1. INTRODUCTION

Community owned interventions are key to reaching and providing ongoing support to children affected by HIV and AIDS in Africa. (*Global Framework, Children on the Brink*) The use of participatory community-based management information systems (CBMIS) is an approach to strengthen community responses, allowing for decentralized decision-making at the community level. Through the development of indicators, collection of information, and the utilization of data for decision making, communities have the potential to monitor and maintain the quality of interventions. For example, community based health information systems are used by child survival programs to enable communities to regularly assess progress towards achieving certain child health goals such as improved immunization coverage, improved growth of children under five, among other key child health outcomes. While the use of such systems is common for facility-based interventions and for many development programs targeting children, little has been systematically studied and documented about the effectiveness, strengths and challenges of information systems that are used by communities to provide support to orphans and vulnerable children in AIDS affected areas. The research described in this document attempts to address this gap.

The objective of the research is to assess whether or not (and how) communities are able to use data to guide action to improve the wellbeing of children. The research questions are as follows:

1. What is the global state of the art in CBMIS and other similar methods of tracking and utilizing data to improve child wellbeing at the community level?
2. What can Scale up Hope's experiences in Mozambique tell us about the practical successes and challenges of CBMIS in OVC (orphans and vulnerable children) projects and how to scale up this approach?
3. How does CBMIS help communities to assess child wellbeing and take action and/or make adjustments to achieve local goals?
4. What are the most appropriate and realistic ways that communities, external implementing organizations, and policy initiatives can provide support to community initiatives that collect and utilize data in their efforts to respond to children and families in AIDS affected areas?

2. METHODOLOGY

This research was conducted in three phases. The first phase consisted of a literature review of published documents, as well as web-based and program reports. After conducting the literature review, the team carried out primary data collection in Mozambique, where Save the Children is implementing a national level program for orphans and vulnerable children. This second phase consisted of focus group discussions were conducted with community groups responsible for providing services and gathering data on children who received services in Xai-Xai, Gaza Province. At village level, interviews were requested with: OVC committee president, secretary, at least two members of the committee, and community leaders. In addition, in-depth interviews were conducted with the community mobilizers (Save the Children/US staff member) from the district in which interviews took place. Researchers also met with district representatives of the Ministry of Women and Coordination of Social Action (MMCAS). In Xai-Xai, in-depth interviews were conducted with the SUH manager of Gaza Province and the regional SUH manager. Representatives of MMAS and the national AIDS organization, CNCS, were also interviewed at the provincial level.

Community and district level interviews were based on questionnaires that were pre-tested in two villages the week prior to the beginning of the research. Focus groups were conducted with community members in eight villages during the week of September 10, 2007. The focus groups consisted of between 5 to14 community members, including - in most cases - the requested representatives, as well as beneficiaries and other members of the community. Interviews were conducted in Changana, the local language. Two translators, who were fluent in Portuguese, Changana, and English, accompanied each of the two principal investigators to all interviews at district and community level.

The third and last phase of the research consisted of national level interviews with key stakeholders, including Scale Up Hope project partners (Save the Children/UK, Save the Children/Norway, HACI), government officials, national level implementing partners and key staff of USAID, and the Ministry of Women and Social Action. Stakeholders who are involved in developing the national system of data collection regarding OVC were also interviewed.

The research was supplemented by a series of informal interviews with community members and implementing organizations in Ethiopia, where similar data collection systems have been introduced by Save the Children/US. The results of these interviews are included in the "Findings" section.

3. BACKGROUND

A. Scale Up Hope (SUH) Program

Save the Children/US received funding from the President's Emergency Plan for AIDS Relief (PEPFAR) to implement the *Scale-up HOPE project* (SUH) in partnership with the Save the Children Alliance and the Hope for African Children Initiative (HACI) in 2004. Through on-going support to local community-based organizations, faith-based organizations and community groups, the program's goal is to scale up and enhance the quality of interventions responding to the needs of orphans and other children made vulnerable by HIV and AIDS (OVC), their families and communities. In partnership with the Ministry of Women and Coordination of Social Action (MMCAS), the Ministry of Health (MISAU), the Conselho Nacional de Combate Ao HIV/SIDA (CNCS), District (NDCS), and Provincial (NPCS) AIDS Councils, the project works to empower local communities to make decisions that would improve the health and wellbeing of orphans and vulnerable children. The project uses monitoring and tracking forms that record household status and level of need and service provision.

