Community-Level Program Information Reporting for HIV/AIDS Programs

Tools and Processes for Engaging Stakeholders

Module 4: Information System Rollout

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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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Introduction

Often, the process through which program data requirements are set and indicators are selected takes place without carefully considering what information is really needed by the program for management purposes, and what information is needed by service providers to help them make decisions that will improve the delivery of services. Indicators are frequently selected without regard to the generally weak monitoring and evaluation (M&E) capacity of the service providers responsible for collecting that information. What typically happens instead, unfortunately, is that a heavy emphasis is placed on gathering information solely to fulfill reporting requirements to host country governments and donors.

In recent years, however, many countries and organizations have expressed interest in improving the completeness, accuracy, and use of information from community-level programs for decision-making at all levels of the system. The CLPIR tool kit was developed on the premise that a successful community-level program information system must involve service providers and data collectors from the beginning, to make sure that their information needs are reflected in the system. Therefore, it is recommended that service delivery organizations participate in all CLPIR processes, including CLPIR's rapid assessment process (outlined in module 2) and indicator harmonization (in module 3), in addition to the program-level rollout process described in this document (module 4).

Module 4 builds on CLPIR's three other modules. However, module 4 can also be used indenpendently by service delivery organizations to strengthen their program monitoring and reporting systems. For example, if a country already has harmonized indicators or is not in a position to harmonize indicators at the national level, module 4 can be used on its own to build the capacity of individual service delivery organizations to collect, analyze, and use information to improve program performance.

Purpose of Module 4

The purpose of module 4 is to provide detailed step-by-step guidance on how to develop an information system to capture community-level HIV/AIDS data and to roll out this process to program-level stakeholders through participatory workshops. The process of rolling out the information system to the program level involves three stages, summarized in table 1.

The preparation for the rollout process starts with identifying program-level stakeholders involved in community-level HIV/AIDS activities, and coming up with a plan to involve them in the rollout process. During this planning stage, a workshop approach that is appropriate for the given context should be selected, and a detailed plan for the rollout should be developed.

After these preparations have been made, the first program-level rollout workshop will be conducted to help service delivery organizations identify the objectives and information needs of their programs, share their experiences, and create ownership and incorporate their comments into a system that will reflect their considerations from the design stage. This process is an important follow-up to the national indicator harmonization process, which results in a set of

indicators mainly for national-level monitoring and reporting, but does not necessarily address the information needs of specific programs and organizations. The first program-level rollout workshop will provide step-by-step guidance on how to define program objectives and develop program-specific indicators by using case studies, lectures, participatory group discussions, and individual exercises. Depending on the number of implementing organizations that can be trained in the country, this workshop (and the subsequent workshop) may need to be conducted several times.

Table 1. Description of Rollout Stages

Rollout Stages	Objective	Users of Module 4	Target Audience	Time Frame
Preparation	To develop a detailed plan for conducting the roll-out workshops	Rollout task force of the CLIPR steering committee Master trainers	Not applicable	Two to three weeks
Program-Level Rollout Workshop 1: Defining Program Information Needs	To engage program-level stakeholders to develop program/organization specific indicators which include the host government and donor reporting requirements	Master trainers	Implementing partners, NGOs, FBOs, and CBOs	Four days
Program-Level Rollout Workshop 2: Program-Specific Data Collection	To conduct training on program/organization specific data collection tools	M&E officers from implementing partners	NGOs, FBOs, and CBOs	One day
Ongoing follow-up and capacity building	To provide ongoing capacity building support	CLPIR steering committee, M&E officers of implementing partners, sub-national government officials	NGOs, FBOs, and CBOs	Ongoing

Once program-specific indicators have been defined, M&E officers from the organizations that participated in the first workshop will go back to their respective organizations and develop program/organization-specific data collection tools, user guides, and indicator reference sheets to define and guide data collection and to measure the selected indicators. Instead of starting from scratch, the M&E officers will use the generic CLPIR data collection tools, found in module 1. (Note: In following the CLPIR process, these tools would have already been adapted once by the harmonization task force following the stakeholders' workshop on indicator harmonization, to reflect the national reporting requirements defined at the stakeholders' workshop. In this way, M&E officers have something to start with that can be modified to meet

their organization's program specific objectives and indicators.)

After the generic CLPIR data collection tools have been adapted, the second workshop is conducted. During this workshop, the program-specific data collection tools, user guides, and indicator reference sheets will be presented to other program staff in the organizations participating in the workshops. During this workshop, different types of follow-up mechanisms will be discussed to provide ongoing support to implementing organizations, especially those organizations that have a lower level of capacity.

Users of Module 4

The rollout task force of the CLPIR steering committee will be involved in planning and organizing the process of rolling out the community-level information system to programs and organizations working on community-level HIV programs. The task force will recruit master trainers, who will be involved in planning, organizing, and facilitating both rollout workshops.

If the country has functioning sub-national units, representatives from these units should play a part in the rollout process. Ideally, they should identify information needs at the sub-national level, be involved in preparing for and planning the program-level rollout workshops, take part in facilitating the workshops, assist implementing organizations adapt the generic CLPIR data collection tools, and provide ongoing capacity building support and feedback to implementing organizations working in their catchment area.

Preparing the Rollout Workshops

The rollout task force should go through the following steps to prepare for the program-level rollout workshops.

Identify Master Trainers and Participants

The rollout task force should identify master trainers to facilitate the program-level rollout workshops and to assist service delivery organizations roll out the community-level information system. Master trainers should have a background in M&E and training, and experience with community-level HIV/AIDS programs. They should be committed and motivated to do this work, and be able to allocate sufficient time to the process.

Similarly, the task force should identify the service delivery organizations that will participate in the workshops. From each organization, it is ideal to invite both program management staff and service providers. Ideally, there should be no more than 30 or 40 participants in each workshop. If there are many service delivery organizations within a country that need to be trained, there may be the need for multiple workshops.

Select a Training Approach

The training workshops can be conducted using a variety of approaches. The approach that is selected should reflect what is appropriate and feasible for the country. When selecting the training approach, take into consideration important factors such as the available budget, availability of master trainers, and number of implementing organization that need to participate in the workshops.

Recommended approach: direct training of service delivery organizations — The training approach that is recommended by CLPIR is one in which the master trainers conduct a workshop for a group of participants from both the implementing partner and the nongovernmental organization (NGO), faith-based organization (FBO), and community-based organization (CBO) levels. From a training quality perspective, this approach is preferable over the cascade approach (described below) because under this approach, the master trainers directly train the service providers who are ultimately responsible for collecting data. This approach will also ensure that data needs for all levels are jointly identified and addressed, which will promote a cross-functional understanding of the program.

Alternative option: cascade training — Although direct trainings are favorable, in certain situations it may be necessary to use a cascade training approach. For example, in countries that have many service delivery organizations, the master trainers may not have the time needed to train all service delivery organizations directly. In a cascade approach, the master trainers conduct a training of trainers (ToT) workshop. The ToT may be for staff at the national or sub-national government levels or for M&E staff from implementing partners. Once trained, the implementing partners would be responsible for planning and facilitating training workshops to train their counterpart CBOs, FBOs, and other direct service providers. Since the trainings are "stepped down" to multiple levels, the disadvantage of this approach is that it is difficult

to ensure that the quality of the cascade trainings is consistently maintained. If a cascade approach is used, the quality can be improved or maintained by having the master trainers observe or facilitate some of the cascade trainings.

Develop a Training Rollout Plan

Once the training approach is selected, the rollout task force and master trainers should develop a comprehensive training rollout plan. This plan should detail when and where the trainings will take place; who will organize and facilitate each workshop; who will participate in each workshop; how much each workshop will cost; and who will cover these costs. In addition, the task force and master trainers also need to think about how they will involve the sub-national government units in planning and conducting these workshops. This is especially important to think about in countries with highly decentralized systems, where standard protocol does not allow trainings to proceed without the involvement of local authorities. The task force should be responsible for sending out invitations and taking care of logistics.

Adapt the Generic Program-Level Rollout Curricula

The master trainers should be responsible for adapting the generic program-level rollout workshops curricula that are included in this module. They should also develop a day-by-day agenda for the training workshops. The rollout task force should also be involved in the adaptation process and should review and provide feedback to the master trainers on the adapted curricula prior to the training. Master trainers should have a series of meetings to prepare for the workshops, make decisions on who will facilitate each session, and finalize the curricula.

Program-Level Rollout Workshop 1: Defining Program Information Needs

The objective of the first rollout workshop is to engage service delivery organizations to identify their program objectives and information needs, and to develop program-specific indicators. These indicators should also meet the minimum reporting requirements of the host country government and donors. The four-day workshop will provide step-by-step guidance on how to develop program-specific indicators.

There are a total of nine sessions in the first workshop. The first six sessions are for all technical staff of these organizations, while remaining sessions, which deal with preparing for the second workshop, are specifically for M&E officers from the organizations. A generic training curriculum is included in this module, beginning on page 15. The master trainers are responsible for reviewing and adapting the generic curriculum prior to the training workshop.

Users of the Curriculum, Target Audience, Outputs, and Preparation

The main users of this curriculum are the master trainers and the rollout task force of the CLPIR steering sommittee. The target audience for the workshop includes the following:

- ***Implementing partner-level:*** program officers, M&E officers and other technical staff involved in the implementation of community-level programs; and
- ***NGO/FBO/CBO-level:*** front-line service providers (volunteers, community health workers, religious committee members, etc.), program officers, and other technical staff involved in the implementation of community-level programs.

In instances where NGOs/FBOs/CBOs are grantees to or managed by an implementing partner, we recommend that participants from both the implementing partner and the NGO/FBO/CBO attend the same workshop so that the two levels can jointly identify program objectives and indicators.

One output of the first rollout workshop is that each program or organization will have a harmonized list of indicators for community-level programs that incorporates data needs for program management, as well as host country government and donor reporting requirements. Another output is that each program or organization will define the flow of information and feedback mechanisms within its program-monitoring and reporting system.

Prior to the workshop, the master trainers should review and adapt the generic workshop curriculum to the context of the host country. The final curriculum should also be reviewed by the rollout task force. This includes meetings among master trainers to discuss questions, decide who will facilitate specific sessions of the workshop, and making final adjustments to the curriculum.

Summary of Sessions 1-6

The first six sessions are designed for all program staff, from both the implementing partner-level and the NGO/FBO/CBO-level. Staff titles of participants might include program officers, M&E officers, community health workers, volunteers, religious committee members, or other types of technical staff and direct service providers.

Session 1: The Value of Information

It is easy to overlook the value of information while we collect information on a daily basis. Even if the value of information is understood, we often do not relate the information that is collected to our daily work. The first session is designed to help participants understand the value of information and realize how it can be used to help their daily work. A case study will be used to demonstrate the common issues faced by direct service providers in the field. By the end of the session, participants will be able to relate the case study example to their own experience and understand the value of information.

Session 2: Defining Programs

It is often assumed that everybody who is involved in program implementation has a common understanding of the program goal, objectives, and activities. However, this is not always the case. Even if the project goal, objectives, and activities are clearly defined on paper, often these details are not shared with all staff involved in the program, including service providers. Session 2 will allow participants to re-visit their project goal, objectives, and activities to develop a common understanding. This step is necessary before selecting indicators to ensure that the indicators selected will be useful for both program monitoring and management. This session is delivered through small group exercises.

Session 3: Identifying Information Needs and Developing Indicators

Once the program goal, objectives, and activities are clearly defined, session 3 introduces different tools to provide guidance on how to develop indicators that reflect the needs of service providers and program managers while meeting the minimum reporting requirement of donors and the host country government. Important questions are asked in order to identify a minimum set of indicators, such as: How can indicators be used to make practical decisions? What is the significance of these decisions? Who will be using the information? How many indicators are enough? Different considerations and tips are incorporated into the curriculum. The CLPIR illustrative program indicators and indicator reference sheets (in module 1) are additional resources that are used during these exercises for this session.

Session 4: Setting Up an Information System for the Program

Once program/organization-specific indicators are selected and defined, the next step is to identify how information moves from one level to another, who is responsible for collecting

information and how feedback is provided. Session 4 introduces different tools to identify sources of data, information flows and feedback mechanisms.

Session 5: Promoting Information Use

Data cannot be used unless they are converted to meaningful information. This exercise will introduce the concept of catchment area and performance targets, and demonstrate how information that is collected can be used against performance targets to monitor progress. This session provides step-by-step guidance on how to set up periodic targets for individual service providers and for programs. During the session, participants will set monthly performance targets with their supervisors.

Session 6: Introduction to Problem Solving Skills

Being able to collect data, interpret the results, and monitor performance is not the same as being able to use information to take appropriate action. This session will take participants to the next level by linking information to action. The cause-and-effect analysis and prioritization will be presented to strengthen problem solving skills. By the end of this session, participants will be able to understand how individuals can take responsibility for solving problems within their spheres of influence while referring problems outside their spheres to higher authorities within their organizations.

Summary of Sessions 7-9

The remaining three sessions are designed specifically for M&E officers from service delivery organizations, to prepare them to carry out the next phase of the rollout workshop. The master trainers will also facilitate this part of the workshop. M&E officers or other technical staff from the participating organizations should be selected to participate in the following exercises.

Session 7: Identifying the Design of the Program

The way a program is designed often dictates the way the information is gathered. In order to design the most appropriate information system, it is essential to first identify the way a program operates and the way information is collected. Session 7 will introduce different program approaches for community-level programs including the "integrated/family centered" approach and recommend the most appropriate data collection tools for each approach.

Session 8: Understanding How to Adapt the Generic CLPIR Data Collection Tools

Following the national stakeholder workshop for indicator harmonization, the harmonization task force should have already adapted the generic CLPIR data collection tools in order to meet the national reporting requirements that were identified through the harmonization process. Session 8 describes the process through which these adapted versions of the generic CLPIR data collection tools can be further adapted to meet program specific-information needs identified

during the previous exercises sessions of the program-level rollout process.

Session 9: Preparing for the Program-Level Rollout Workshop, Part 2

Once the M&E officers have finished adapting the generic CLPIR data collection tools, the second phase of the training (part 2 of the workshop) will focus on training participants on program/organization specific data collection tools. The participants will be the same participants from the first phase of the training (part 1 of the workshop). M&E officers from each organization will be responsible for training their colleagues on the program/organization specific data collection tools that they have developed in session 8. Session 9 provides guidance on what needs to be done to prepare for the part 2 phase of the workshop.

Program-Level Rollout Workshop 2: Training on Program-Specific Data Collection Tools

Objective

The objective the second workshop is to present and train participants on program/organization-specific data collection tools. A generic training curriculum is included in this module (beginning on page 52). This curriculum should be adapted by master trainers prior to the workshop.

Users of the Curriculum, Target Audience, Outputs, and Preparation

The main users of this curriculum are the master trainers, who will train M&E officers from implementing partners, NGOs, FBOs, and CBOs; and M&E officers who will return to their respective organizations to train other program staff. Specifically, the users include:

- at the implementing partner level, program officers and other technical staff involved in the implementation of the community-level HIV/AIDS programs; and
- at the NGO/FBO/CBO level, frontline service providers (volunteers, community health workers, religious committee members etc), program officers and other technical staff involved in the implementation of the community-level HIV/AIDS programs.

