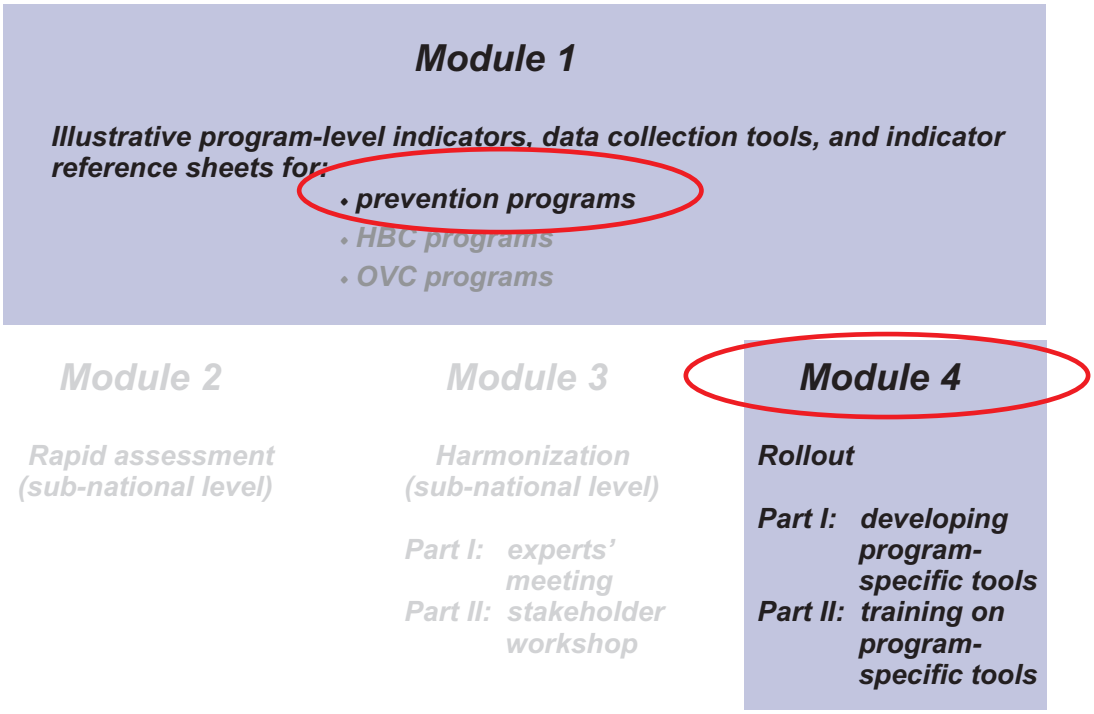

Figure 4. Specific aspects of CLPIR are relevant and useful for different programs. For example, a prevention program might use the prevention programs tools from module 1 and module 4, program-level rollout.

CLPIR: Illustrative Implementation

The committment and leadership of in-country stakeholders is essential when building a harmonized information system for community-level HIV/AIDS programs. If the country is interested in building a national system, we recommend that a national community-level information system steering committee be formed at the beginning of this process. This committee is responsible for leading the effort to strengthen or build an information system for community-level programs for the country. The terms of reference for the steering committee are described in detail below. In some situations, there may already be a group or body with a similar mandate. If this is the case, it may make sense for that group to take on this role, as opposed to creating a separate committee. These types of considerations have to be examined closely, country by country, when planning the implementation. However, the goal is for the steering committee to adapt and use the CLPIR tools and processes, to help create harmonized information systems for community-level programs.

Steering Committee Terms of Reference

The steering committee is central to building a harmonized information system for community-level HIV/AIDS programs. Therefore, it should have a high-level mandate from the government and should have support and membership from various government agencies, including the ministry of health; ministry of social and women's affairs (or equivalent); national AIDS councils (or equivalent); major donor agencies, such as UNAIDS, World Bank, GFATM, U.S. Agency for International Development (USAID), etc.; and major implementing partners, NGOs, FBOs, and CBOs working on community-level HIV/AIDS programs and activities.

The successful rollout of a national information system for community-level programs will depend a great deal on the effectiveness of this committee. In addition to fulfilling a leadership role, the steering committee will also function as a working group and will be actively involved in planning and facilitating the rapid assessment, indicator harmonization, and rollout processes. Therefore, it is very important that the steering committee members understand this and are able to commit the time that is needed.