B. PEPFAR Data Requirements

The collection of data for the SUH program is in line with PEPFAR requirements for information on children being served by OVC programs. The *U.S. Emergency Plan Five Year Global HIV/AIDS Strategy* identifies the following goals for developing OVC programs: to scale up rapidly compassionate care for OVCs; to build capacity for long-term sustainability of care; to advance policy initiatives with direct outcomes that support care for OVCs; and to collect strategic information to monitor and evaluate progress and ensure compliance with "Emergency" Plan policies and strategies. (PEPFAR OVC guidelines, July, 2006) As explained in the PEPFAR guidance on OVC funding: "*To evaluate improved well-being, and to ensure effective, quality programs, the Emergency Plan requires program- and national-level monitoring and evaluation. The amount of information required by the U.S. Congress on the progress of PEPFAR is limited to national total numbers of OVCs serviced (direct and indirect), caregivers trained, and monies spent. However, more detailed information is needed in-country on the program level to monitor and evaluate adequate progress toward improving the well-being of children affected by HIV/AIDS.*" In addition, the guidance states that "*U.S. Government country teams should support implementing partners and national Governments to develop coordinated monitoring-and-evaluation plans for OVC programs and community-based efforts based upon the UNAIDS principle of having one, agreed-upon, country-level monitoring-and-evaluation system*". The Guidance also acknowledges that "*Output and outcome data along with other records of measurable results are needed to track improvements in the well-being of children served and the effectiveness and quality of programs*.'

PEPFAR requires that programs receiving PEPFAR funds report regularly on a set of global indicators, which provide the number and the types of services being provided to each child. The classification of the level and type of support received by beneficiaries comes from data that is gathered by programs at community level. The PEPFAR OVC Guidance emphasizes the importance of ensuring that essential core program areas of support are available to children who have been identified as OVC. The six core program areas include: food/nutrition, shelter and care, protection, health care, psychosocial support, and education. At the level of the child, these core program areas should be regularly monitored. "*Comprehensive, quality services should be then designed to meet each child's specific needs.*" (PEPFAR OVC Guidance; page 8)

While PEPFAR provides a framework for the type of data to be collected globally, at national level, USAID/Mozambique and the Ministry of Women and Coordination of Social Action also have plans to collect data on orphans and vulnerable children. Data collection systems used by programs to collect information for their donors is often made even more complicated by the requirements that implementing agencies have for additional data to track program progress and quality. Much of the data are collected by volunteers or lower level paid staff. This may involve filling out multiple forms to document various community activities and filling out registers of children attending other services such as early child hood education centers, which have their own set of reporting requirements. The amount of data and the level of detail expected by the donors and implementing agencies can make for a very complex system, which ultimately has the potential to undermine use of the data by the community.

4. LITERATURE REVIEW

A. Community ownership and action

Community ownership and action have a long and rich history in efforts to catalyze positive change in the developing world. In the 1960's, Paulo Freire, the Brazilian educator, articulated principles of community mobilization, whereby communities identify their needs and are empowered to address them. Freire recognized and promoted the role of dialogue with community members as a means toward building critical awareness of the world in which they live (STEP Handbook). By participating in this dialogue, community members link the process of knowing and learning in an ongoing cycle of taking action and reflecting on that action. By linking these concepts, community members begin to critically understand and analyze the world around them. This critical awareness motivates individuals and groups to actively participate in the development of their community. As they learn to work effectively together, they increase their capacity to act, to access resources, and to address the inequalities that exist within their community and society, ultimately improving their opportunities for a better life: *To mobilize communities to manage and sustain their development activities, an underlying assumption must therefore be that human potential exists. Participation in community mobilization is therefore a process of active community involvement in organizing, exploring the issue, planning, implementing activities, and monitoring and evaluating results. Through the mobilization process communities transform co-management of a program (with external help) into autonomous management which has the capacity to be sustained over time.* (STEP handbook).

> *The surest way to convert risk into probability of success is to base action on locally specific, constantly updated data. When local people can gather accurate information about their perceived problems, natural resources, culture, geography, and financial parameters, the local grounding of their action makes success more likely, and their shared ownership of that knowledge galvanizes them to work together.* (pg 245-footnote2)

Based on Freire's perspective of the community, Carl Taylor and Daniel Taylor-Ide in their book, *Just and Lasting Change: When Communities Own Their Futures*, (2002) developed a system they refer to as "SEED"

(Self-Evaluation for Effective Decision-Making). SEED provides a regular database that supports community action, based on objective information. SEED has two components: self-evaluation, or objective data-gathering, in which communities assess their changing circumstances and set priorities; and effective decision making, in which communities, experts, and sometimes officials, join in analyzing the causes of local problems, choose their priorities, then analyze the response to be taken and assign roles to distribute shared responsibility and accountability. They describe their approach as an alternative to such methods as Participatory Rural Appraisals (PRAs), Rapid Assessment Procedures (RAPs), and Planning, Learning, and Action (PLA) because, whereas they do incorporate aspects of these methods, they stress the importance of gathering and utilizing objective facts, rather than opinion. They explain that "data-driven action", which is based on a clear assessment of priorities, will result in decision making that can transcend differences among community members and "point toward the most efficient path to change". They stress the importance of community members performing at least part of the data collection themselves, using simplified methods they understand. *"Only then will they trust the findings and act on them – and typically the cost will be less"*. They also point out that data collection should be ongoing in order to monitor progress and to provide clear evidence over time of what is working.