Outputs include the training of the target audience on program/organization-specific data collection tools, user's guide, and indicator reference sheets.

Prior to the workshop, M&E officers should adapt materials from module 1 — the generic CLPIR data collection tools to develop program/organization specific data collection tools, CLPIR user's guide, and CLPIR indicator reference sheets. If available, master trainers can work with M&E officers to make these adaptations or review the adapted documents prior to the workshop.

Workshop Sessions

The adapted data collection tools will be presented to participants with step-by-step instructions on how to complete each form. Participants will be guided through a series of practical exercises to familiarize them with each tool. During this process, participants will also identify common mistakes that could be made during the data collection, aggregation and compilation process.

Ongoing Follow-up and Capacity Strengthening

Building a viable community-level information system does not end with training. Follow-up activities and ongoing capacity strengthening are required to maintain and strengthen the knowledge that is gained during these workshops. Specific follow-up and capacity strengthening activities should be defined to fit the particular context. Such activities include ongoing training, regular program review meetings, supportive supervision, and ongoing performance monitoring.

The Steering Committee will be responsible for identifying ongoing follow-up and capacity strengthening strategies and mechanisms and coordinating with stakeholders, including the national government, sub-national government units, and donors to carry out these activities after the program-level rollout workshops.

Ongoing Activities

The following are some illustrative ongoing follow-up and capacity strengthening activities (this list is not exhaustive and specific details will vary from country to country):

- **Ongoing training and mentorship:** Staff from organizations implementing community-level HIV/AIDS programs should receive ongoing training to equip them with the knowledge and skills they need to collect information and, more importantly, to use that information. Depending on the need, such trainings may include use of data collection tools, information use, and data quality.
- **Regular review and feedback meetings:** Regular meetings will allow direct service providers from community-level HIV/AIDS programs to express their frustrations, challenges, and successes, as well as to get feedback from their supervisors on their work. During these meetings, program results (status, trends, comparisons, etc.) and individual staff performance should be discussed.
- **Support systems and supportive supervision:** Direct service providers, who are often volunteers and community health workers, need a strong support system to help them carry out their work and collect and use information. Existing community groups can play an important role in doing this. They should be empowered and enabled to provide support and motivation to direct service providers. In addition, formal health workers from the government system and NGOs and FBOs should have the capacity, formal mechanisms, and tools needed to provide regular supportive supervision to direct service providers.
- **Ongoing performance monitoring:** Developing and implementing a performance-monitoring plan to monitor the performance of the community-level information system will help identify weaknesses and problems in the system, and provide a means to continuously improve the system.
- **Regular feedback mechanisms:** Developing a feedback mechanism paves an

important pathway between information collectors and information users. Likewise, incorporating a feedback mechanism into a community-level information system creates opportunities for information sharing. When developing an effective feedback mechanism, it is important to take the following points into consideration: What information is being collected? In what form is this information received? Who will benefit from feedback regarding this information? What kind of information will be most valuable to provide as feedback? In what format and forum should this data be presented? Who is responsible for supporting feedback tasks? Examples of feedback mechanisms include regular meetings to share aggregated service provision data from the community, sub-national, or national level with health managers and service providers from that level; meetings between donors and implementing organizations to review existing information and discuss programmatic challenges and successes; and dissemination of reports, organized in a user friendly formats, containing this information.

- Routine data quality assessments: Conducting routine data quality assessments allows programs to continually assess the quality of their data and strengthen data management and reporting systems. A data quality assessment system also provides a way to verify data reported for key indicators and generally assesses the ability of data-management systems to collect, manage and report quality data.

CLPIR Tools and Processes for Engaging Stakeholders

Curriculum for Program-Level Rollout Workshop 1: Defining Program Information Needs

Community-Level Program Information Reporting for HIV/AIDS Programs — Module 4

Introduction

This curriculum is for the first program-level rollout workshop. Although this module builds on the others in CLPIR, it is possible to use module 4 on its own to support the development of program/organization-specific information systems for community-level HIV/AIDS programs. Prior to the program-level rollout workshops, the users of the curriculum should adapt the content based on country-specific needs and context. About four days are needed to carry out the first workshop.

Purpose, Users, and Target Audience of the Curriculum

The purpose of the curriculum is to provide step-by-step guidance for carrying out a practical workshop that engages service delivery organizations to identify their own information needs, share their experiences, create ownership, and incorporate their comments to develop program specific indicators. The curriculum includes case studies, examples, lectures, participatory group discussions, and individual exercises.

Users of this curriculum are:

- master trainers identified by the rollout task force of the CLPIR steering committee;
- if the country has a decentralized health system with functioning sub-national units that play a role in managing community-level programs, it is recommended that staff from these units be involved in the program-level rollout (in addition to helping prepare for and organize the workshops, these individuals can also serve as some of the master trainers or participate as observers during the workshops; ideally, provincial/district health officers or directors would be able to participate); and
- the M&E officers from service delivery organizations.

The target audiences include organizations implementing community-level HIV/AIDS programs. As previously outlined, the first workshop contains nine sessions. The first six sessions are for all technical program staff from the participating service delivery organizations. The last three sessions are specifically for the M&E officers from those implementing organizations, to help them develop program/organization specific data collection tools and prepare for the second workshop, where they will train their staff to use the program/organization-specific data collection tools.

Specific staff recommended to attend the workshop include M&E officers (for all nine sessions) and field officers, volunteers, and other direct service providers (for the first six sessions). It is important to involve both office-based program staff and field-based direct service providers, since program objectives and indicators are being defined during this time.

In instances where implementing partners work with NGOs, FBOs, or CBOs to provide community-level HIV/AIDS programs, staff from both levels should participate in the workshop.

Workshop Sessions

The first workshop typically covers four days. In addition to the nine sessions, the first day should include a introduction session. Each day should begin with a review of the previous day's work. The following is a detailed description of each session.

Introduction Session

Objectives: The introduction allows participants to become more engaged in the workhop's overall objectives, which include:

- understanding the value of information;
- defining their own program's goal, objectives, and activities;
- developing indicators to measure their program objectives;
- setting up an information system, including information flow and feedback mechanisms; and
- promoting information use.

Recommended Time: About 30 minutes is the recommended time.

Instructions: Open the workshop by introducing facilitators to the participants. Then, ask participants to introduce themselves to the group and ask what their expectations are for the workshop. If a national stakeholders' workshop for indicator harmonization has taken place prior to this workshop, describe how the harmonized indicators that resulted from that process are related to this workshop. Review the workshop objectives, agenda, and timetable for the workshop.

Additional Notes for Facilitators: A national indicator harmonization process may have taken place prior to this workshop. During this process, a group of stakeholders will have developed a harmonized list of indicators for community-level HIV/AIDS programs to be tracked at the national level. However, these national level indicators do not necessarily meet all the information needs of program-level implementers and managers to enable effective decision-making for program management, monitoring, and improved program performance. This workshop and the overall program-level roll-out process are therefore essential to enable implementing organizations to develop program/organization-specific indicators and data collection forms to meet their information needs.

Session 1: The Value of Information

Purpose: It is easy to overlook the value of information. Even if the value of information is understood, on a practical level we often do not make use of this insight in our daily work. This session is designed to help participants understand the value of information and point out how information can be used to assist with day to day work.

Objectives: By the end of the session, participants will:

- understand the importance of information;
- understand the difference between reporting and using information for performance improvement; and
- appreciate how information can contribute to day to day work.

Recommended Time: About 50 minutes is the recommended time for this session.

Exercise 1.1: Value of Information — Small Group Discussion

Recommended time: Thirty-five minutes.

Materials: Flipcharts, markers, copies of exercise 1.1 handout of case study (found in the appendix) are needed.

Instructions: Present participants with the case study described below and give them 10 minutes to read through it individually (the case study and its questions are included in the exercise handout, found in the appendix in a format suitable for making printouts). Following this, divide participants into smaller groups to answer the three questions below. Each group should summarize its main discussion points on a flip chart. Then, in the larger group, a representative from each small group will present the small group's discussion points in plenary. The facilitators will then summarize key points at the end.

Case study: Mr. Kofi, a community health volunteer for a local faith-based organization working on a home-based care and OVC program, is discouraged. He has been working as a community health volunteer for two years and providing services for 30 families in his community. Sometimes he visits one family per week and other times he visits five families per week, but it all depends on how much time he has available.

Today, he visited one person living with HIV/AIDS to provide palliative care services. However, he could not provide opportunistic infection treatment due to a lack of the essential medicine (a stock-out). He also visited an OVC in his community and realized that the child needs a school uniform. He went back to his supervisor and requested an additional uniform. His supervisor asked him about the 20 school uniforms given to him last month and the activity report, which indicates how many of these uniforms were distributed to OVC in the community.

Mr. Kofi, however, has lost the activity report from the previous month. Unfortunately, his supervisor did not accept his new request without the previous month's activity report. What's more, some of the family members in his community have complained to Mr. Kofi's supervisor that Mr. Kofi is not providing appropriate services. In fact, Mr. Kofi does not know which services are necessary for each client, how to plan his activity and how to provide services according to the family's needs. Mr. Kofi is now confused and does not know what to do. In spite of his hard work trying to help the community, some people in the community do not appreciate his work.

Case study questions:

Question 1: Think about different things that a volunteer has to manage in the

course of providing services. What are some of the problems faced by Mr. Kofi?

Examples of answers include:

- Mr. Kofi does not know how to manage stock of supplies.
- Mr. Kofi collects information but does not use information to provide appropriate services to the family.
- Mr. Kofi does not know the needs of the individual clients and families.
- Mr. Kofi does not have an activity plan or targets.

Question 2: What type of record keeping forms or procedures could help Mr. Kofi avoid some of these problems mentioned in question 1? Briefly describe how these instruments or procedures could help Mr. Kofi.

Examples of answers include:

- Stock control register: to help Mr. Kofi keep track of the # of items/stocks on hand and know how many to request each month.
- Activity record: to help Mr. Kofi record the type of services provided to clients and families (including materials distributed such as school uniforms).
- Household Assessment: to help Mr. Kofi understand the condition of each family in his catchment area and the services that need to be provided to each family member.
- Target setting: to help Mr. Kofi keep track of his progress to make sure that he is making progress toward his goal.

Question 3: How does this case study show the importance of information across different levels of the program? Why is this information important?

Examples of answers include that the information helps:

- provide better service to clients (as opposed to meeting reporting purposes);
- in making appropriate decisions;
- identify problems and potential solutions;
- track progress toward goals;
- demonstrate effort, success, and lessons learned;
- to become efficient with time and money;
- identify gaps in services;
- assure accountability; and
- plan for future activities.

Additional notes for Facilitators: After each breakout group presents to the full group, summarize the key points and emphasize that information is essential to provide better services to the community. The breakout presentations and your summary should take about 25 mintues.

Session 2: Defining Programs

Purpose: We often assume that everybody who is involved in the program has the same understanding of the program's overall goal, and its objectives and activities. However, this is not always the case. Even if a program's goal, objectives, and activities have been clearly defined, they are often not shared with all program staff. Session two allows participants to review and, if necessary, define or modify their program's overall goal, objectives, and activities; and to arrive at a common understanding about them. *(Important consideration: The program goal, objectives, and activities vary from organization to organization, even when different organizations work together as partners. It is recommended, therefore, that the following exercise be done by each organization separately, to reflect accurately each organization's program goal, objectives, and activities.)*

Objectives: By the end of the session, participants will be able to understand the difference between a goal and an objective; and be able to identify their own project's overall goal as well as its objectives and activities.

Recommended Time: About an hour is the recommended time for this session.

Exercise 2.1: Defining Program Goal, Objectives, and Activities — Small Group Discussion

Materials: Flip charts, markers, exercise 2.1 handout on results framework (found in the appendix) are needed.

Recommended time: Forty minutes.

Instructions: Explain to participants why it is essential that staff have a shared understanding of the program's overall goal and its objectives.

Divide participants into breakout groups by implementing organization. In each small group, participants will identify their community-level HIV/AID program's overall goal, as well as the program's objectives and activities. To help them complete this exercise, provide handouts of the results framework.

The facilitator should first define the term "goal:"

> *A "goal" is a broad statement of a desired, long-term outcome of a program, and achieved through the combined efforts of multiple programs.*

Use the following questions to get participants to describe the ultimate goal of their community-level HIV/AIDS program.

- What is the purpose of our project?
- Why are we doing these activities?
- What do we want to achieve at the end?

Examples of answers to describe a program's overall goal might be "to prevent the transmission of HIV/AIDS" or "to provide care and support to patients and family members infected and affected by HIV/AIDS," or "to provide care and support to OVC infected and affected by HIV/AIDS."

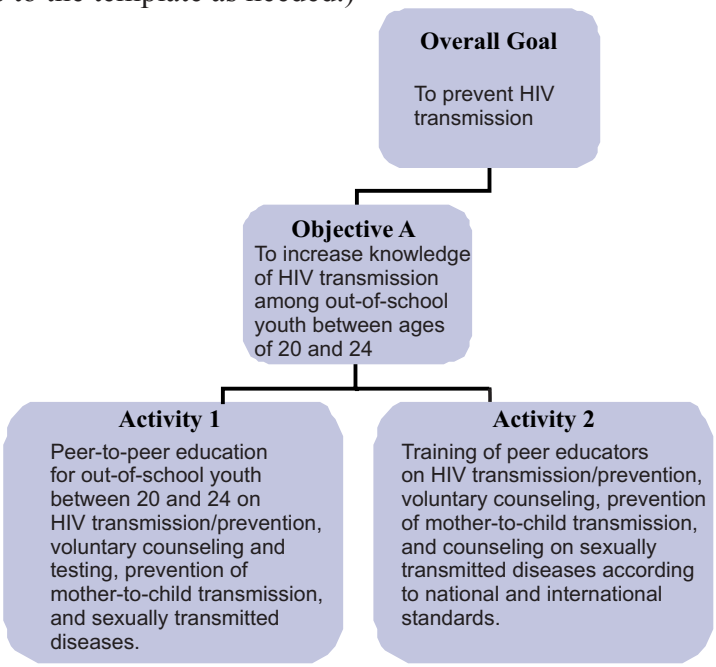
Ask participants from each program to reach a consensus on their program's goal. Once consensus is reached on the goal, ask participants to describe the desired program results (objectives) that contribute towards achieving the goal.

The facilitator should then define the term "objective:"

> *An objective is a statement of desired, specific, realistic, and measurable program results. Objectives are stated in terms of results to be achieved, not processes or activities to be performed.*

Ask participants to think about how and when to achieve the overall goal, who is the target audience, and what sources are required in order to describe the objectives of the program accurately. (If there are more than two objectives and four activities under a program's overall goal, add more objectives or activities to the template as needed.)

Example of Exercise 2.1 Handout, Showing a Group's Descriptions of Goal, Objective, and Activities.



Program with overall goal of preventing HIV transmission through one objective and two activities.

Participants should consider the SMART characteristics in developing strong program objectives. Write the SMART characteristics on a flip chart and ask participants to consider them when developing their objectives. SMART is an acronym to help remember the following important criteria for well-designed objectives:

S*pecific:*	The objective identifies concrete events or actions that will take place.
M*easurable:*	It quantifies the amount of resources, activities, or changes to be expended and achieved.
A*ppropriate:*	The objectcive logically relates to the overall problem statement and desired effects of the program.
R*ealistic:*	It provides a realistic dimension that can be achieved with the available resources and plans for implementation.
T*imely:*	A time within which the objective will be achieved is specified.