The chair of the committee provides leadership for the process and is therefore a critical position. In many countries, a national AIDS council that has a multisectoral mandate to coordinate HIV/AIDS activities throughout the entire country is well-positioned to provide a chair for the committee. If that is the case, a senior-level staff member from a government unit responsible for coordinating community-level programs would be a good fit for the position.

The size and composition of the steering committee is also critical and will depend on the country context. Efficiency will be an important consideration for the steering committee; therefore the size of the committee should not be so large that timely decision-making and performance are negatively impacted by the size of the group. Limit the size to a manageable number. Fifteen to 20 members should allow efficiency without sacrificing the manpower needed to get the job done.

Each member of the committee should expect to play an active role and should agree to share the workload. Early in the process, the committee can divide itself into smaller task forces that can be organized around the different implementation processes that will be undertaken (i.e., rapid assessment task force, harmonization task force, rollout task force, etc.). Task force members should understand that they are responsible for all aspects of implementing the process (leading, planning, facilitating, etc.).

Sub-national government units have an important role to play in this process, especially in countries that have a decentralized health system. They represent a critical part of the information system and offer a valuable perspective. Therefore, to the extent possible, they should be included in the planning and decision-making process. Ideally, the steering committee should have representation from the sub-national level.

As mentioned earlier, although written from the perspective of building or strengthening a national system, CLPIR can be adapted for other contexts as well. For example, CLPIR may be used to build an information system for community-level programs supported by a specific donor, such as PEPFAR. In this situation, we still recommend forming an in-country steering committee to lead the effort, even though the composition of the committee may vary from the one described above. In this case, the committee might consist of in-country USAID and PEPFAR representatives, major implementing partners, and representatives from the host country government, among others.

Illustrative Implementation Process

We previously explained how CLPIR is organized into four modules. The expectation is that each country will identify its needs and adapt and use the modules that will be useful within that particular context. Because of this, there is a high degree of flexibility built into the design of the CLPIR tool kit. With that said, and recognizing that this is a systems-building exercise that requires action on multiple fronts and levels, in this section we provide a summary of the entire process of building/strengthening a harmonized national information system for community-level HIV/AIDS programs using the entire tool kit. For clarity, the process is divided into several steps, described below, *noting again that the steps only need to be followed if that process is being implemented*.

Step 1: Introduce the Steering Committee to the CLPIR Process

The objectives of this step are to:

- introduce the steering committee to the CLPIR tools and processes;
- finalize and clarify the terms of reference with the steering committee;
- divide the steering committee into smaller task forces; and
- decide which modules are applicable and how they need to be adapted or modified to suit the particular context.

The activities and process include the following:

- The chair of the steering committee leads this meeting.
- The chair presents an overview of the community-level health information system and discusses the gaps that exist and the future vision with the steering committee.
- The chair introduces the CLIPR tool kit.
- The committee decides which specific modules of the tool kit are useful for implementation in the country and what kind of adaptations are needed.
- The committee discusses the terms of reference, and revises and clarifies as needed.
- The steering committee divides itself into smaller task forces organized around the different CLPIR processes. There should be at least three task forces (one each for the rapid assessment, indicator harmonization, and rollout). However, if the steering committee is large, it may make sense to form additional task forces to divide the workload. Each task force should have around between three to five members. Each task force is responsible for leading, planning, facilitating, etc. all aspects of the implementation process. If additional specialized help is required for a specific task or activity, the task force identifies the assistance that will be required and identifies individuals who are best suited to provide that assistance.
- The committee reviews the desired output and time frame for the implementation of the entire process.
- Budgetary needs and sources of funding are also discussed.
- Finally, the committee discusses next steps.

Outputs of this step include:

- reaching a consensus on to which modules to use to strengthen the information system for community-level HIV/AIDS programs;
- agreeing upon the committee's terms of reference and establishing smaller task forces to carry out discrete tasks associated with the different implementation processes; and
- developing a time line and next steps.

Step 2: Conduct a Rapid Assessment

The objective of this step is to use the rapid assessment module (module 2) to assess what type of systems are in place to monitor community-level HIV/AIDS programs. The activities including the following:

- The rapid assessment task force leads the planning, preparation, and facilitation of the rapid assessment.
- A rapid assessment of the information system for community-based programs using the rapid assessment module (module 2) is conducted.

- ❒ The results of the assessment are used to decide how to move forward and which steps need to be implemented. A detailed work plan and timelines for the CLPIR process is developed.