B. Community Generated Data for Quality Improvement in the Health Sector

The availability of literature on the use of CBMIS to improve child well being through strengthened multi-sectoral community responses is extremely limited and is most likely to be found in unpublished program reports. More extensive documentation is available to describe quality assurance efforts to improve the effectiveness and efficiency of health facilities and health sector interventions. In the quality improvement literature, monitoring systems are described as a process for regular collection and analysis of a core set of indicators. The system provides data that can be used for assessing problems, making decisions to improve the situation, and monitoring progress. An effective monitoring system should meet the following criteria:

- Data are used to identify the presence and causes of performance problems
- Data are collected regularly to monitor the trend of indicators over time
- Data are used to guide management decisions
- Data collection is a routine activity integrated into daily tasks.

(From: Health Manager's Guide; Monitoring the Quality of Primary Care; by the Quality Assurance Project

In a report produced by the Child Survival Technical Support (CSTS) Project (Feb, 2003), the authors describe community participation in collecting health data along a continuum, depending on many factors, and especially depending on the goal of the Health Information system. The motivation of health development agencies to encourage community participation ranges from a purely utilitarian motivation to a broader goal of community empowerment. The utilitarian perspective views participation as a means to an end, typically increasing the effectiveness of health programs through better information or cost sharing. The empowerment model views participation as an end in itself, building community awareness and capacity to determine and act on health priorities, including generating and allocating resources. Between these two models of community participation is a continuum of overlapping roles that a community can play in respect to health and development. Table 1 provides an example of activities that a community involved in health information systems may conduct, as determined by its main role along this participation continuum.

TABLE 1

Table 1. Role of the Community within Varying Models of Participation in an HIS
(CORE CB-HIS report)

Participation Continuum

Utilitarian Model ⟷ Empowerment Model

Role of the Community

Advisory and Consultative	*Resource Mobilization*	*Decision-making and Planning*
Provision of information on perceived health problems and priorities; socio-economic, cultural, and political context and expectations from health services	Provision and use of information on human, material, and financial resources and on health services in the community	Design and implementation of HIS Participatory use of data for community decision-making

There are multiple examples of health information systems in which the role of the community varies according to the purpose of the information collection systems and the level of "ownership" by the community. The following are examples of different types of efforts that involve communities to varying extents and for varying purposes.

An example of monitoring to improve health systems is the work conducted by CARE in Peru, where a community-based health surveillance and response system (CB-SRS) was developed to enable the collection and analysis of critical information on women and children and was designed to complement an existing health information system used by the Ministry of Health (MOH). This system resulted in a culture among staff at the MOH facilities and the community workers that led to increased utilization of information for decision-making. In fact, community data collectors even took the initiative to attend monthly meetings so that they could be involved in action planning. CB-SRS, however, was found to be most feasible where there is already a community-based system for provision of essential preventive and curative services. (ref)

In rural Honduras, Catholic Relief Services (CRS) and its local partner COCEPRADII implemented a program to identify pregnancy-related health issues and to develop a system of data collection by traditional birth attendants. Analysis of the data provided a basis for household level activities by the TBAs and for decision-making at the community level. Each month, TBAs met with a public health official to analyze the information that they collected. Together, they planned responses based upon this analysis. The information influenced action at specific MOH facilities, as well as village health committees. Aggregated data was also used for coordination and management at district and central levels. (ref)

In a rural area in southern Mozambique, World Relief Corporation (WRC) and the Ministry of Health implemented a project whereby 220 care groups of 10-15 volunteer mothers conducted regular home visits to provide health education and advice on key health behaviours and services. The data for a community-based health information system was primarily collected and used by the volunteer mothers, who were both illiterate and literate women elected by their communities. During biweekly meetings of the care groups, the volunteer mothers reported data orally, and the care group leader transcribed the information. This systematic group reporting provided an opportunity to double-check the information provided by each volunteer and to discuss appropriate actions. Each month, the care group leader sent a written report of the data collected from the volunteer mothers to the local health post, where the nurse was able to review the report and take appropriate action. The nurse compiled the reports from the different care groups, to be presented and discussed at the monthly Village Health Committee meeting. The report was also shared with the district officer who could use it to detect discrepancies among the various health posts covered by the care groups. (ref)