Example of answers might include "to increase knowledge of HIV transmission among out of school youth between age of 10 and 17," "to increase the percentage of OVC who have an access to one of the six core services," or "to increase condom use among commercial sex workers."

Once consensus is reached on the program objectives, ask the group to come up with a list of activities that are carried out to achieve the stated objectives. (If there are more than two activities for any single objective, or more than two objectives, etc., a small group may add them as needed to the template.)

Exercise 2.2: Synthesizing the Program Goal, Objectives, and Activities — Plenary

Recommended time: Twenty minutes.

Materials: Flip charts and markers are needed for this exercise.

Instructions: Once each individual organization has gone through exercise 2.1, bring everyone together into one group. Have the larger group compare and review each organization's overall goal, objectives, and activities. Since they are working together as partners, it is ideal to have a coherent project goal, objectives, and activities to define the partnership. However, that is not to say that there should only be a single set of goals, objectives, and activities since some sub-grantees may be receiving funds from multiple implementing partners. The objective of this exercise is to have a common understanding of each program's needs.

Session 3: Identifying Information Needs and Developing Indicators

Purpose: Session 3 will introduce different tools to provide step-by-step guidance on how to develop indicators that relate to program goals and objectives; and reflect the needs of service

providers and program managers, while meeting the minimum reporting requirements of the host country government and donors.

Objectives: By the end of the session, participants will be able to:

- identify their main information needs;
- understand the information needs of others;
- understand how different types of indicators meet these information needs;
- develop a harmonized list of program-specific indicators (that is also consistent with any national-level list of harmonized indicators); and
- define each program specific indicator.

Recommended Time: This session takes about six hours and 45 minutes.

Exercise 3.1: Measuring the Activity — Small Group Discussion

Recommended time: Thirty minutes.

Materials: Flip chart, markers, and exercise 3.1 handouts (from the appendix) are needed for this exercise.

Instructions: Ask participants to work in the same small groups from session 2. Instruct participants to review the organization-specific overall program goal, objectives, and activities they developed in the previous session and answer the following questions:

Question 1: Have we achieved (or made progress towards achieving) what we are supposed to do?

Question 2: How do we know if each activity was carried out successfully?

Question 3: How can we show other people that our work is making a difference?

Ask participants to come up with different types of questions that indicate that their program and activities have been successful. Ask them to come up with a question for each activity and objective, and write down the questions on the flip chart. (Examples of their program-specific questions might include: Did we reach enough out-of-school youths? Did we reach the out-of-school youths in our target range of 10-16 year old? How about the quality of the service? Did clients understand the HIV transmission/prevention, VCT, PMTCT, and STI messages that we disseminated? Did the project train enough peer educators? Did we respond to the needs of the community?)

Explain to participants that the answers to such questions can be expressed through either qualitative or quantitative data, and explain to participants the difference between quantitative and qualitative information. Point out that qualitative and quantitative information often complement each other to give a more complete picture of what is happening with a program.

Numbers alone (quantitative data) do not provide all the information needed to answer some of these questions. Qualitative information, such as information from individual interviews and focus group discussions, will also help in understanding why problems are occurring and how to address these issues.

Describe the definitions of the two terms (listed next) and refer to the exercise 3.1 handout, which compares qualitative and quantitative data (found in the appendix).

Excercise 3.1 Handout Table

Qualitative	Quantitative
Descriptive Usually not quantified in numbers More in depth Open ended questions	Able to quantify Closed ended questions Able to make broader generalizations
Strengths	
Allows one to look at emotions and ideas Usually less expensive to implement compared with quantitative research Can yield better information about causes and processes Needs fewer people to participate	Easier to measure compared to qualitative approaches Can present data graphically Easier to administer per person Reaches more people Can generalize results to a larger population if sampling is done properly
Weaknesses	
Needs well-trained staff to conduct interviews, facilitate focus groups, etc. Unable to generalize results to the population as a whole	Can be more expensive Can be more easily falsified Can be subject to interviewer errors Can introduce bias through sampling Needs a large number of people to participate

Quantitative information: Structured and standardized approaches are used to collect and analyze numerical data. They help answer questions about "how much" and "how many." These approaches involve recordkeeping and numerical counts. Quantitative information can be expressed as:

- counts
- calculations (percentages, rates, ratios, etc.)
- indices, composite measures
- thresholds (presence, absence; pre-determined level or standard)

Qualitative information: This involves non-numerical informatin, relying mostly on semi-structured or open-ended methods. These approaches help answer questions about "how well" a project element is being conducted. Examples of qualitative methods include focus group discussions, interviews, and success stories.

Although qualitative information provides further insight into an identified issue, the following exercise will focus on quantitative information. We will return to qualitative information issues when we discuss design of data collection forms, feedback mechanisms, and information use.

Exercise 3.2: What is an Indicator?

Recommended time: Fifteen minutes.

Materials: Flip charts, markers, and handout (shown below, available in the appendix in a format suitable for printing copies).

Excercise 3.2 Handout

Type of Indicator	Definition	Example
Input (monitoring)	Resources needed to carry out the activities.	Staff, finance, materials, time
Output (monitoring)	Set of activities in which program resources are used to achieve the results expected from the program.	Number of workshops or training sessions
Outcome (evaluation)	Immediate results of activities.	Number of people reached, number of commodities distributed
Impact (evaluation)	Long-term effects, such as changes in health status. This can be through special studies with wide district, regional, or national coverage.	Reduced HIV/AIDS incidents rate among youth

Instructions: Ask participants to review the list of questions they developed in exercise 3.1. How can we respond to these questions? What are some of the possible answers? Use the following example to demonstrate how the questions can be answered:

Activity: Peer-to-peer education for out-of-school youth on HIV transmission and prevention.

Question: Did we reach enough youths?

Answer/indicator: Yes, we reached enough youth because we know the number of out-of-school youths reached through the program.

Additional notes for facilitators: Explain to participants that the "number of out-of-school youth reached through the program" is an indicator. An indicator can be defined as a variable that measures one aspect of a program, project, or health outcome. Then present the different

types of indicators listed in the exercise 3.2 handout. Although outcome and impact level indicators are important for the program, such indicators are usually collected through non-routine data sources using tools such as surveys. The next exercise will focus on indicators that can be collected through routine information systems.

Exercise 3.3: Developing Indicators — Small Group Discussion

Recommended time: Ninety minutes.

Materials: Flip charts, markers, list of questions from previous exercises, exercise 3.3 handout (illustrated on the next page and found in the appendix in a format suitable for printing copies), and illustrative indicators from CLPIR module 1 are needed for this exercise.

Instructions: Discuss the list of key considerations on the handout and some examples of good and bad indicators, discussing why the indicators are good or bad. Then ask participants to form small groups by organization and come up with indicators to answer the questions developed during exercise 3.1. The groups should use the exercise 3.3 handout as a template to do this exercise. They can also use the CLPIR illustrative indicators as an additional resource.

Review and contrast well-defined indicators to poorly defined indicators: Some examples of poorly defined indicators include the following:

- number of people with AIDS knowledge
- number of contraceptives distributed

Some examples of good indicators include the following:

- number of out-of-school youths between age of 10 and 24 who could answer at least three HIV transmission routes correctly
- number of female condoms distributed to the commercial sex workers during last three months

Excercise 3.3 Handout

	Statement	Possible Indicator
Goal	To prevent HIV transmission	
Objective 1	To increase knowledge of …	Number of youth correctly answering at least three ways of HIV transmission etc…
Activity 1	Peer-to-peer education	Number of peer educators trained
Activity 2		
Objective 2		
Activity 1		
Activity 2		

Key Considerations of a Good Indicator

Validity:	Measures only the condition or event it is intended to measure.
Reliability:	Produces the same results when used repeatedly to measure the same condition or event.
Precision:	Is defined in clear and unambiguous terms.
Independence:	Non-directional (can vary in any direction).
Measurable:	Quantifiable using available tools and methods.
Timeliness:	Provides a measurement at time intervals relevant and appropriate in terms of program goals and activities.
Comparability:	Generates corresponding values across different population groups and program/project approaches.
Programmatically important:	Linked to a public health impact or to achieving the objectives those are needed for impact.

Exercise 3.4: Use of Information for Decision-Making — Small Group Discussion

Recommended time: One hour.

Materials: Flip chart, markers, completed handouts from exercise 3.3 are needed.

Instructions: Once the groups have a draft list of indicators, ask the groups to come up with at least one example of using such information to make a decision. Examples should be specific and realistic. Please consider the perspective of both the data user and the data producer to make sure that there is agreement on the selected indicator. A lack of a consensus between producers and users of information can often lead to inaccurate and or incomplete data being gathered through a system. Use the CLPIR indicator reference sheets (found in module 1) for examples of data use for each indicator.

At the end of the exercise, bring the small groups back into a plenary session and ask a representative from each group to share the indicators their group selected, along with examples of data use for each indicator.

Addtional notes for facilitators: Explain to participants that if they cannot come up with a good example of data use for a given indicator, they should NOT include that indicator in their list. Indicators must be ACTION oriented.

Exercise 3.5: How Many Indicators Are Enough? — Small Group Discussion

Recommended time: One hour.

Materials: Exercise 3.5 handout (found in the appendix in a format suitable for printing copies) flip chart, markers, organization-specific list of indicators from exercise 3.4, list of indicators currently used by each organization, national level indicators required by government, list of indicators required by donors, any other indicator sets required for reporting, and CLPIR illustrative program indicators (from CLPIR module 1) are needed for this exercise.

Instructions: Ask participants to continue to work in their small groups to review the list of indicators currently used by their program, national harmonized indicators required for reporting by the government and donors, any other indicators required for reporting, and the CLPIR illustrative program indicators found in CLPIR module 1.

Ask the groups to compare the lists of indicators they identified during exercise 3.4 with the other indicator sets listed above. Then ask them to decide which indicators to keep and which to drop from their lists. The goal is to come up with a minimum set of indicators that will be useful for both reporting purposes and program management. Indicators mandated for reporting purposes by government and donors will likely need to be kept on the list, so the exercise may be focused on selecting a set of indicators to add to the reporting indicators, for purposes of better management and decision-making at the program/organization level. Use the exercise 3.5 handout. While selecting indicators, the groups should also refer to the CLPIR illustrative program indicators and CLPIR indicator reference sheets in module 1 as resources

to help them prioritize indicators.

Addtional notes for facilitators: Explain to participants that the process of identifying a minimum set of indicators is not a linear process. Participants may need to go back and forth between results from previous exercises to select an appropriate and useful minimum set of indicators.

Exercise 3.6: Synthesizing Indicators

Recommended time: Twenty minutes.

Materials: Flip charts, markers, and lists of proposed indicators from exercise 3.5 are needed.

Instructions: Ask participants representing implementing partners to form a group with their corresponding NGOs, FBOs, and CBOs. Have each organization represented in the large group compare and review their list of indicators from exercise 3.5. The implementing partner and NGO/FBO/CBO levels should ideally have common indicators that cut across both levels.

Exercise 3.7: Defining Indicators

Recommended time: One hour and thirty minutes.

Materials: Exercise 3.7 handout, flip chart, markers, list of indicators from the previous exercise, CLPIR module 1 (indicator reference sheets) are needed.

Instructions: Instruct each group to pick two indicators selected during exercise 3.5 and use them to discuss why "defining" indicators is important. Once participants understand the importance of properly defining indicators, ask each group to define each indicator in their minimum set from exercise 3.5. Instruct groups to use the exercise 3.7 handout form, List of Indicators by Disaggregation, to complete this exercise (the handout is in Appenidix A in a format suitable for printing copies). Again, the groups can refer to the CLPIR indicator reference sheets in module 1 to see how indicators should be defined. After 30 minutes, ask each group to present its indicators and indicator definitions in plenary.

Some examples of indicators and questions about them include:

- "Number of OVC who received educational services." What does the phrase "education services" actually mean? It could be school uniforms, tuition fees, pens, and individual tutoring, etc.
- "Number of new PLWHA." What does this mean? Does is mean the person was just infected by the HIV virus? Does it mean the person is newly enrolled in the program?
- "Number of patients referred." Does this mean that a patient was told to go to a certain clinic or hospital? Does it mean the patient actually received the service at the receiving site?

It is important for everybody to measure the same thing in the same way. For example, we can improve the definition "number of new PLWHA" by making it more specific, e.g., "number of

newly-registered and enrolled PLWHA into our HBC program during this reporting period." Developing standardized definitions is critical for a program to be able to measure its indicators accurately.

Exercise 3.8: Disaggregating Indicators — Small Group Discussion

Recommended time: Forty minutes.

Materials: Flip chart, markers, list of indicators selected from the previous exercise (exercise 3.7 handouts), CLPIR indicator reference sheets (module 1) are needed.

Instructions: Once the indicators have been defined, each group will review the CLPIR indicator reference sheets (in CLPIR module 1) as a resource, to decide if it is necessary to disaggregate any of the indicators. Use the following questions and the completed handout forms from exercise 3.7 to complete this exercise. At the end of the exercise, each group will present its list of indicators and show if and how they were disaggregated.

Additional notes for facilitators: Explain to participants that deciding at which level disaggregation is necessary, and is as important as choosing the indicator. Aggregated data are useful as they give a broader picture of what is happening in the program. However, aggregated data can conceal diversity within different geographical areas, age categories, sex, or social groups. The decision of disaggregation should be decided according to a program's needs.

Some examples of disaggregation include:

- **age range:** 10-15, 16-19, 20-25, >25
- **sex:** male or female
- **case type:** new or follow-up
- **location:** village, township, district, province, national
- **social group:** out-of-school youth, commercial sex workers, etc.

Questions to ask include: Do we need this information disaggregated (by age, gender, etc.)? What age categories are most appropriate for our program? Are these categories consistent with internationally agreed upon categories? Is the disaggregated information importing for decision making? If so, what are the decisions? Do we have the resources to respond to the findings?

Suggest that participants disaggregate information only if doing so is critical for the program. This is because disaggregation can severely increase the complexity of the data collection tools and overburden the service providers who collect this information. For example, if your program does not have an accurate count of the number of clients receiving services, then you may not need to know the age and gender of your clients at this point, since that information may not be very reliable. After your program has more accurate data on the number of clients receiving services, then you can disaggregate certain indicators and start collecting information by gender and age.

Session 4: Setting Up an Information System

Purpose: Once a minimum set of indicators is selected and defined, it is important to know who is responsible for collecting which indicators, how the information will move from one level to another, and how feedback will be provided. Session 4 introduces tools to identify sources of data, information flows, and feedback mechanisms.

Objectives: By the end the session, participants will be able to:

- identify the sources of information; frequency of reporting; and the persons responsible for collecting, aggregating, and reporting data to the higher level;
- understand the likely information flows in the system; and
- understand potential feedback mechanisms that could be used.

Recommended Time: This session five takes about an hour and 30 minutes.

Exercise 4.1: Identifying the Sources of Data — Small Group Discussion

Recommended time: Forty-five minutes.

Materials: Flip chart, markers, CLPIR indicator reference sheets (from CLPIR module 1), exercise 3.7 handout (List of Indicators by Disaggregation, found in the appendix), the generic CLPIR data collection tools (module 1).