Outputs of this step include:

- ❒ a current situation and gaps analysis is conducted;
- ❒ measures to strengthen the community-level information system are identified;
- ❒ a work plan for carrying out CLPIR implementation, with specific tasks and responsible individuals, is developed; and
- ❒ a date is set for the indicator harmonization experts' meeting and a list of invitees is developed.

Step 3: Convene an Experts' Meeting for Indicator Harmonization

The objective of this step is to use the indicator harmonization experts' meeting guide in module 3 to develop a draft list of national indicators for community-level HIV/AIDS programs, indicator definitions, and routine reporting tools.

The harmonization task force will lead the planning, preparation, and facilitation of the experts' meeting. Prior to the meeting, the task force will:

- ❒ collect indicators from implementing partners, NGOs, FBOs, CBOs, donors (including PEPFAR, GFATM, World Bank, etc.) working on community-level HIV/AIDS programs and activities and consolidate this information into one document to facilitate a review of these indicators during the meeting; and
- ❒ determine who should participate in the meeting and organize logistics.

During the meeting, the task force will:

- ❒ explain the purpose of the meeting and the expected outcomes;
- ❒ divide participants into groups by program area and instruct each group to use the consolidated list of indicator to recommend a concise list of national level indicators that are consistent with the country's strategic plan and M&E framework for community-level programs;
- ❒ instruct the groups to define each indicator;
- ❒ have each group present its listed indicators and definitions, and review and finalize these in plenary;
- ❒ ask the larger group to discuss information flow and reporting frequency, and draft a routine reporting tool that programs will use to report to the national level; and
- ❒ draft an agenda for the broader indicator harmonization stakeholders' workshop (step 4).

Outputs of this step include:

- a concise list of national indicators for community-level programs along with indicator definitions, as a basis for discussion at a stakeholders' workshop;
- a draft reporting tool that will be used by service delivery programs to report to the national level (sub-national) level on a routine basis; and
- an agenda for the stakeholders' workshop.

Step 4: Conduct a Stakeholders' Workshop for Indicator Harmonization

The objective of this step is to use the indicator harmonization guide in module 3 to reach national consensus on a minimum set of indicators and indicator definitions for community-level HIV/AIDS programs.

The harmonization task force will lead the planning, preparation, and facilitation of the stakeholders' workshop and will do the following:

- prior to the workshop, develop an invitee list and circulate invitation letters to implementing partners, NGOs, FBOs, CBOs, donors, and others service providers working on community-level HIV/AIDS programs and activities;
- organize materials, venue, logistics etc. for the workshop;
- invite a high-level official to make the opening remarks at the workshop to emphasize the importance and implications of having a nationally harmonized set of indicators to monitor community-level HIV/AIDS programs;
- at the workshop, present the process through which the indicators and definitions were developed;
- divide workshop participants into groups by program area; and in each group, present the listed indicators for that program area, and ask the group to review and comment on the indicators and definitions;
- ask participants to reconvene in plenary and ask each group to present a summary of its discussion;
- if many suggestions are made during the workshop and consensus cannot be reached, ask the steering committee to convene to review the feedback and generate a final harmonized list; and
- after the workshop, adapt the CLPIR generic data collection forms, instructions, and indicator reference sheets (found in module 1) to incorporate the national harmonized indicator set.

Outputs of this step include the following:

- Harmonized minimum set of national indicators and indicator definitions for community-level HIV/AIDS programs for reporting to the national level are developed through a participatory process.
- The CLPIR generic data collection forms, user guide, and indicator reference sheets

are adapted to incorporate the national harmonized indicator set for community-level programs.

- An official report of the harmonization workshop is prepared for public dissemination, which includes the harmonized minimum national set of indicators, indicator definitions, and a draft reporting tool.

Step 5: Prepare for Rollout

The objective of this step is to develop a detailed plan for the rollout training workshops, which includes identifying master trainers and identifying appropriate provincial or district officials in the planning and implementation of the training workshops; selecting participants; choosing an appropriate training approach; preparing a detailed agenda for the training workshops; and adapting the rollout curricula in module 4.