Save the Children worked with indigenous communities and local health personnel to develop a community based health information system in a rural area of Bolivia as part of the SECI project. Volunteer health promoters (VHPs) were trained to use simple forms and community maps to collect health data during household visits and other interactions with the community. At the end of each month, the VHPs, the health personnel, and Save the Children staff consolidated the community-based data with data collected in the health posts and hospitals. A team consisting of a VHP and a doctor or nurse from the nearest health facility presented this information to the community. An evaluation of the project, comparing communities that participated in the project with other communities that had the same health activities, except for the information systems, revealed that children in the SECI communities were more than three times more likely than children in the comparison communities to be completely immunized by age 5, and were also more likely to be immediately breastfed, to possess a health card, and to receive vitamin A supplementation. The evaluators concluded that respectful dialogue and use of locally specific data improved communication between the communities and the health services personnel and that this greatly contributed to the strength and sustainability of the project in promoting positive health behaviour and improving the health status of women and children. (ref)

In Western Kenya, a child survival project initiated by CARE in 1995 focused on training, equipping, and supervising locally elected community health workers (CHWs) to provide health services to mothers and children. The project also supported the formation of village health committees (VHCs) to manage and support CHW activities. VHC members were expected to collect, analyze, and interpret information to promptly identify health problems, implement disease prevention activities, and promote appropriate health behaviours. The CHWs entered and summarized the data. On a monthly basis, VHC members were responsible for reviewing the data from the CHWs' registers, interpreting changes and patterns, and developing action plans to address problems. Although the community was expected to use the data, it was the project staff that had determined the data sources, data collection tools, and indicators based on the needs of the project. The final evaluation of the project revealed that, despite the emphasis of the project on developing community management capacity and using participatory methods, the CHWs viewed data collection as burdensome and did not understand much of the data they collected. Further, the VHCs lacked support from the community for their activities, and the use of data remained very low. In 2000, the project was redesigned before its expansion into new districts, and an evaluation is not yet available.

As is evident from the examples above, the potential contribution to health systems of data collected by communities is enormous. Depending on how these efforts are carried out, the involvement and the commitment of community members will vary. As one technical expert in quality assurance pointed out: *One of the central issues seems to be an absence of validation of the data, which is also an issue for clinic records. When the data collection process is seen as merely contributing to a report produced by someone far away, and the results are not really used for anything locally, people seem to learn to cut corners.* (Email to author)

C. Community Based Management and Information Systems within "OVC programming"

The previous section provided examples of the use of community information systems that were facility-based or were otherwise used to improve health sector results. Though far more limited, some information is available with regard to attempts to use community based information systems to enhance multi-sectoral efforts by the community to respond to children in AIDS affected areas. Much more has been written about *how to* conduct such efforts such as the CORE Leader Initiative produced a manual on "Participatory Monitoring and Evaluation of Community- and Faith-Based Program" (Sept, 2006). It emphasizes participatory approaches to build and promote community ownership. Involving the community from the beginning, community activities are thus predicted to be more responsive to local conditions, as well as more effective and sustainable. Participatory monitoring and evaluation is described whereby the community, beneficiaries, and implementers - in consultation and collaboration with donors - decide what will be monitored and how the monitoring will be conducted. As described in the manual, participatory monitoring has the potential to enable project participants to generate, analyze, and use information for their day-to-day decision making as well as for long-term planning.

A similar process is described in a handbook on the Tigwirizane approach (*tigiwirizane* means joining hands together in Chichewa, the local language of Malawi), produced by the STEP project in Malawi. (STEP Manual) It describes a Community Action Cycle (CAC), which is a six-phase community mobilization process – a process whereby communities identify their needs and are empowered to address them. The following are the six Phases:

Phase 1: Prepare to mobilize
Phase 2: Organize the community for action
Phase 3: Explore the HIV/AIDS issues and set priorities for action
Phase 4: Plan together
Phase 5: Act together
Phase 6: Evaluate together

Phase 6 is considered a time to take stock of what the community has achieved, identify what has and has not worked, and make recommendations on how to improve future efforts. The following are the ten steps involved in the participatory evaluation process:

1. Determine who wants to learn from the evaluation.
2. Form a representative evaluation team with the community and other interested parties
3. Determine what participants want to learn from the evaluation
4. Develop an evaluation plan
5. Develop evaluation instruments and train team members in their use
6. Conduct the evaluation
7. Analyze the results
8. Provide feedback to the community to validate results
9. Share lessons learned and recommendations for the future.
10. Prepare to reorganize

Collection of data is one component of the evaluation process, which is preceded by participants deciding what they want to learn, and is followed by their use of the data to make decisions based upon the information gleaned through the data collection and analysis process. (STEP handbook)

In Uganda, the CORE Initiative has field-tested a process of data collection through community mapping and has drafted a manual describing the process. Local partners that receive funding for OVC programming will be trained and supported to use this methodology. Participatory mapping has the potential to enable communities to define and identify OVC and their needs within their community.