Instructions: Continue working in the same groups to identify sources of data, responsible persons who complete the forms/report, and the frequency of the reporting. Complete the exercise 3.7 handout by using the CLPIR illustrative program indicators, generic data collection forms, and instructions from module 1 as resources.

Ask participants to respond to the following questions:

- Where do we capture this information (indicator)?
- What is the most appropriate data source for this indicator?
- Who is responsible for collecting this information? Who is going to aggregate this information?
- How often will data be collected, complied and reported?
- Is there any requirement from donors or the host country government in terms of reporting frequency?

Examples of data sources include sign-in logs/registers, assessment forms, registration (enrollment, intake) forms, daily activity reports, tally sheets, patient/family cards, monthly/quarterly/annual reports, and referral forms.

Exercise 4.2: Information Flow — Large Group Discussion

Recommended time: Twenty minutes.

Materials: Flip chart and markers are needed.

Instructions: Once each group has identified who collects what information and how often information is processed, instruct each group to draw an information flow diagram. At the end of the exercise, a representative from each group should share their group's information flow diagram with the larger group.

Exercise 4.3: Feedback Mechanisms — Large Group Discussion

Recommended time: Twenty minutes.

Materials: Flip chart, markers, and information flow diagrams from exercise 4.2 are needed.

Instructions: Ask participants why feedback is important. Record responses on the flip chart.

Some examples of goods answers are to:

- assist the lower level to understand and compare its performance with its colleagues;
- identify issues and problems as they arise;
- acknowledge and appreciate the effort of staff;
- demonstrate that information sent up the system has value and is used; and
- learn from the best and worst performers.

Once participants have acknowledged the importance of feedback mechanisms, ask participants to identify who should provide feedback, how the feedback should be provided, and how often it should be provided.

Typical questions to ask include: Who will analyze the data? How often will analysis occur? How often and to whom will the results be disseminated?

After participants have discussed these issues and identified responses, this information should be added to the information flow diagrams that were developed during exercise 4.2. Next, ask participants to identify what should go in a feedback report. Example answers include:

- whether data are accurate and submitted on time;
- whether the information is used to make certain decisions at each level;
- comparing performance against targets;
- compare performance by periods; and
- identify issues or problems and suggesting possible solutions.

Additional notes for facilitators: State that feedback is very important for service providers to know about their level of performance and also presents an opportunity between supervisors and staff to share experiences and strengthen communication. It is also an important way to uncover problems that are systematic and require action from the management level. Feedback also providers a way for supervisors and staff to come up with action items for identified

problems. Feedback strengthens the staff's confidence towards management and shows staff members that their supervisors are concerned about their performance and about their motivation and commitment.

Session 5: Promoting Information Use

Purpose: Often raw data is not useful until it is converted into meaningful information and analyzed/interpreted to improve program performance. Session 5 introduces the concept of catchment areas and performance targets as a way to use collected information better to monitor performance over time.

Objectives: By the end of the session, participants will:

- understand the difference between data and information;
- be exposed to the concept of catchment areas;
- understand why it is important to set up targets;
- understand program targets; and
- be able to monitor performance against targets.

Recommended Time: This session takes about four hours.

Exercise 5.1: Converting Data into Information — Small Group Discussion

Recommended time: Forty-five minutes.

Materials: Flip chart, markers, and handout of case studies (found in the appendix) are needed.

Instructions: Participants will continue working in the same groups from the previous exercises. First, present participants with the first case study exercise in the exercise 5.1 handouts (found in the appendix) and give them five minutes to read through it individually. Then ask participants to work in their groups to answer the questions listed with the case study, and to write key discussion points on the flip chart.

Next, give them five minutes to read through the second case study in the handout. Then ask each group to answer the questions listed and write their key discussion points on the flip chart.

At the end of the session, a representative from each group will share the group's key discussion points with the larger group in plenary, and a facilitator will summarize the key points.

Questions for both case studies are: Can you assess the performance of these two health workers? Who is performing better?

Examples of reasonable answers to the first case study include:

- Mr. Joseph is performing better because he is reaching more clients than Ms. Fatima and successfully enrolling new clients into the program.
- We cannot assess the performance from the given information.

- Examples of reasonable answers to the second case study include:
- Although Mr. Joseph is seeing more clients (15) than Ms. Fatima (10), Mr. Joseph did not visit five clients in need during this month, while Ms. Fatima visited all of those needing care in her catchment area.
- Although Mr. Joseph was successful in recruiting one new client to the program, there are 10 more people who are in need of HBC services in his catchment area.

Additional notes for facilitators: Ask participants what information was missing from the first case study compared with the second. Ask how the additional information helped them understand the performances better in the second case study. Examples of good answers might be:

- The estimated number of clients in the catchment area was missing.
- The enrolled number of clients needing HBC services was missing.
- Having a denominator helps interpret the result more accurately.

Explain to participants that it is important to have a reference point or denominator to understand the level of activity or performance. This helps in making comparisons and in calculating parts of the total. If the total number of clients enrolled in the program in Ms. Fatima's catchment area was 30, then her performance could be viewed as poor. Similarly, if the total number of clients enrolled in the program in Mr. Joseph's catchment area was 15, his performance could be viewed as excellent. Thus, without a denominator, the interpretation of the results can be very misleading.

Exercise 5.2 What Is Your Catchment Area?

Recommended time: Forty-five minutes.

Materials: Flip chart are markers are needed.

Instructions: As was demonstrated through exercise 5.1, having a clear idea of catchment area, target audience, and how many members of the target auidence are currently being served are critical for successful program implementation and monitoring. Once service providers have a clear idea of their target population, and understand their role and responsibility with regard to the target population, they will be much more capable of using data to monitor their performance.

Begin the exercise by asking each group to respond to the following questions. Then, compare the responses within a program and find out if participants have a good understanding of their catchment population.

- What is the catchment area of your program?
- Who are the people in the target audience in your catchment area?
- Do you know how many of them need services from your program?

Examples of good answers might be:

- district A and B for catchment area;
- OVC for people in the target audience; and
- an estimated number needing services (e.g. 500 OVC or 800 OVC).

Next, ask the same questions to the following subgroups within each program: client management level (volunteers/community health workers); provider management level (supervisors of volunteers and community health workers); and program management level (M&E officers or program managers).

Examples of reasonable answers to "What is your catchment area" might include specific communities for the client management level (e.g. three communities), more communities for the provider management level (e.g. 10 communities), and all of the district for the program management level.

An answer to "Who are the people in your target audience?" would be OVC for all levels.

Answers to "Do you know how many of them possibly need a service from your program?" would vary depending on the level's area. For example, 20 OVC might be correct at the client management level, 100 at the provider management level; and1,000 at the program management level.

Compare the answers within sub-groups to find out if participants have a good understanding of their catchment population. It is important to have a common understanding of the target population and the estimated number of clients in the catchment area. Spend enough time to go through the numbers and try to come up to an agreement within each program, if possible.

Additional note for facilitators: Catchment areas can vary from one service provider to another within a program. The purpose of this exercise is for the participants to have a better understanding of their target population within their catchment area. If an agreement about the specifics cannot be reached during the workshop, service providers and their supervisors can continue the discussion after the workshop.

Exercise 5.3: Why Set Targets? — Plenary Group Discussion

Recommended time: Fifteen minutes.

Materials: Flip chart and markers are needed.

Instructions: Once participants understand the catchment area that they are responsible for and the estimated number of clients in that catchment area, the next step is to set targets so that progress can be monitored over time. First, ask participants why setting targets is important.

Then ask the group these following questions:

- Why do we set targets?
- What are targets for?
- Who needs these targets?

Examples of good answers to why, what, and for whom include:

- *To prioritize activities:* With targets, there is a clear direction of where the program is trying to go.
- *For self-improvement:* With targets, we know if each of us are meeting expectations.
- *To promote accountability:* With targets, responsibility and accountability of each staff is clear.
- *To motivate staff:* Targets that are realistic but challenging can be motivating and create a sense of ownership.

Additional notes for facilitators: Performance targets are set for several reasons. Being aware of the purpose of the target will inform the way in which the target is addressed. Thus, it is important to convey the message that targets are not set to punish or penalize individuals. Not meeting a target is NOT necessarily a sign of failure. There are other ways of assessing performance, such as comparing with past performance or comparing performances among individuals. Even if targets are not met, there is still an opportunity to focus on what has been achieved and share experiences and learn from those experiences where possible. If the target is either unrealistic or too difficult to achieve, staff will likely become demotivated. Explain to participants that we set targets for positive reasons — to encourage improved performance and to motivate staff where there is a probability of success.

Exercise 5.4: Setting Targets

Recommended time: Forty-five minutes.

Materials: Flip chart, markers, and exercise 5.4 handouts (found in the appendix) are needed.

Instructions: Once the objectives of target setting are clear, each program should come up with draft performance targets for the minimum set of indicators that were previously selected. Since there is not enough time to develop targets for an entire program during this workshop, participants will go through the process of target setting for a few select indicators. Then, after the workshop, each program should develop program targets for all desired indicators.

Step 1: Select a few priority indicators for target setting. From the minimum set of indicators identified during the previous exercises, select two critical indicators to set up performance targets.

Step 2: Define those indicators. This step involves understanding the chosen indicators in terms of the target and the time reference for the target.

Step 3: Estimate the target based on past performance and other program-specific information. This step involves taking into account past results and program-strategic planning to estimate expected achievements in a program area, within specified time periods or budget limitations. Estimates for targets should be based on the history of service delivery and adjusted for changes in funding and

program planning. (Participants should set targets for those indicators for which they know or have some of this historical data.)

Step 4: Estimate the target based on more general information. This step involves ensuring that targets make sense and are feasible given past trend data, the nature of the epidemic, populations to be reached, resources available for program delivery, and overall infrastructure of the national government.

Some issues to consider during this exercise include the following:

- The target should be selected on the basis of the current situation and what is attainable in a given situation.
- As a general rule, improvements become more difficult as levels improve.
- If a particular indicator has continuously worsened in the recent past, it may not be realistic to set a target indicating a substantial improvement in the short term.
- It is essential to consider the resource implications of the selected targets (both human and financial).
- Discuss with program managers/project officers all fiscal, program, and other relevant information needed to accurately estimate results achieved in the past and targets that can be realistically expected in the future.

Targets should be developed based on baseline data, if there are any; past trends; national targets, if there are any; the level where the program would like to go and should be able to reach; available funding and human resources; and similar activities achieved elsewhere, if there are any.

Participants should also consider the following questions when setting targets:

- Is the target realistic (not too difficult to achieve but still challenging)?
- Who is accountable for the result?
- Who is monitoring the performance?

Next, overall program targets should be broken down into periodic targets. Refer to the program-level targets worksheet in the exercise handout. Then, target percentages need to be converted into numbers by applying the target population in your program's catchment area, as shown in the example of a completed handout on the next page.

After overall program targets have been set, targets can be set for individual service providers. This can be done by supervisors working closely with each of their service providers by using the individual targets worksheet in the exercise handout. It is important to make sure that each target is realistic (not too difficult to achieve but still challenging) and that the service providers are comfortable with the targets that they are collecting.

The example of a completed handout (next page) uses a program's indicator of "percentage of PLWHA enrolled in our program" and program and individual targets of 90% of the estimated PLWHA will become enrolled over four years throughout the program's catchment areas and

over four months within the individual service provider's catchment area.

Excercise 5.4 Example of a Completed Handout

Program-Level Targets Worksheet

Indicator	Program targets over 4 years)		First year	Second year	Third year	Fourth year
Percentage of PLWHA enrolled in our program	90% of estimated # of PLWHA in our catchment area* is enrolled in our program *(*For this example, there are 500 PLWHA in the program's catchment areas)*	Target (%)	75%	80%	85%	90%
		Target (#)	375	400	425	450
		Actual performance (#)	350	390	420	460

Individual Targets Worksheet

Indicator	Program targets over 4 years)		First month	Second month	Third month	Fourth month
Percentage of PLWHA enrolled in our program	90% of estimated # of PLWHA in an individual catchment area* is enrolled in our program *(*For this example, there are 30 PLWHA in the catchment area)*	Target (%)	75%	80%	85%	90%
		Target (#)	23	24	26	28
		Actual performance (#)	14	22	27	25

Exercise 5.5: Monitoring Results — Small Group Discussion

Recommended time: One hour and 30 minutes.

Materials: Flip chart, markers, CLPIR module 1 (indicator reference sheets), and exercise 5.5 handouts are needed.

Instructions: Before breaking out into small groups, ask participants to discuss the following

questions in plenary:

- How do we use targets to monitor our performance?
- How should we interpret results?
- What kinds of decisions can we make from these results?

Then instruct participants to break out into small groups and use the table and graph in the exercise 5.5 handout (found in the appendix) to answer the following questions (also listed in the handout). Assume that a program is at the end of the period five and we are trying to review its performance over the last five periods. One person from each group should list discussion points on a flip chart and a representative from each group will present their discussion points to the larger group.

Questions on the handout are the following, with examples of correct answers in italics:

- How many people living with HIV/AIDS are currently enrolled in your program?
  There are 170 currently enrolled.
- Are you achieving your target for this reporting period?
  Yes, we are reaching our target.
- Compared to previous reporting periods are you expanding your program by reaching new patients?
  Yes, we reached 20 new clients during this reporting period. Compared with previous reporting periods, our performance this period is good.
- Are you successfully keeping the same patients in the program from the previous reporting period?
  Yes, at the end of the previous period, there were 150 people enrolled in the program and nobody dropped out of the program during this reporting period.
- Do you see any trend over time?
  Yes, we see a positive trend over time.
- What are some possible interventions/actions you can take?
  We will continue to do what we are doing.

Additional notes for facilitators: After the groups share their key discussion points in plenary, ask each group to pick one more example from the CLPIR indicator reference sheets in module 1 (see suggested list of reference sheet examples below). This time, ask participants to look at the data and explain in words what the data tell them.

Good examples to use from the prevention programs section of module 1 include the following from the reference sheet for illustrative indicator 1:

- Figure 14 (page 34), showing the number of people reached over five periods for a program with a target of reaching 70 people (an example of target vs. performance); or
- Figure 17 (page 36) showing the percentage of target population reached by a

program over five periods.

In the home-based care section, good reference sheet examples are found on page 81 for illustrataive indicator 1:

- left chart in figure 39 showing target vs. performance over four periods;
- right chart in figure 39, showing enrollment by gender;
- left chart in figure 40 showing performance by period; or
- right chart in figure 40 showing performance by geographic areas (by villages).

In the OVC section, good examples from the reference sheet for illustrative indicator 1 are found in figures 67 and 68 (pages 139-140):

- top chart in figure 67 compares targets with performance over five period;
- bottom bar chart in figure 67 shows this comparison by gender;
- left chart in figure 68 shows proportion of total OVC being served by period; or
- right chart in figure 68 shows proportion of total OVC being served by geographic are (by village).

Explain to participants that this kind of analysis should take place on a regular basis — at the end of every reporting period, during supervisory visits, for self-improvement purposes, and in general to ensure that the program is performing well. It is important to emphasize again that information is not only for reporting purposes but also for the program performance improvement.

Session 6: Introduction to Problem Solving Skills

Purpose: Being able to collect data, interpret the results, and monitor performance is not the same thing as being able to use information to take appropriate action. Using program monitoring data, the following session (two exercises) will help participants identify root causes of problems and will build upon their capacity to take appropriate action to address those problems.