The activites and process include the following:

- The rollout task force identifies master trainers and works with the master trainers to prepare, organize, and facilitate the rollout training workshops.
- Master trainers should have a background in M&E, community-based programs, and training (a skill-set that may not be present in the task force). Probably four to six master trainers are needed to facilitate a workshop. If a series of workshops are required to cover all program implementers in the country, it might be a good idea to have a pool of master trainers available to draw from.
- Decide on the training approach that is most appropriate for the country, taking into consideration the available budget; availability of master trainers; number of implementing partners, CBOs, FBOs, etc. that need to be trained; and other relevant factors. The recommended training approach is direct training of implementing partners and their NGO/FBO/CBO counterparts, together in one workshop, by skilled master trainers. In this approach, all training is conducted by skilled master trainers. As a result, the quality of the training is high and there is greater assurance that the lowest level service providers, who are responsible for collecting data, are adequately trained. However, this approach may not be feasible in all situations, and there may be the need to employ a cascade training model. In a cascade approach, the master trainers conduct a training-of-trainers session for participants from the implementing partner-level, and those participants are then responsible for planning and conducting a series of training workshops for their counterpart NGOs/FBOs/CBOs. If a cascade approach is used, the quality of the training may be enhanced by having the master trainers observe or facilitate some of the cascade training workshops.
- Once a training approach is decided upon, the task force members and master trainers should develop a training rollout plan with details on when and where the workshops will take place, who will be responsible for organizing and facilitating the workshops, who will participate in the workshops, and how much each workshop

will cost. In addition, the master trainers should think about how they will involve provincial or district level officials in the trainings.

- Next, participants are identified for the workshops. The optimal number of participants for a workshop is between 30 and 40 people. Consider which individuals will be invited from each organization.
- The master trainers should develop an agenda and develop a plan to adapt the generic rollout curricula in module 4 to tailor the materials for the specific country context. The rollout task force should plan to review the adapted curricula and provide feedback to master trainers prior to the training.
- The master trainers should also develop a plan to adapt the CLPIR sample data collection tools to meet the reporting requirements identified during the national harmonization workshop. Tool adaptation needs to take place prior to the second phase of the rollout training workshop (part 2 of the workshop). After the tools have been adapted to reflect national data needs, each organization will further adapt the tools to meet their program specific information needs.

Outputs of this step include the following:

- An appropriate and feasible training approach is selected and a time line for rolling out the training is developed.
- Master trainers and participants of the workshop are identified.
- The generic rollout curricula in module 4 are adapted for the specific country context.
- An agenda for the rollout training workshops is developed.
- A plan for adapting the generic CLPIR data collection tools to meet national reporting requirements is developed.

Step 6: Conduct the First Phase of the Rollout Workshop

The objective of this step is to the part 1 curriculum of the rollout in module 4 to conduct a workshop for implementing partners, NGOs, FBOs, and CBOs to identify their information needs and develop organization specific indicators and data collection forms.

The process for this step includes the following:

- The master trainers and rollout task force will plan, organize, and facilitate part 1 of the rollout workshop to train implementing partners and their counterpart NGOs/FBOs/CBOs to identify their information needs and develop organization specific indicators and data collection forms.
- Depending on the number of implementing organizations that need to be trained, several of these workshops may need to be conducted.

An output for this step is that the implementing partners, NGOs, FBOs, and CBOs have program/organization specific indicators and data collection forms that they can use for program

management and decision-making, and that these indicators and forms are also consistent with national reporting needs.

Step 7: Develop Program/Organization-Specific Data Collection Forms, Instructions, and Indicator Reference Sheets

The objective of this step is to use the generic tools in module 1 to develop program/organization-specific data collection forms, instructions, and indicator reference sheets to meet the information needs of each organization.

M&E officers from each organization who participated in the first phase of the rollout workshops, with support from master trainers, will use the generic CLPIR data collection tools to develop program/organization tools. An output for this step is that the generic CLPIR tools are adapted to incorporate program/organization specific indicators identified during the first phase of the rollout workshop.

Step 8: Conduct Part 2 of the Rollout Workshop

The objective of this step is to use the part 2 curriculum in module 4 to conduct a workshop for implementing partners, NGOs, FBOs, and CBOs to train them on how to complete the program/organization specific data collection tools.

The M&E officers who participated in part 1 of the rollout workshop and who were involved in adapting the generic forms will facilitate a workshop within each of their organizations. In this workshop, service providers and those involved with data collection at each organization are provided with step-by-step instructions on how to complete their own program-specific or organization-specific forms.

After this workshop, the steering committee, master trainers, and provincial and district government officials should continue to work with implementing partners, NGOs, FBOs, and CBOs to get their information systems up and running; and jointly develop strategies to address issues related to supportive supervision, data quality, and data use.

An output for this step is that program staff from community-level HIV/AIDS programs involved with data collection are trained on the program/organization-specific data collection forms, instructions, and indicator reference sheets.

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