In Tanzania, FHI-IMPACT, together with the Department of Social Welfare, UNICEF-TZ and other United States Government partners, used a participatory process to develop a system at local and national levels to identify the most vulnerable children and their needs, as well as key service providers. They report that community participation and involvement was key to creating a database with information that was accurate and could be used. (Kikoyo, Levina, Presentation at FHI IMPACT End of Program Meeting, June, 07)

In China, Save the Children/UK worked with children to design a survey which they used to collect information from their peers. Interventions have been developed, using the information collected by the children to inform the design of the projects, and the process and the findings have been documented. (Listen secrets)

Similar methods have also been used in post-disaster situations. Following the earthquake in Pakistan in 2005, Save the Children/Sweden's actions aimed at child protection were community driven, with the intention of increasing their sustainability. Their experience demonstrated that it is relatively easy for the community to identify the protection needs and existing community responses. They also found that children can be the best source by which to identify some of the critical issues facing their peers, such as sexual abuse, discrimination, early marriage, child trafficking, etc. (Tsunami USAID doc)

5. FINDINGS

A. Community level findings - Save the Children/US

Community members from eight villages in Gaza were interviewed for this research. All community "OVC Committees" were formed between 2002 and 2005, when Save the Children/US (sometimes accompanied by district government representatives) came to their village to help mobilize village committees. Each committee consisted of approximately ten members, representing various functions, such as health, farming, home visits, education, fundraising, home-based care, CBCC, community leader, and child representatives. The committees have a president, treasurer, and secretary. The secretary can read and write and is generally the person who is responsible for recording and keeping the data. (In the villages visited, the ability of the community members to read and write in Portuguese is limited.) Some committees meet weekly; others meet monthly; some meet twice a month; while others meet weekly to conduct farm work and monthly to conduct other activities.

Data Collection at Community level: Community members fill out a variety of forms, depending on the type and source of external support they receive. While the communities had this experience, none reported having had input into the development of the forms used to collect the data. Rather, the forms are provided by the donor organization(s) or government agency. Some of the forms have the logo of the donor or partner organization. Because it is difficult to fill out the forms, training is generally provided. Respondents in the villages consistently associated the forms with Save the Children or other donors who are providing inputs to the community. They explained that the forms are filled out at the request of the donor.

> *"They don't keep track of the number of times they visit. The volunteers live around the children. Volunteers feel responsible for children and monitor their situation. They have a system to visit and keep track of the kids…Maybe we say they don't have a system, but they do it orally and it is useful for them."* (Program administrator)

Typical forms found at the community level included 1) a registration form used by volunteers to record information about vulnerable children receiving support from the OVC committee/program; 2) forms used by the communities to list the number and type of services received by each child; 3) forms used to record distribution of material support, usually consisting of a list of children who received a particular item such as food or school materials; and 4) registers of children attending the community based child care center (CBCC). It was necessary for the person who completed the forms to be able to read and write.

Tracking the number of services and the types of services provided to children is required by the Scale Up Hope Program. Each month, a community mobilizer collects data on the number of children served, by type of service and by gender. The community mobilizer then aggregates the data and gives the information to the provincial SUH manager on a quarterly basis. However, the information about the children and how they are served seems to be primarily oral, among community members; some of it is recorded in writing, depending on the efficiency of the systems developed to do so. As explained by community members, "*We live with these children; we visit them all the time. We always know to find out from them*". Some community mobilizers explained that they go to the communities, get the information, and then come back to the Center to record it. In some communities, the secretary, who is able to write, is solely responsible for filling out the forms. This creates some difficulties when, for example, the secretary is not available when the community members are ready to provide oral information to be recorded on the forms. Some community members record the information in exercise books during the month. In one community interviewed, the home visitors reported that they had all been given exercise books to record services they provided. When asked how many of the six home visitors who were in the focus group were able to write in the exercise books, they explained that only two were literate. When asked how they were able to use the exercise books if they could not write, they smiled and exchanged glances among each other. In one community, pictorial forms were used that had been introduced to the community before the current form. This form was not found in the other communities that were visited.

In general, it seemed that many areas of support provided to orphans and vulnerable children are not captured in written form by the data collection tools. One of the managers explained the difficulty inherent in requesting written records of community activities such as home visits, "*…Visiting is a cultural activity. It is something that you just do. They don't see this as a job. It is just something that you do. It is very hard to ask them to write everything you do*".