Objectives: By the end of the session, participants will be able to:

- identify issues and problems, and come up with possible solutions;
- develop a cause-and-effect diagram; and
- prioritize issues that need attention and action.

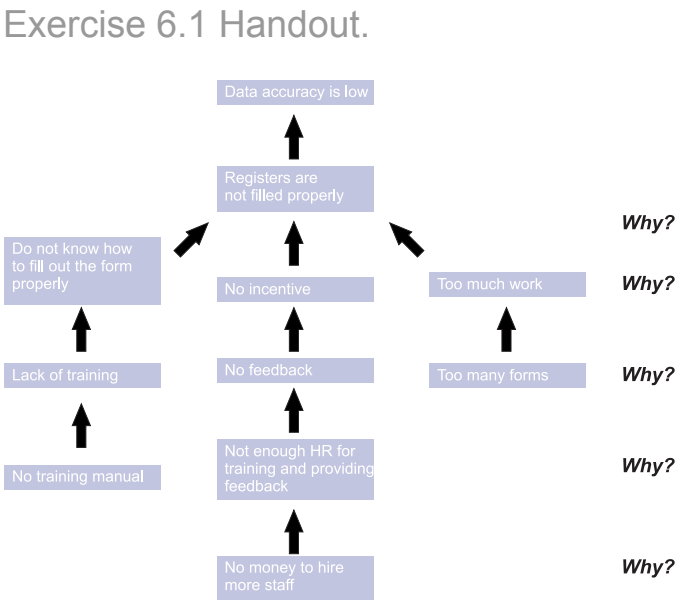
Recommended Time: This session takes about an hour and 15 minutes.

Exercise 6.1: Cause and Effect — Small Group Exercise

Recommended time: Forty-five minutes.

Materials: Flip chart, markers, and exercise handouts of cause-and-effect diagram are needed.

Instructions: Use the exercise handout with the cause and effect diagram example (found in the appendix in a format suitable for printing copies and shown at right) to go through this exercise. First, divide participants into small groups and ask each group to draw a case-and-effect diagram by following the instructions below.



Start by identifying the immediate cause of the problem at hand. For example, if the problem is "data accuracy is low" (shown at the top of the handout example), we first identify an immediate cause and then explore secondary or proceding causes. Why is data accuracy low? The answer may be "because registers are not filled in properly" (the second line in the handout). After identifying the secondary level causes, we repeat the same process over again until we reach a saturation point where no further causes can be identified. Alternatively, another reason to stop may be because we have identified sufficient causes to help us have a better understanding of the problem. The rule of thumb is that five rounds of questioning should provide enough causes to understand the problem better and to think about potential solutions.

Additional note for facilitators: A cause-and-effect diagram provides us with a comprehensive picture of what is causing what, and ultimately affecting the overall problem. Is it due to lack of knowledge and skills among staff members? Is it because materials such as equipment, forms, or registers are not available? Is it because responsibilities are not clearly defined or are not distributed properly? Is it because the process of carrying out a task is not clear? Is it a combination of various factors? Are some causes more important than others?

Exercise 6.2: Prioritizing the Issue and Identifying Solutions — Small Group Exercise

Recommended time: Thirty minutes.

Materials: Flip chart, markers, and exercise handouts are needed.

Instructions: Once the groups have developed a case-and-effect diagram, the next step is for participants to think through how high a priority an issue is and whether they can influence the issue on their own, or if they need to refer the issue to someone else who has the capacity or power to influence it. People often ignore issues because they feel that it is not their responsibility or they feel that they do not have the power to resolve the issue. It is therefore essential not only to identify the causes but also to determine who can influence them, or no action will be taken and the issue will remain unresolved.

Ask participants to stay in the same group from the previous exercise and transfer the key issues identified from exercise 6.1 to the prioritization matrix in the exercise 6.2 handout. For each cause listed, decided how high a priority it is to solve the problem in your particular situation. If you or someone you know could influence the cause, place an X in the column entitled "Capability to influence." If you think you cannot influence the cause, put an X in the column entitled "Limited capacity to influence." Finally, propose a solution to as many causes as possible, especially those that are high priority and for which there is capability to influence the issue. An example of a completed matrix is shown below, using the cause-and-effect diagram from the previous exercise.

Additional notes for facilitators: Suggest using a similar prioritization matrix during regular program meetings or during supervisory visits to help service providers and their immediate supervisors develop an action plan for identified issues and problems. If issues identified through the matrix or cause-and-effect diagram require the involvement of more senior staff, these issues should be brought to the attention of senior management by a supervisor or other appropriate person. If decisions are made by senior management and actions taken based on those decisions, it is important to share this information with relevant staff.

Example of Completed Matrix Using Exercise 6.1 Handout

List of causes affecting...	Priority			Capability to influence	Limited capacity to influence	Possible solution
	High	Medium	Low			
no training manual	X				X	
too many forms	X			X		
no money to hire more staff			X		X	
do not know how to fill out the form properly						
no incentive						
too much work						
no feedback						
lack of training						

This concludes the first six sessions of the first workshop. The remaining three sessions are intended to be done by M&E officers only from the implementing partners, NGOs, FBO, and CBOs. Others who participated in the sessions up to this point are now finish with the workshop and should be thanked for their time and effort.

Each organization participating in the workshop should designate their M&E officers or other appropriate staff to participate in the remaining three sessions. These sessions will be facilitated by the master trainers, as a training-of-trainers event, to help participants plan and conduct part 2 of the workshop (Designing Program Specific Data Collection Tools). Upon completion of part 1 of the workshop, participants are expected to finalize their program/organization-specific data collection forms and be able to conduct part 2 among staff at their respective organizations.

Session 7: Identifying the Design of the Program and Information System

Purpose: Community-level HIV/AIDS programs offer a variety of services, such as palliative care, prevention programs, and services for OVC. Some programs offer a combination of several services while others offer only a specific service. When a program offers a combination of services, sometimes the services are offered in an integrated manner and other times they are offered more or less vertically. What services a program offers and the way they are offered influences the way information is gathered. Therefore, in order to design an appropriate data collection tool for a program, it is first essential to understand the program's design. Session 7 introduces the concept of an integrated/family centered approach, and compares it with vertical approaches of service delivery. Participants will use the information presented in this module to identify their program's design and identify the most appropriate design for their program-specific data collection forms.

Objectives: By the end of the session, participants will be able to understand the concept of an integrated/family centered approach and be able to identify the most appropriate design for the program-specific data collection tools they will be developing.

Recommended Time: This session takes about 45 minutes.

Exercise 7.1: Integrated Service vs. Vertical Services — Group Discussion

Recommended time: Forty-five minutes.

Materials: Flip chart, markers, exercise 7.1 handouts of the three approaches and table (found in the appendix) are needed.

Instructions: Describe the three service delivery approaches illustrated in the handout and give participants 15 minutes to read through the approaches individually. Then, briefly describe the characteristics of each approach to make sure participants understand the differences among the approaches. In this discussion, the definition of "comprehensive integrated service" includes OVC services, palliative care, and limited prevention services.

- **Approach 1: Services integrated at the service delivery point —** In a given community-level HIV/AIDS program, if a single health worker provides comprehensive services (e.g., OVC services, palliative care, and limited HIV/AIDS prevention services) to a household, it is suggested that the program develop an integrated data collection system and use integrated forms at the service delivery

point, such as the CLPIR Integrated Activity Register (Form I_1), found in module 1, appendix A. Regardless of types of services provided to the household or individual, the same design of the register can be applied if services are offered in an integrated manner. The Integrated Activity Register (Form I_1) allows the service provider to deliver family oriented care and helps reduce the burden of data collection on service providers.

- **Approach 2: Services integrated at the program level —** When a single program provides comprehensive services (OVC services, palliative care, and prevention services) to a household but through several vertical activities within the program, and multiple service providers are involved in delivering the services, it is suggested that the program use forms such as the Family Record Card (Form I_2) and Individual Service Record (Form I_3) found in CLPIR module 1, appendix A. In this case, service providers would use non-integrated forms at the service delivery points, and then transfer information to the Individual Service Record (Form I_3) to integrate information from vertical activities. This record allows service providers to see a comprehensive picture of all the services provided to the individual through vertical activities. The Family Record Card (Form I_2) links individuals from the same household.
- **Approach 3: Services are not integrated —** When multiple programs provide services to the same household, it is suggested that the programs use forms such as the Family Record Card (Form I_2) and a household identification number (ID) to keep various service providers better informed about which services are being provided to the individual or household across different program. In this case, programs should consider using non-integrated forms and registers to collect and aggregate information, and use a family card to record the different services provided through vertical programs, which will hopefully lead to better coordination, if not integration. The family card stays within the household so that providers of non-integrated services can quickly see the range of services being provided to an individual or household, and can likewise record information from their visit to inform other service providers.

The idea of a family card (such as the CLPIR Family Record Card, Form I_2) is similar to an immunization card that is kept at the household and updated by different service providers who visit the household. All community-level programs active in the same geographical area should coordinate and use the family card to capture comprehensive services provided to the family and individuals in the household. (Ideally, the information captured on the family card would even go beyond HIV/AIDS information.) This approach can also be applied to all the scenarios listed above, but is especially important when services are not integrated and there are a variety of organizations providing different services to the same individuals and households.

A family card allows a program to provide family-oriented (patient-oriented) service, identify other needs that are not covered by your own program, link with or refer to other service providers (including health facilities), verify data accuracy (by cross-matching data from the register), and provide quality and continuity of care to the clients.

Ask participants to categorize their programs into one of the three approaches by answering the questions below (which are also included in the exercise handout's table). Ultimately, each program's participants should determine if their program has an integrated or vertical program approach, and based on that information they will be able to identify the most appropriate design for their program-specific data collection tools.

Question 1: Does your program provide OVC services and palliative care services to the same household?

Question 2: If you answered "yes" to the first question, are these services provided by a single service provider or by multiple service providers?

Session 8: Understanding How to Adapt the Generic CLPIR Data Collection Tools

Purpose: After identifying their program design and the degree of integration present in the program design, and using the essential program-specific indicators identified through the previous exercises, participants should come up with appropriate and user friendly data collection tools.

Objective: By the end of the session, participants will know how to adapt the generic CLPIR data collection forms (found in module 1) to develop their program/organization-specific data collection forms and how to plan and conduct the second workshop among staff from their respective organizations.

Recommended Time: This session takes about an hour and 45 minutes.

Exercise 8.1: Identifying Indicators that Are Unique to Each Program — Individual Exercise

Recommended time: One hour.

Materials: The exercise 3.5 handout previously used during session 3 (indicator by level of use worksheet, found in the appendix), harmonized program level indicators, harmonized national level indicators, and standardized national reporting form are needed.

Instructions: After the national stakeholders' workshop on indicator harmonization, the CLPIR harmonization task force should have already adapted the generic CLPIR data collection tools to meet the national reporting requirement (i.e., the process that was completed using CLPIR module 3). Participants should use this adapted version of the generic CLPIR tools and revise them to meet their own program-specific indicator needs. This exercise provides tips and useful resources to guide participants in doing so.

Begin by comparing the harmonized national level indicators (from the national stakeholders' workshop on indicator harmonization) to the harmonized program-level indicators, to identify those indicators that are unique to each program. Use the exercise 3.5 handout to review the

selected program level indicators.

Once unique indicators have been identified, participants should go through the modified version of the generic CLPIR tools (i.e., those that were designed to meet national reporting requirements) to see if any indicators unique to their programs are already expressed within the modified national version. The completed exercise 3.5 handout should include proposed data sources for each of these indicators. Look at the data sources and compare the sources against the CLPIR tools to see if:

- an existing CLPIR tool can generate the indicators unique to the program;
- an existing CLPIR tool can be modified to generate those unique indicators; or
- a new form needs to be developed.

If all the program-specific indicators can be generated through the adapted versions of the generic CLPIR tools, skip rest of this session and go to session 9. Otherwise, complete exercise 8.2 before going to session 9.

Exercise 8.2: Adapting the CLPIR Tools or Creating New Data Collection Tools — Optional Individual Exercise

Recommended time: Forty-five minutes.

Materials: The materials used in the previous exercise are needed.

Instructions: If participants need to modify the generic CLPIR tools or develop new tools, they need to consider the issues described below (this optional exercise is not necessary if participants do not need to modify CLPIR tools or develop new tools).

The following eight conceptions are helpful for participates to consider when designing data collection tools:

- *Capacity of the data collectors* — Capacity and literacy level of the service providers who collect data needs to be carefully considered. Depending on their level of literacy, the length and complexity of the forms may need to be adapted. If the service providers are illiterate, data collection forms should be designed as pictorial. When pictorial forms are designed, it is important to field test the forms to make sure that the pictures represent the intended messages.
- *Include qualitative fields* — Always allocate space for observations (i.e., for remarks, suggestions, success stories, etc.) where qualitative information can be reported. Such qualitative information can be used as a memo for the service providers or as a communication channel between supervisors and supervisees to add meaning to the quantitative information that is reported. Review the design of the generic CLPIR tools for examples of qualitative fields.
- *Good design of the forms serves multiple purposes* — Forms should serve the needs of clients, programs, and overall public health. They should focus on the interests of the client (his or her health condition, service needs, types of services provided,

etc.), as well as program management concerns (e.g., amount and type of services delivered, retention rate of staff, number of individuals who received services, etc.) In addition, they should also provide helpful information relevant to public health overall, beyond the individual client or program levels (e.g., service coverage, catchment populations, service utilization, etc.).

- *Standard geographical units* — Try to use the standard geographical units that are officially used by the government. This becomes particularly important if the program uses geographical information systems to display information through maps. For example, use the government's standardized names of villages, districts, or provinces to locate service provision, trained personnel, or client distribution.
- *Ensure confidentiality* — The issue of confidentiality needs to be considered when designing data collection tools. Some information, such as a client ID number, can be used to ensure privacy of the individual. If there is a policy guideline on confidentiality, relevant regulations must be followed strictly and included in the instructions for using the data collection forms.
- *Data storage system* — Data storage guidelines should be included in the instructions. For example, how long must such information be kept and who has access to what type of information. This is particularly important from a confidentiality perspective, as well as a contractual perspective.
- *Minimize aggregation mistakes* — Forms should be designed so that forms from one level look similar to forms from other levels. The most common record keeping errors occur during the aggregation of data from one form to another. Review the design of the following CLPIR data collection forms as examples: Home Visit Register (HBC_2) and Home Based Care Provider Report (HBC_04), found.
- *Avoid double-counting* — OVC, palliative care, tuberculosis, and HIV/AIDS prevention program indicators are more prone to double-counting because of the difficulty inherent in tracking the individuals being served and/or the multiple types of programs implemented to assist clients. (Common types of double-counting are described below.)

Common types of double counting: The final concept mentioned above, avoiding double-counting, may need further elaboration. Here are some examples of common types of double-counting:

- *Double-countint within a program (same service)* — Mr. Emmanuel received nutrition service five times during this reporting period, from the same OVC program. Do you count him as one or five? This depends on what program is trying to measure. If the program is counting the number of "individuals" served, then Mr. Emmanuel should be counted as "one individual." However, if the program is measuring the amount of services or number of visits provided to clients, then Mr. Emmanuel's five nutrition services should be counted as "five." Consequently, the unit of measurement must be clearly stated in the instructions, and must be understood by everyone who uses the forms.