Community members raised concerns about some of the forms they are required to complete. One data column related to children that was consistently left blank was the column requesting information about the child's primary needs. As one community member explained, "*we don't fill that out because it will raise expectations*". The registration form was described by some as very useful in reviewing the relative vulnerability of children and their households, because it specifically asks for information on the adults and the children that could contribute to vulnerability - such as the relationship of the child to the head of household, whether the household has a poverty certificate, and disability of adults in the household. Communities also use the information captured on the registration forms to identify priority households/beneficiaries. For example, names of those who were most vulnerable were indicated on the form by a "tick". However, community members do not usually update the registration forms. Once a child or beneficiary is enrolled in the program, communities generally do not monitor improvements in their situation. In addition, the form only attempts to capture activities funded through a specific program, such as Scale Up Hope, but failed to capture the contributions to the same children from other organizations. Though the registration form was also developed to keep track of the ongoing services received by the children through the SUH project, committee representatives explained that there is not enough room to track services over time or include additional services that were not necessarily funded by SUH in the small boxes that are available on the form. Community members also described conditions under which it is difficult to continue to track the situation of children, such as when they drop out of school and leave the area.

The four categories that were used to track activities on the registration form led to under-reporting of the support that is being provided because there were not specific categories for activities in which the communities are actually engaged. For example, home visiting is one of the most common activities in some communities, but it is not clear how that information can be captured on the current form, which does not include an activity category for "home visits". In addition, terms used in the forms to describe certain categories of services appeared unclear to communities. For example, even though communities give emotional and social support to children, there is widespread confusion about the meaning of the term "psychosocial". This is a category of service for which reporting is required by PEPFAR. A representative of FDC, another PEPFAR funded implementing organizations, explained that they have been trying to tackle how to identify and address psychosocial needs of children within the context in which they live: "*...we have a problem assessing [the] psycho-emotional condition of the child. We base our assessments on western psychology. In our culture, it is a child who is well-behaved… [We] do have traumatized children, but we don't really know how to identify them. The culture even helps to hide them [and makes it difficult to find them].*"

On the other hand, communities were able to gather data fairly consistently on specialized services such as early childhood education. Most of the communities visited have a community-based child care center (CBCC). Community volunteers, called "animators", are trained by Save the Children/US to work in the CBCCs. Data forms were fairly specific to the services provided at the CBCC site and included an evaluative component of the animator, conducted by their supervisors. The CBCCs also had rigorous standards for "quality" service provision, including adequate student teacher ratios and existence of locally relevant play materials, among other criteria, which may have enhanced the rigor of data collection at the sites. World Food Program (WFP) also provides food resources for the CBCC. The animators keep complete lists of all the registered children and they complete daily attendance records, usually in an exercise book. However, in many cases, the forms filled out by the CBCCs were not cross-checked with the registrations forms held by the OVC committee, thus presenting a challenge in terms of double counting.

*"…They do great things, but it is difficult to write or read. It's easy to sit with them and they will explain to you the achievements and what they are doing. It becomes difficult for them to write…we tried to introduce pictorial forms but it is difficult. You have to use a different form for each child. It is too many forms"…(*Program administrator)

The researchers found that communities were best able to track information related to distribution of material support where communities maintain lists of beneficiaries according to the type of support provided (i.e. food, school materials, and uniforms). Distribution was generally recorded publicly. "*When they get the materials, they call all the children out to get them and they are recorded on the forms…*" Public distribution allows for ease of distribution and, at the same time, enables the community to observe the work of the committee. As one committee explained, "*they [the community] are happy because they are seeing tangibles [food that was distributed]* ". It also gives the committee respect in the eyes of the community, a potential source of motivation for committee members. However, in many programs, it was reported that such public distributions, which single out children from among the others, has a tendency to label the beneficiaries as different – as "OVC" or "orphans", rather than as children who are like their peers. This could result in negative consequences for the beneficiary in the form of increased stigma and discrimination. In addition, the children are sometimes subsequently considered to be the responsibility of the donor organization. For example, they are referred to as "Save the Children's children." This tends to reinforce the transfer of responsibility for those children to the organization, rather than to reinforce the responsibility of family and community.

WFP provides food to beneficiary households, as well as to CBCCs. Those who are eligible to receive food are given a blue card with their name and a list of the types of food distributed. The cards are kept at the household. When food is distributed, *"we call them to come to the committee with their cards so whoever receives this help was registered on their cards."* The types of food received are "ticked off" on the card and the beneficiary signs (usually with a finger print). The committee also maintains a list of beneficiaries, which is used to keep track of those who have received food. The data on food distribution seems to be consistently recorded, collected, aggregated by the community, and shared with ministry officials. Comprehensive data on the food distributed, to the number of recipient households, broken down by geographic area, was shown to the researchers by both district and provincial representatives of MMCAS. The data collected through this system to record the number of children and households receiving food does not include food that is provided through informal community support, such as food shared by neighbors or even by members of the OVC committee.

Home-based care forms were also consistently filled out when the home-based care volunteers, who had been trained to provide care, visited sick people. Some of the volunteers had pictorial forms displaying the types of services received, on which the volunteer indicates whether the specific services were provided at the time of the visit. The home-based care system, which has been recently introduced in some of the villages receiving OVC support by SUH, is supervised by the Ministry of Health and has a separate system of data collection apart from the SUH program. Volunteers receive training and supervision by the Ministry of Health and data are linked to MOH data systems, resulting in more rigorous data capture. The home-based care systems of tracking the services provided by these volunteers seem to be more rigorous than those that are used to track services to OVC.

When asked whether data on children could be collected in a process similar to that used in home-based care systems, one administrator explained, *"Home-based care is very clear about what needs to be done. OVC is many types of interventions. It would be too much to collect. It would be a book… [instead of a short and concise form]".* Another administrator explained that the home-based care volunteers "*also are trained to observe the physical condition of the person they monitor over time. For home-base care, it is easier because you are measuring the health of the person. But for OVC, how do you get into the heads of the child? "*

The OVC committees and community mobilizers mentioned frequent changes in the reporting formats based on donor requirements, resulting in increased training efforts and sometimes frustration on the part of the communities. In one community, the mobilizer noted that he spent much time in the last year retraining staff, which meant he could not properly follow up on implementation of the program activities; this has implications for program quality.

The community mobilizer is not only responsible for collecting data from communities on the number of children served and the types of services provided on a monthly basis, but he/she is also responsible for aggregating the data and sending it to the Provincial office of SUH. In addition, the community mobilizer is responsible for filling out a number of forms for different types of activities, including assessments of the OVC committee capacity, assessments of the CBCC, lists of material goods provided, and number of trainings conducted and meetings held.

Similar systems were found in Ethiopia, where Save the Children/US is implementing a national program targeting 500,000 OVC using community core groups (similar to OVC committees). The core groups are responsible for capturing data on all the relevant services provided to OVC in the community and submitting to their supervisory national NGO and then to Save the Children and its other Tier I partners, comprised of international NGOs. During visits to the community, one researcher consistently found visual displays of data including: 1) a community map (detailing all the key service points in the immediate and surrounding communities; 2) a detailed table, showing the numbers of children served, disaggregated by sex; and 3) a listing of the numbers of children receiving particular services. In addition to the visual displays of information, the researcher also found very detailed records that were well organized in the offices of the core groups. Each child had his or her own record in a folder and in some cases, core groups went as far as to include pictures of the child receiving services.

In Ethiopia, community core groups are using 10 different formats to capture data, though for reporting purposes they stated that they were using only one. These formats were similar to what was found in Mozambique. They also included a referral form used by community volunteers to refer children onto health services. This referral form was supposed to be based on the community mapping which all communities had conducted.

Terms used for data capture on the forms also seemed to create similar confusion in Ethiopia. For services such as psychosocial support, committees showed similar misunderstandings of the term and in some cases, resistance to the provision of this type of support. One committee, when explaining what they did to provide psychosocial support to children noted that they bring some of the children together (usually not all the vulnerable children identified) and provided them soft drinks and cookies. When asked why all children did not benefit from psychosocial support, they responded that this support requires resources (to purchase the food and drink). When recording the numbers of children provided this support, they only counted those that they had done this activity with, excluding those who had received home visits or other types of counseling during the reporting period. In a strategic planning meeting, when this question was raised again, the core group leaders often noted that the children are poor and therefore would not benefit from psychosocial support, preferring to receive “one birr” (local Ethiopian currency worth approximately 10 US cents). In some cases, there were reports of parents refusing to send children to other psychosocial activities (such as play groups) because the “children did not receive anything”.

Community Use of Data: With the use of participatory approaches to CBMIS within OVC programming, the expectation is that communities would be able to use the data they gather to make decisions about the children. The researchers, however, found little evidence of this in the research communities. As part of the community action cycle, communities would have written action plans. However, this is frequently an oral process. Community leaders consistently mentioned that “*we do plan activities in our meetings…we sit with the community and they present the difficulties they have and from there they set priorities…collect information concerning each difficulty*”. Another community representative explained, “*We normally have our plans written in our mind*.” They also explained that, as the local authority, they used to collect information before Save the Children came to their community, but they failed to respond to some of the difficulties that came from the community until the arrival of Save the Children.