- *Double-counting within a program (different services)* — Mr. Emmanuel received nutrition service once, educational service once, and psychosocial service once from the same OVC program in this reporting period. Do you count him as one or three? Once again, this depends on what the program is trying to measure. He is "one individual" if that is the the unit, but there were three instances of service, if that is the unit of measurement.

Additional notes to facilitators: How do we avoid such double-counting? When you add together findings about how many individuals were involved, make sure you are not summing the same person multiple times. Every program should find a way to identify each individual receiving a service uniquely, so that, at the end of the reporting period, there are accurate, legible lists of individuals (by name, by ID number) that can be used to make a direct count of individuals receiving training or service provision. Review the design of the following CLPIR data collection tools as examples: Home Visit Register (HBC_2) and OVC Register (OVC_3), found in CLPIR module 1.

- *Double-counting between programs* — A child received nutrition service from an FBO and an educational service from a CBO during the same reporting period. Both agencies are supported by PEPFAR. Is the child going to be counted as one OVC served under the FBO and one OVC served under CBO? Does that mean two OVC are served? Also, if the program needs to report on "number of OVC who received at least three services," how do you avoid double-counting when reporting to PEPFAR? There is no easy answer to resolve this kind of double-counting problem. One recommendation is that it is important to know who is working in which geographical area to provide what type of service. Then, try to coordinate among partners to use tools such as the Child Status Index (CSI). CSI captures information about service providers and the type of services provided to each OVC. The data can potentially help the program to understand the risks and magnitude of double-counting.
- *Double-counting number of staff trained* — Because registration forms for training are often designed to list participants by name, position, address, etc., it is often quite challenging to follow the same individual across different reporting periods to avoid double-counting. For example, Mr. Emmanuel someone may be trained on the same topic (initial training and refresher training). Mr. Emmanuel might have received training on abstinence and being faithful in January, and refresher training on the same topic two months later. At the time of the quarterly report covering January through March, you need to report the number of people trained on this topic. How do you avoid double-counting Mr. Emmanuel? Training can also involve different services within the same program. Mr. Emmanuel might have received training on psychosocial support in January and nutritional support in February (two different services), both under a single palliative care program. At the time of the quarterly report, you need to report number of individuals trained on "palliative care." How do you avoid double-counting? One recommendation is to allocate space on training forms for each individual to enter

his or her previous training (e.g., "When was the last time you received training from the palliative care program?"). This will help clarify how many different individuals received training during the period.

Session 9: Preparing for the Second Program-level Rollout Workshop

Purpose: Trainers will ensure that participants have the information, knowledge, and skills they need to carry out the second workshop among staff at their respective organizations. Upon completion of the following exercises, participants should be able to carry out the training of other service providers and other data collectors on how to fill out their program-specific data collection tools.

Objectives: By the end of this session, participants will be able to:

- understand the curriculum and materials for part 2 of the workshop; and
- conduct part 2 of the workshop to train staff at their respective organizations to use the program/organization-specific data collection forms.

Recommended Time: This session takes about three hours.

Exercise 9.1: Training-of-Trainers for Part 2 of the Rollout Workshop

Recommended time: Three hours.

Materials: Flip chart; markers; training curriculum for the program-specific data collection tools; and the generic CLPIR tools, instructions, and reference sheets (CLPIR module 1) are needed.

Instructions: In this exercise, trainers will orient participants to the curriculum used in part 2 of the rollout workshop. For those exercises that cannot be done without preparation, go through the process together, as a group, to make sure the the process is clear. Take this time as an opportunity to adapt the curriculum to the specific country and program or organization context. If some sections of the curriculum are not relevant, examples are not applicable, or the tone of the document is not appropriate for the target audience, adjustments should be made prior to part 2 of the workshop.

Explain to participants that upon a completion of part 1 of the workshop, the generic CLPIR tools, instructions, and reference sheets must be adapted to meet each program's needs, prior to conducting part 2 of the workshop. If requested, trainers can work with individual M&E officers to help prepare these documents. Revised documents should be reviewed by trainers before the documents are used in part 2 of workshop.

Conclusion of the First Program-Level Roll-out Workshop

Facilitators should close the workshop by reminding participants that they now should understand the value of information; the concepts of program goals, objectives and activities; different types of indicators and how they are linked to program goals, objectives, and activities;

characteristics of good and bad indicators; how to develop indicators that meet program needs and reporting requirements; how to define information flows and feedback mechanisms; and problem-solving techniques.

Before moving on to the second workshop, M&E officers from each organization will have adapted the data collection forms that capture program-specific indicators identified during this workshop; the instructions explaining how to fill out each of the data collection forms and registers; the indicator reference sheets; and the training curriculum for the second workshop to train service providers and others in using these forms to capture key indicators.

CLPIR Tools and Processes for Engaging Stakeholders

Curriculum for Program-Level Rollout Workshop 2: Program-Specific Data Collection

Community-Level Program Information Reporting for HIV/AIDS Programs — Module 4

Introduction

The second workshop builds upon the outputs of the first workshop. During the second workshop, each program or organization should have a minimum set of program/organization-specific indicators, reference sheets, data collection forms, and instructions for filling out the forms. The second workshop focuses on training service providers and other data collectors at each organization on how to fill out the program-specific data collection forms that monitor a program's performance over time.

The curriculum for this workshop is designed to equip service providers with the necessary skills and capacity to collect, aggregate, analyze, and use this information. The curriculum includes step-by-step guidance, and also addresses data quality issues and ways to minimize reporting errors. The workshop typically takes a day to complete (about five hours).

Users of the Curriculum and Target Audience

Users of the curriculum include trainers identified by the rollout task force of the CLPIR steering committee and M&E officers from implementing partners, NGOs, FBOs, and CBOs who participated in the final three sessions of the first workshop (sessions 7-9).

The target audience for the workshop includes organizations implementing community-level HIV/AIDS programs, including implementing partners, NGOs, FBOs, and CBOs. Specific staff recommended to attend this workshop are all service providers and data collectors, including field officers, community health workers, volunteers, and other types of direct service providers.

Workshop Session

The workshop is divided into the following sessions, totaling about five hours:

- introduction of participants, and explaination of workshop objectives and expected outputs (30 minutes);
- first exercise — presentation of program-specific data collection tools (two hours);
- second exercise — using the data collection tools (one hour);
- third exercise — accuracy checks (one hour); and
- review and conclusion (30 minutes).

Introduction

The facilitators or trainers will begin by introducing themselves and explaining the progress that has been made as a result of the first workshop. They will then describe objective of this workshop to participants. They will explain that the objective is to familiarize program staff on program-specific data collection forms, instructions, and indicator reference sheets.

By the end of the workshop, participants will be able to:

- complete the data collection forms and registers correctly;
- understand their roles and responsibilities;
- understand the common mistakes that can occur during data collection and aggregation; and
- identify methods to minimize such errors.

First Exercise: Presentation of Program-Specific Data Collection Forms

Recommended time: Two hours.

Materials: Flip chart, markers, projector, the adapted data collection tools, information flow diagram (from exercise 4.2 in part 1 of the workshop), and Microsoft PowerPoint presentation are needed.

Instructions: Provide step-by-step instructions on how to complete each of the program-specific data collection forms and tools that were developed by the M&E officers. Use the program-specific instructions and reference sheets as resources.

Before presenting each tool to participants, review the information flow diagram that was developed by your organization's group during exercise 4.2 in the first workshop. Explain how the data collection forms are related and at what level of the program (program management level, provider management level, or client management level) each form should be completed, who should complete each form, and to whom each completed form should be submitted. Once participants understand the forms, ask them to classify their roles and responsibilities into one of the three categories listed within your organization's information flow diagram. Split participants into three groups accordingly. Then present the data collection tools that are relevant to each of these groups separately.

For example, direct service providers (volunteers, community health workers, etc.) who interact with clients to provide services should be in the client management group; field supervisors and program officers who aggregate information submitted by district service providers would be in the provider management level group; and M&E officers who prepare periodic reports aggregated from several sites would be in the program management level group.

For each data collection form, state the following:

- purpose of the form
- source of data
- person responsible for collecting and aggregating data
- frequency of the reporting period

This should be followed by detailed instructions on how to fill each cell in the forms. Once participants are familiar with the forms, the facilitator should link each indicator to the forms. This helps participants to see the connection between the forms and program-specific indicators, allowing them to appreciate how and why the indicators were derived.

Second Exercise: Using the Tools

Recommended time: One hour.

Materials: Fip chart, makers, pre-filled forms and registers, and blank forms/registers/reports are needed for this exercise.

Instructions: During this exercise, which is done in the small groups formed during the previous exercise, participants will become familiar with the tools most relevant to their jobs by engaging in a practical exercise on how to complete the forms. Each group will follow the instructions listed below. Any questions and issues encountered should be noted and shared within the small group at the end. The adapted user's guide and indicator reference sheets should be used as supporting materials during the exercise.

Client management group — This group's activities involve role playing. Assign one person to play the role of a client and another person to be a service provider, and ask them to role play their daily activities while completing the blank forms. The rest of the group will observe the interaction between those two to complete primary data collection forms (e.g., home visit form, OVC register, activity report, etc.).

Provider management group — This exercise involves aggregation of data. Use pre-filled client encounter forms (i.e., forms that are completed by direct service providers), which should be prepared by the facilitator prior to this exercise. This group will transfer the data to a blank aggregation/tally sheet (i.e., a form that is completed by supervisors). This exercise should be done individually. Participants can use the handout, found in the appendix, as an example. The handout provides a completed example of a CLPIR Home Visit Register (HBC_2), which is a form completed by a direct-service provider; and its corresponding CLPIR Home-Based Care Provider Report (HBC_4). Another example of a form completed by direct service providers is the CLPIR OVC Register (OVC_3), found in CLPIR module 1. In this case, the corresponding form completed by supervisors is the CLPIR OVC Service Provider Report (OVC_6).

Program management group — This exercise also involves aggregation of data. Use the pre-filled aggregated forms (i.e., the form that is completed by supervisors, e.g. CLPIR OVC Service Provider Report) which should be prepared by the facilitator prior to this exercise, and transfer the data to the blank periodic sheet (i.e., the form that is completed by the M&E Officer). Examples of periodic forms, from CLPIR module 1, are the CLPIR Periodic Summary Report (P_9) used for prevention programs; the CLPIR Periodic Summary Report (HBC_9), used in HBC programs; and the CLPIR Periodic Summary Report (OVC_12), used in OVC programs. This exercise should be done individually. The exercise handout shows an example of a completed form from the provider management level that is used in completed a periodic summary report form.

Once all three groups have completed the exercise, ask participants to come together and respond to the following questions:

- Was it easy to complete the form? If not, which parts were difficult?

- Do you have any suggestions on improving the design of the form?
- Is there any information missing from the form?
- Did you find the relevant instructions clear and easy to understand?

If participants come up with any serious issues that need to be addressed, the M&E officers should take note of the issues raised and, if necessary, modify the data collection tools based upon these suggestions. (If forms or other tools are revised, they should be shared with relevant program staff before being used.)

Additional notes for facilitators: Explain to participants that the process of developing appropriate data collection tools is a continuous effort. This is just the first draft of the program-specific data collection tools and they will be modified according to the comments and recommendations that come out of the experience of using the tools in the field. After using these tools for two or three months, there should be an opportunity to make adjustments to the tools as needed.

Third Exercise: Accuracy Checks

Recommended time: One hour.

Materials: Flip chart, makers, output from exercise 5.1 of part 1 of the workshop are needed for this execise, which is conducted among the small groups formed during the first exercise.

Instructions: Have participants break out into the same three groups as before. At the end of this exercise, the large group will reconvene and a representative from each small group will share the list of common mistakes they encountered during this exercise. It is important for the field supervisors/program officers to know the common mistakes faced by direct service providers, and for the M&E officers to know the common mistakes faced by field supervisor/program officers. The lessons learned from this exercise should be used to check data accuracy during routine monitoring or supervisory visits to the field and to self-assess the quality of data that are collected.

Client management group — One person in the group will be asked to share how he or she filled out the form. If others recorded something differently, the group should discuss why and find out why there was such a discrepancy. Participants must follow the relevant instructions for the form. One person should summarize the discussion points on the flip chart.

Provider management group — Compare the aggregated data that were prepared by participants during the previous exercise and the answers to the questions that were prepared by the facilitator. As a group, discuss the following points and have one person summarize the discussion points on the flip chart:

- Did you come up with the correct answers? If not, what types of mistakes did you make?
- Did others also make similar mistakes?

- ❑ Identify the patterns of these mistakes.

Program management group — Compare the aggregated data prepared by participants during the previous exercise with the answers to the questions prepared by the facilitator. As a group, discuss the following points and have one person summarize the discussion points on the flip chart:

- ❑ Did you come up with the correct answers? If not, what types of mistakes did you make?
- ❑ Did others also make similar mistakes?
- ❑ Identify the patterns of these mistakes.

Additional notes for facilitators: After each group presents its list of common mistakes, the facilitator will end this exercise by saying that recognizing the patterns of mistakes is the first step to minimize such errors. Small mistakes can accumulate over time or as data are aggregated, which could lead to incorrection assumptions influencing important program decisions. It is the responsibility of each participant to make sure that that collected data are accurate, representing a truthful portrait of what is happening in the field.

Concluding Review

Recommended time: Thirty minutes.

Instructions: In concluding the workshop, part 2, the facilitators should review the important discussion points with participants and make sure that the objectives and overall goal of this workshop have been met. The objectives and overall goals were for participants to understand how to complete the program specific data collection forms and to identify and understand common data collection and aggregation errors.

Building a strong community-level program information system does not end with this workshop. Explain that, in order to use these forms effectively, a schedule to begin using them and a follow-up plan is needed. After using the tools for a few months, it is suggested that feedback is solicited from the users of the tools, to make any necessary adjustments. Follow-up activities and ongoing capacity building will also be required.

Appendix: Exercise Handouts

The following handouts used in workshop exercises are provided in this appendix, in a format that allows printing for direct use:

Workshop 1, Exercise 1.1 Handout
Value of Information Session Case Study

Workshop 1, Exercise 2.1 Handout
Defining Program Goal, Objectives, and Activities: Results Framework

Workshop 1, Exercise 3.1 Handout
Qualitative vs. Quantitative Approaches

Workshop 1, Exercise 3.3 Handout
Developing Indicators Template

Workshop 1, Exercise 3.5 Handout
Identifying a Minimum List of Indicators

Workshop 1, Exercise 3.7 Handout
List of Indicators by Disaggregation

Workshop 1, Exercise 5.1 Handout
Two Case Studies

Workshop 1, Exercise 5.4 Handout
Setting Targets

Workshop 1, Exercise 5.5 Handout
Monitoring Results

Workshop 1, Exercise 6.1 Handout
Example of a Cause-and-Effect Diagram

Workshop 1, Exercise 6.2 Handout
Prioritization Matrix

Workshop 1, Exercise 7.1 Handout
Integrated Services vs. Vertical Services

Workshop 2 Exercise Handout
Examples of Completed Forms

Workshop 1, Exercise 1.1 Handout

Value of Information Session Case Study

Mr. Kofi, a community health volunteer for a local faith-based organization working on a home-based care and OVC program, is discouraged. He has been working as a community health volunteer for two years and providing services for 30 families in his community. Sometimes he visits one family per week and other times he visits five families per week, but it all depends on how much time he has available.

Today, he visited one person living with HIV/AIDS to provide palliative care services. However, he could not provide opportunistic infection treatment due to a lack of the essential medicine (a stock-out). He also visited an OVC in his community and realized that the child needs a school uniform. He went back to his supervisor and requested an additional uniform. His supervisor asked him about the 20 school uniforms given to him last month and the activity report, which indicates how many of these uniforms were distributed to OVC in the community.

Mr. Kofi, however, has lost the activity report from the previous month. Unfortunately, his supervisor did not accept his new request without the previous month's activity report. What's more, some of the family members in his community have complained to Mr. Kofi's supervisor that Mr. Kofi is not providing appropriate services. In fact, Mr. Kofi does not know which services are necessary for each client, how to plan his activity and how to provide services according to the family's needs. Mr. Kofi is now confused and does not know what to do. In spite of his hard work trying to help the community, some people in the community do not appreciate his work.

Case Study Questions:

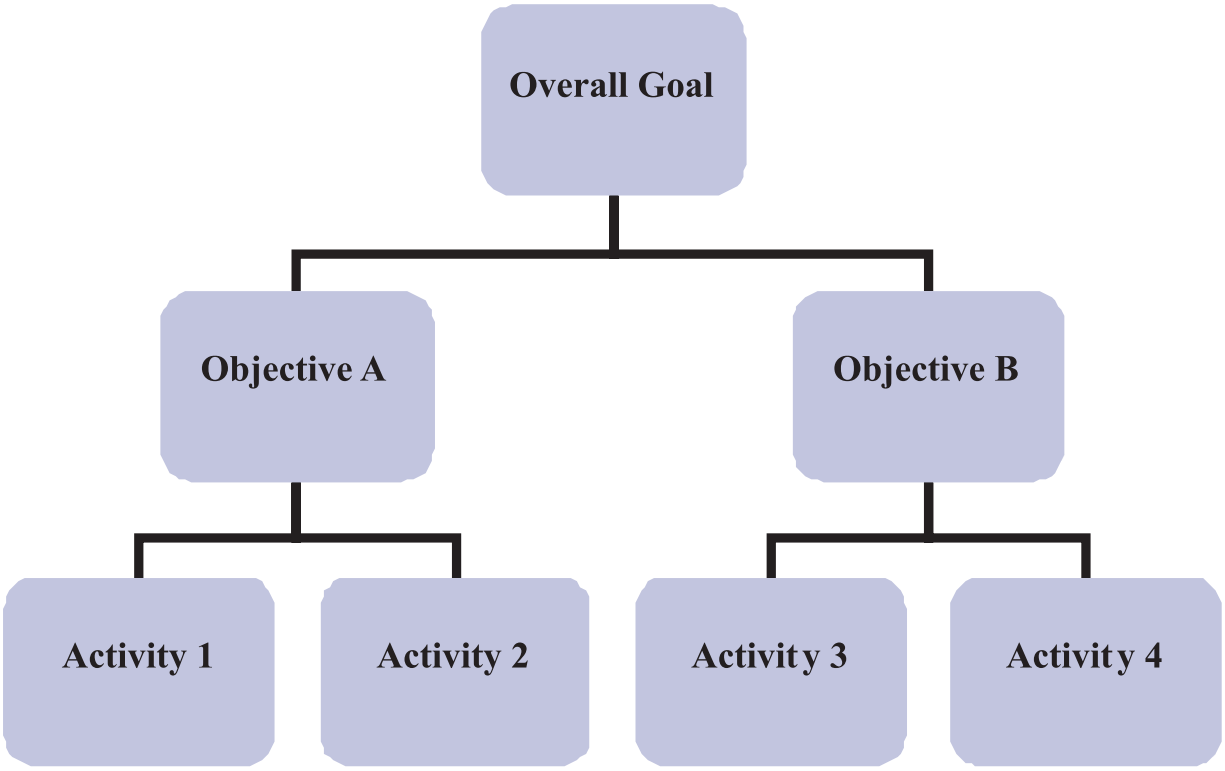
Question 1: Think about different things that a volunteer has to manage in the course of providing services. What are some of the problems faced by Mr. Kofi?

Question 2: What type of record keeping forms or procedures could help Mr. Kofi avoid some of these problems mentioned in question 1? Briefly describe how these instruments or procedures could help Mr. Kofi.

Question 3: How does this case study show the importance of information across different levels of the program? Why is this information important?

Workshop 1, Exercise 2.1 Handout

Results Framework: Defining Program Goal, Objectives, and Activities



Workshop 1, Exercise 3.1 Handout
Qualitative vs. Quantitative Information

Qualitative	Quantitative
Descriptive Usually not quantified in numbers More in depth Open ended questions	Able to quantify Closed ended questions Able to make broader generalizations
Strengths	
Allows one to look at emotions and ideas Usually less expensive to implement compared with quantitative research Can yield better information about causes and processes Needs fewer people to participate	Easier to measure compared to qualitative approaches Can present data graphically Easier to administer per person Reaches more people Can generalize results to a larger population if sampling is done properly
Weaknesses	
Needs well-trained staff to conduct interviews, facilitate focus groups, etc. Unable to generalize results to the population as a whole	Can be more expensive Can be more easily falsified Can be subject to interviewer errors Can introduce bias through sampling Needs a large number of people to participate

Quantitative information: Structured and standardized approaches are used to collect and analyze numerical data. They help answer questions about "how much" and "how many." These approaches involve recordkeeping and numerical counts. Quantitative information can be expressed as:

- counts
- calculations (percentages, rates, ratios, etc.)
- indices, composite measures
- thresholds (presence, absence; pre-determined level or standard)

Qualitative information: This involves non-numerical informatin, relying mostly on semi-structured or open-ended methods. These approaches help answer questions about "how well" a project element is being conducted. Examples of qualitative methods include:

- focus group discussions
- interviews
- success stories

Workshop 1, Exercise 3.3 Handout
Developing Indicators Template

	Statement	Possible Indicator
Goal	To prevent HIV transmission	
Objective 1	To increase knowledge of …	Number of youth correctly answering at least three ways of HIV transmission etc
Activity 1	Peer-to-peer education	Number of peer educators trained
Activity 2		
Objective 2		
Activity 1		
Activity 2		

Key Considerations of a Good Indicator

Validity: Measures only the condition or event it is intended to measure.

Reliability: Produces the same results when used repeatedly to measure the same condition or event.

Precision: Is defined in clear and unambiguous terms.

Independence: Non-directional (can vary in any direction).

Measurable: Quantifiable using available tools and methods.

Timeliness: Provides a measurement at time intervals relevant and appropriate in terms of program goals and activities.

Comparability: Generates corresponding values across different population groups and program/project approaches.

Programmatically important: Linked to a public health impact or to achieving the objectives those are needed for impact.

Workshop 1, Exercise 3.5 Handout
Identifying a Minimum List of Indicators

Logic/link to framework: Do these indicators corresponding to the strategic framework of the country and the community-level HIV/AIDS program?

Programmatic needs/information for decision-making at the level where it is recorded (use form below):

- Can this information be used at the level where it is recorded? An indicator is useful if decisions based on the measurements contribute to improvement of the staff work and program performance and ultimately, improved effectiveness and efficiency of the health system.
- Who will be using this indicator to make what type of decision? Is that decision critical for the program (is it relevant)? Can you list some of the decisions which can be made from this indicator?
- What benefits can it bring to me, my community, my program, my country, etc.?

Sensitivity to program activities: Does the indicator successfully capture changes that occur due to the program activities/interventions?

Resource availability:

- Do you have enough resources (human resource, material resource, etc.) to collect such information?
- How often do you have to collect such information?
- What are the skills necessary to collect such information?

External requirements (e.g. to the government, donors, etc.): Do these indicators fulfill reporting requirements?

Data availability: Are these data available?

Standardized indicators (internationally or nationally accepted indicators): Are these indicators internationally and/or nationally accepted?

Indicator by Level of Use Worksheet

Indicator	National	Provincial	District	Program	Client management

(continued on back)

How Many Indicators Are Enough?

In deciding how many indicators are enough, consider that your program needs:

- at least one or two indicators per key activity or result (ideally, from different data sources);
- at least one indicator for every core activity (e.g. training, BCC, etc.);
- no more than eight or 10 indicators per area of significant program focus; and
- a mix of data collection sources.

What we are trying to develop here is a minimum set of indicators for program management and implementation. Are these indicators "essential" to your program or "nice to know" for your program? It is important to keep the number of indicators to a minimum and not to overburden service providers with data collection. If data collection becomes too complex, service providers may not have time, ability, or motivation to report, or may report poor-quality data. Non-essential indicators should therefore best be listed as "stand-by" indicators for potential future use.

Workshop 1, Exercise 3.7 Handout
List of Indicators by Disaggregation

Program	Indicator	Definition	Disaggregation	Source	Fequency	Responsible person	Example of decision	User level
	# of peer educators trained on A and B	Trained is defined as… Abstinence is.. Being faithful is…	Age	Training recod	Periodically	Master trainer	Conducting refresher training Train more staff, etc.	National, Donor, IP, CBO/ FBO

Workshop 1, Exercise 5.1 Handout

Two Case Studies

First case study: Imagine that you are the supervisor of two community health workers. Ms. Fatima and Mr. Joseph are community health workers for a home-based care (HBC) program supported by a faith-based organization. This month, Ms. Fatima visited 10 HBC clients in her community while Mr. Joseph visited 15 clients. Mr. Joseph was also successful recruiting a new HBC client to the program, while Ms. Fatima did not enroll new clients into the program. At the end of the month, you want to find out whose performance is better and how they can improve their performance.

Questions: Can you assess the performance of these two health workers? Who is performing better?

Second case study: Imagine that you are the supervisor of two community health workers. Ms. Fatima and Mr. Joseph are both community health workers for an HBCe program supported by a faith-based organization. The estimated number of HBC clients in Ms. Fatima's area is 10 clients. Unfortunately, Mr. Joseph is coming from a community that is heavily affected by HIV/AIDS, and the estimated number of HBC clients in his community is 30. Ms. Fatima has been successful in enrolling all 10 clients in the program and providing HBC services to all of them on a regular basis. On the other hand, Mr. Joseph has enrolled 20 clients in the program but has only provided services to 15 of them during this month. Mr. Joseph was successful in enrolling a new HBC client to the program during this month but there are 10 more to go.

Questions: Can you assess the performance of these two health workers?

Who is performing better?

Workshop 1, Exercise 5.4 Handout
Setting Targets

Program-Level Targets Worksheet

Indicator	Program targets		First year	Second year	Third year	Fourth year
		Target (%)				
		Target (#)				
		Actual performance (#)				

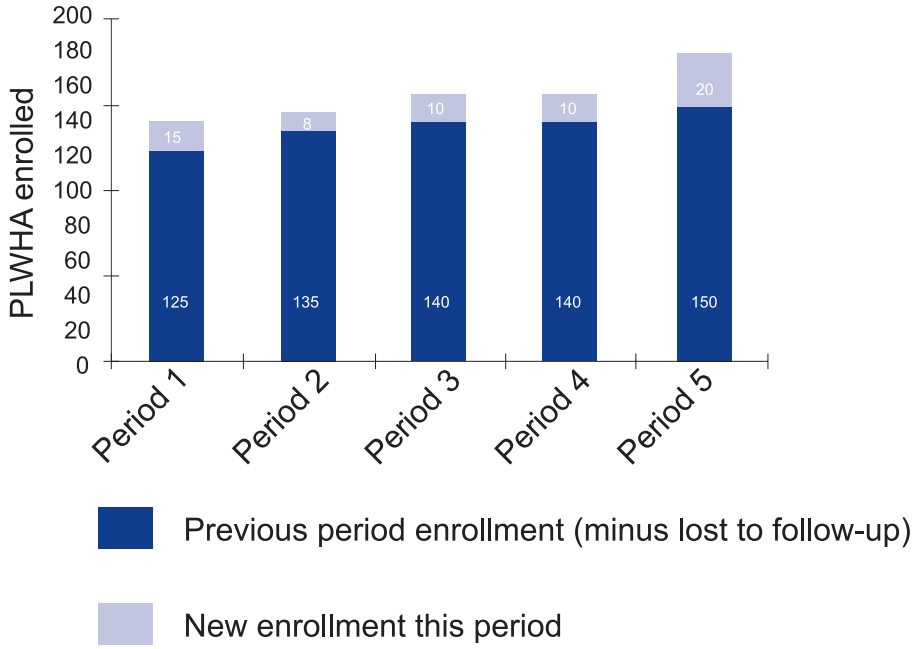
Individual Targets Worksheet

Indicator	Individual targets		First month	Second month	Third month	Fourth month
		Target (%)				
		Target (#)				
		Performance (#)				

Workshop 1, Exercise 5.5 Handout
Monitoring Results

Total Number of PLWHA Enrolled in Your Program

Indicator	Program targets		Period 1	Period 2	Period 3	Period 4	Period 5
Percentage of PLWHA enrolled in our program	90% of estimated # of PLWHA in our catchment area is enrolled in our program	Target (#)	122	134	146	158	170
		Actual performance (#)	140	143	150	150	170



Questions:

How many people living with HIV/AIDS are currently enrolled in your program?

Are you achieving your target for this reporting period?

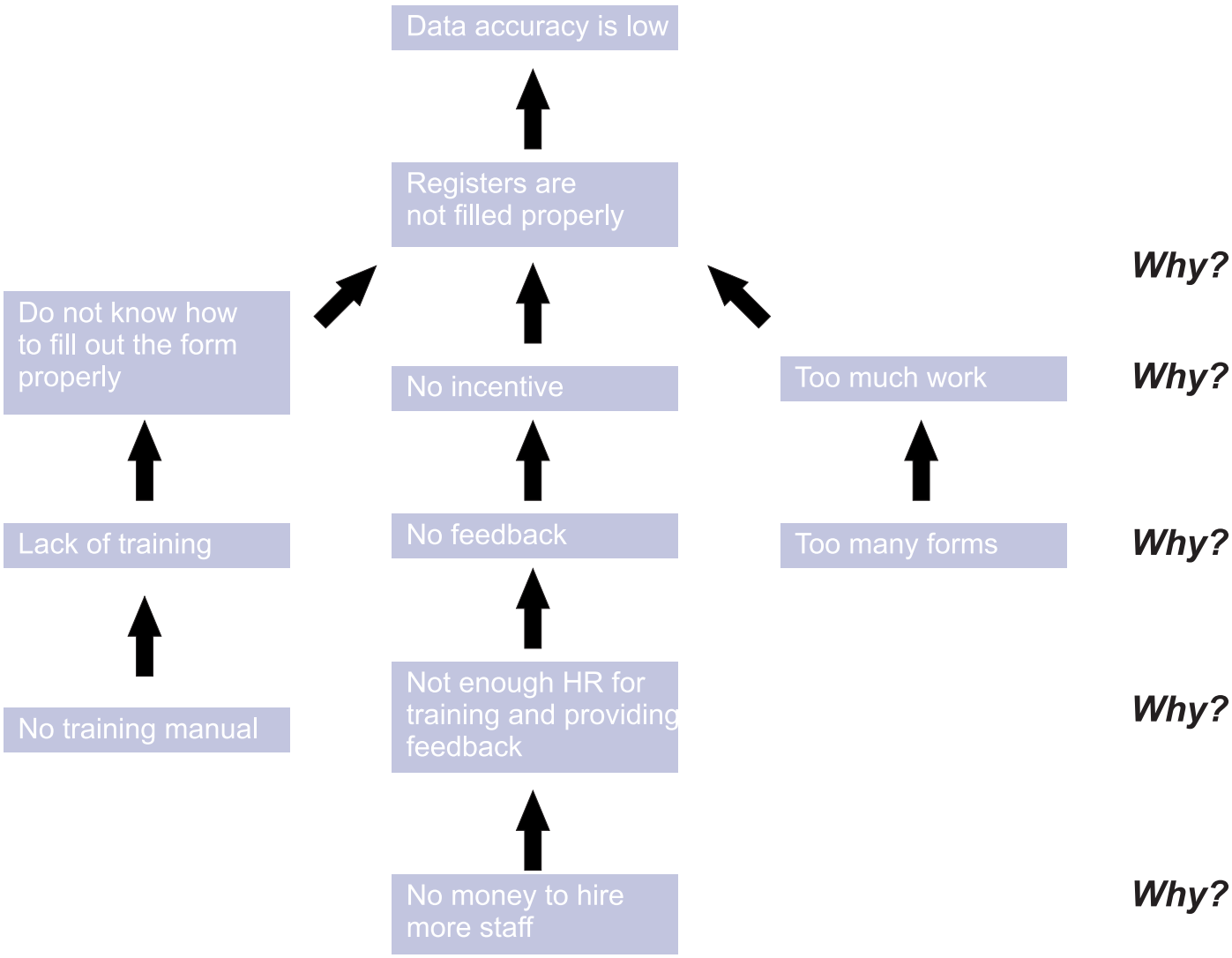
Compared to previous reporting periods are you expanding your program by reaching new patients?

Are you successfully keeping the same patients in the program from the previous reporting period?

Do you see any trend over time?

What are some possible interventions/actions you can take?

Workshop 1, Exercise 6.1 Handout
Example of a Cause-and-Effect Diagram



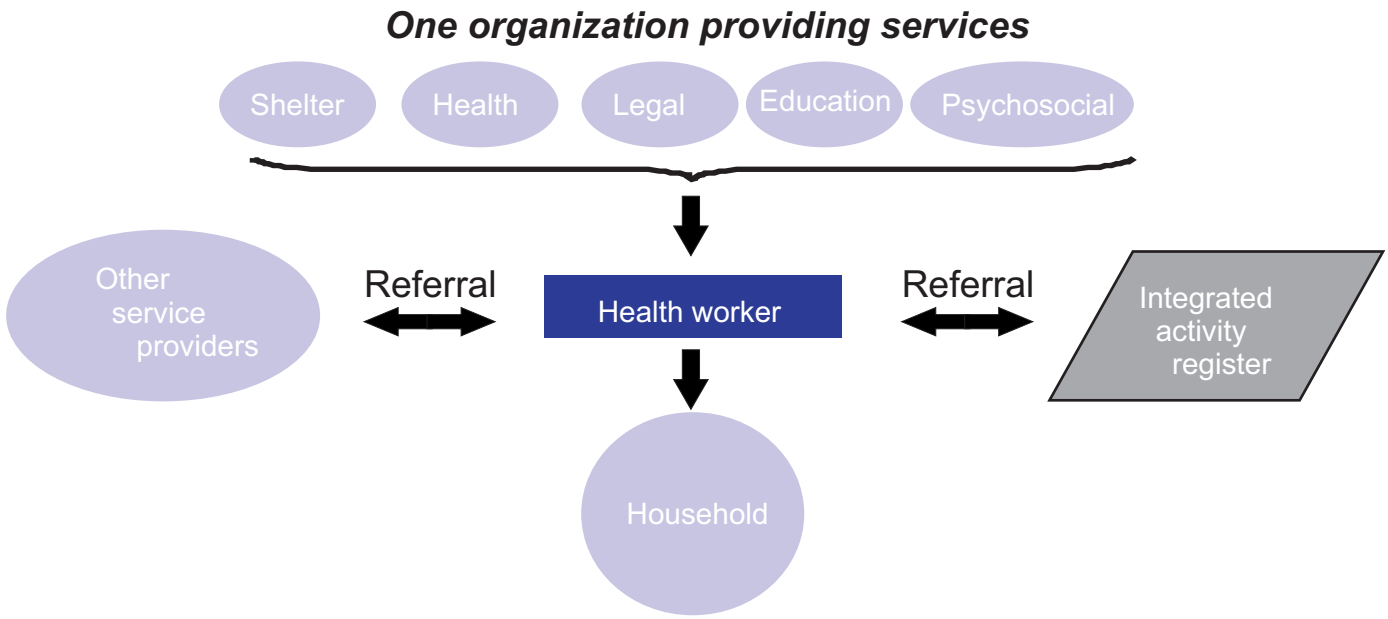
Workshop 1, Exercise 6.2 Handout
Prioritization Matrix

List of causes affecting...	Priority			Capability to influence	Limited capacity to influence	Possible solution
	High	Medium	Low			

Workshop 1, Exercise 7.1 Handout
Integrated Services vs. Vertical Services

Type of services	Program design	Approach	Recommended tool
Does your program provide OVC services and palliative care services to the same household?	If "yes" and services are provided by a single service provider, then use...	Approach 1 (integrated)	CLPIR integrated data collection tools
	If "yes" and services are provided by a multiple providers, then use...	Approach 2 (veritical)	CLPIR non-Integrated data collection tools
	If "no" but other organizations provide these servcies, then use...	Approach 3 (vertical with family card)	CLPIR non-integrated data collection tools and family card

Approach 1: Services integrated at the service delivery point



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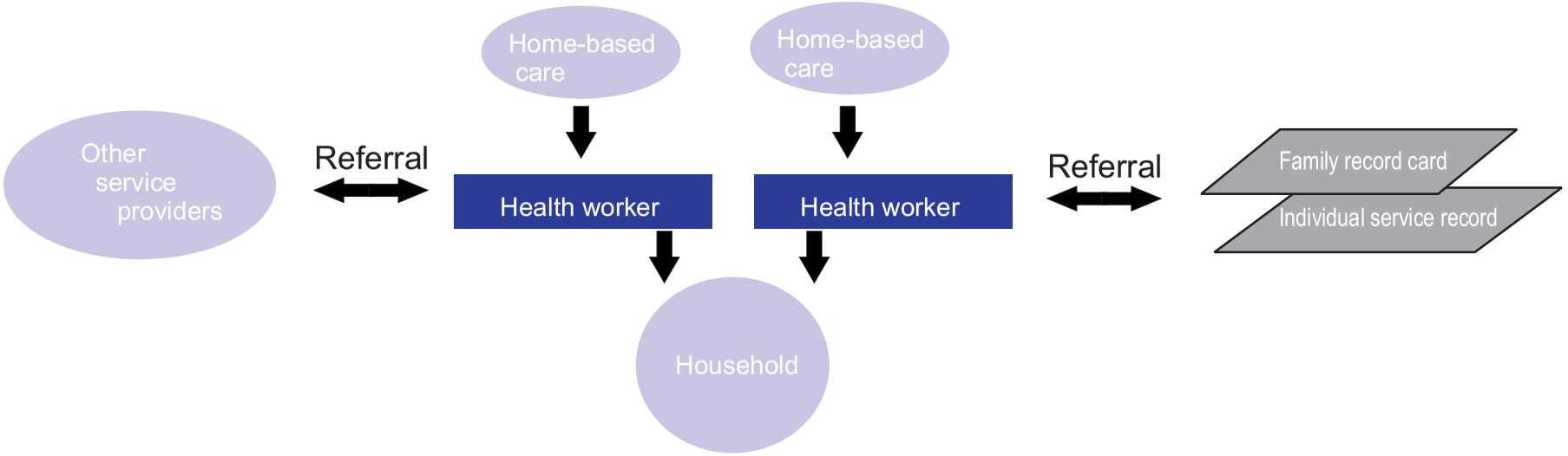
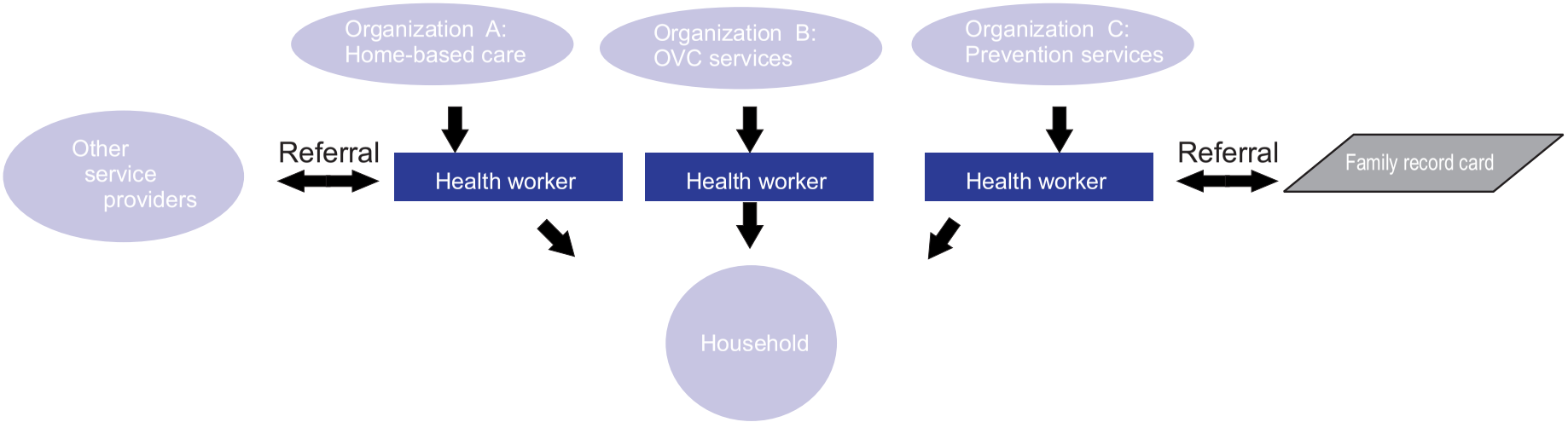
Approach 2: Services integrated at the program level

One organization providing multiple services through multiple health workers



Approach 3: Services are not integrated



CLPIR Tool Kit (HBC_2)

Home Visit Register: For use by Homebased Care Programs

For Local Adaptation

Name of organization: *XXX Faith Based Organization* Reporting Period from Jan 07 To April 07

Name of Servfice Provider: Kofi Anan Province: Kumasi District: Bantama

Name of Patient: Kuwame Osei Gender: **Male** / Female Age: 42

Address of Patient

Province: Kumasi District: Bantama Village: Oseikrom

A: Type of Support Provided to Patient B: Refarral

	Support						ARV Adherence						Referral				
Date	Clinical Care	Psychological Care	Spiritual Care	Supportive Care	Prevention Care	Other (Specify)	Client Education	Pill Count	Pre-ART Counseling	Buddy Support	Other (Specify)	Follow Up Visit	TB	ART	Opotunistic Infection	STI	Other (Specify)
1/01/2007	X			X								X					
1/15/2007							X					X					
1/20/2007	X	X										X					
2/10/2007	X		X									X		X			
3/01/2007												X					
3/29/2007	X							X				X					
4/23/2007	X		X					X				X					
	X	X	X	X			X	X				X		X			

C: Lost to follow up date: Reason for leaving: 1) Dropped out, 2) Migrated, 3) Died, 4) Unknown, 5) Other (Specify)

Comments and Remarks:

Workshop 2, Exercise Handout
Examples of Completed Forms

CLPIR Tool Kit (HBC_04)

Home Based Care Provider Report: For use by Homebased Care Programs

For Local Adaptation

Name of Service Provider: _____ _Emanuel _Osada___ _____ Reporting Period from ___ _Jan 07_____ To____ April 07__

A: Patient provided with service

	Age				
	<18	18-24	25-29	30+	Total
M	XXXXXXXXXX ???? ???? ???????? ???????? ????????	XXXXXXXXXX ???????? ???????? ???????? ???????? ????????	XXXXXXX?? ???????? ???????? ???????? ???????? ????????	XXX?????? ???????? ???????? ???????? ???????? ????????	30
F	XXXXXXXX? ???????? ???????? ???????? ???????? ????	XXXXXXX?? ???????? ???????? ???????? ???????? ????	XXXXXXXXXX ???????? ???????? ???????? ???????? ???	XXXXXX??? ???????? ???????? ???????? ???????? ????	31
Total	18	17	17	9	61

C: Lost to follow up

Age					
	<18	18-14	25-29	30+	Total
M	???? ???? ???? ????	???? ???? ???? ????	???? ???? ???? ????	???? ???? ???? ????	0
F	???? ???? ???? ????	???? ???? ???? ????	???? ???? ???? ????	???? ???? ???? ????	0
Total	0	0	0	0	0

D: Stock Out of Essential Supplies

HBC Kit	HIV Testing Kit	Drugs	IEC Materials	Other (Specify)
0	0	0	0	0

B: Type of Support Provided to Patient

	Support						ARV Adherence						Referral					Reason for leaving			
	Clinical Care	Psychological Care	Spiritual Care	Supportive Care	Prevention Care	Other (Specify)	Client Education	Pill Count	Pre-ART Counseling	Buddy Support	Other (Specify)	Follow Up Visit	TB	ART	Opotunistic Infection	STI	Other (Specify)	Dropped out	Migrated	Died	Unknown
M	XXXX XXXX XXXX XXXX	XXX? ???? ???? ????	XXX? ???? ???? ????	XXX? ???? ???? ????	???? ???? ???? ????	XXXX ???? ???? ????	XXX? ???? ???? ????	XXX? ???? ???? ????	XXXX X??? ???? ????	???? ???? ???? ????	???? ???? ???? ????	XXXX XXXX XXX? ????	???? ???? ???? ????	???? ???? ???? ????	XXX? ???? ???? ????	???? ???? ???? ????	???? ???? ???? ????	???? ???? ???? ????	???? ???? ???? ????	???? ???? ???? ????	???? ???? ???? ????	???? ???? ???? ????
F	XXXX X??? ???? ????	XXXX X??? ???? ????	XXX? ???? ???? ????	X??? ???? ???? ????	XXX? ???? ???? ????	XXX? ???? ???? ????	XXXX X??? ???? ????	XXXX ???? ???? ????	XXXX ???? ???? ????	???? ???? ???? ????	???? ???? ???? ????	XXXX XXXX XXXX ????	???? ???? ???? ????	XX?? ???? ???? ????	???? ???? ???? ????	???? ???? ???? ????	???? ???? ???? ????	???? ???? ???? ????	???? ???? ???? ????	???? ???? ???? ????	???? ???? ???? ????
Total	22	7	6	4	3	7	8	7	9	0	0	24	0	2	3	0	0	0	0	0	0

E: Comments and Remarks:

Signature of Service Provider: _____ Date: _____

Signature of Supervisor: _____ Date: _____

MEASURE Evaluation
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