The researchers found varying degrees of information exchange between the OVC committees and the communities on the work of the committee. Such exchanges are necessary for communities to understand the data that are being collected, analyze the situation and make recommendations for improvement. This was not systematically done at community level, confirming that the data were primarily used for reporting to donors and program management as opposed to meeting the community needs. Indeed, the villages consistently associated the forms they are filling out with Save the Children or the other donors who are providing inputs to the community and requiring the data from the community.

Though in general, the focus of the data collection was to respond to pressure to get the information to donors and not to use it for improved programming, there were examples where it was shared and used by the community. For example, the community mobilizers complete a monthly form to monitor the CBCCs and use it to provide feedback to animators who manage the CBCCs. Though the data are not systematically shared with the community, some OVC committee members have noted progress that is evident to them from the information being collected. As one community committee member explained, *"…we see more children being registered; they are going to school; children are receiving school material …"*

For some communities, data collection efforts have resulted in increased funding opportunities. One secretary of an OVC committee that has kept exceptional records of the committee's data on the number of children who are vulnerable and the number who have received services explained how useful the data has been in making the case for further funding from external visitors to the community. In another community, the secretary of the committee explained that visitors are very impressed by the data when they visit the community. The committee has used the data to document how they have been providing support to OVC and their households. The records also enabled the committee to document how many children are not yet receiving support. They have used this information to request funding from CNCS and subsequently received the funds to provide additional support, including the inputs - such as agricultural inputs - that would enable them to better care for the OVC that are not currently receiving support from the OVC committees. A couple of the OVC committees have submitted proposals and have obtained funds from CNCS for their support to vulnerable children. Others have had their proposals approved, and they are waiting for funding. One village received funds from the provincial directorate for HIV prevention that enabled the CBCC to fund poultry raising activities. In all, 20% of the committees have submitted proposals to CNCS.

If OVC committees and communities were aware of the potential of receiving additional funds as a result of comprehensive data collection, they might be more likely to maintain written information systems. For example, when told of the success of some communities that used their data to obtain external funding, the focus group participants had not heard of these successes and wanted to hear more about them. Though the community mobilizers share information from community to community, there are not opportunities for communities to directly exchange information.

Similarly, in Ethiopia, the researcher found that communities were able to use their data to advocate for additional resources. More so in Ethiopia than in Mozambique, the community core groups had achieved great success in raising funds at the community level as well as through their government officials. In more than one community, core groups reported having negotiated free health services with their Kebele Administration for OVC identified in their area. They had also raised funds through community mobilization efforts for increased support of OVC. For example, some core groups raised money to support the provision of food for OVC.

In Ethiopia, where a majority of the children are food insecure and very vulnerable, the community need is great. Many communities reported that they had registered a number of children but in most cases were not able to serve them all. In some cases, the core groups were able to raise additional services either through the private sector or through community generated funds. In addition, core groups reported regular, bi-weekly meetings to discuss the program but it was not linked to an analysis of the data. These meetings were usually for training, coaching or collating data for reporting by the volunteers. A key hindrance in the use of the data for decision making noted in Ethiopia is that each month, groups had to rewrite the list of the children under their care. One group visited had over 1,000 children whom they were serving. This meant that each month the person responsible for completing the forms had to rewrite over 1,000 names on the form and then report on which services had been received. The amount of time this took meant there was often not much time left to analyze the data that were being recorded on the forms.

It was also clear that there was no consistent feedback mechanism neither between the supervising national NGO and the core group, nor from the INGO to the national NGO. This could be because the numbers are great – there are over 512 community core groups and 34 national NGOs. However, this key step was seen as necessary for communities to be able to better use their data as opposed to collecting simply for reporting purposes.

Data Storage and Management: In Mozambique, some committee members described problems related to data storage. For example, one committee spoke of data that they compiled, but the documents were given to a donor who did not return them; no copies of the data were left in the community. Another committee explained that they are not used to keeping records. They had files, but they were stolen: "*the house was broken into and someone stole the files*." Another committee did not have complete records because "*the first secretary of the committee died and after he left, things were scattered"*

In Ethiopia, the researchers found much better data storage. Each community core group had an office where they maintained very detailed files of the children being served. It was very easy to pull out a form by child's name or identifier number to see what needs they had. What was less consistent was the availability of information regarding the services provided to the children. Though this was supposed to be updated quarterly, the researcher did not find this information consistently. The visual display of data in the offices was also a key opportunity to gain a snapshot of the activities of the core group and indicated the level of organization of the core groups.

Measuring Quality of Programs and Outcomes in Children: Information about the quality of services is not available. As one administrator inquired, "*How can we be sure that we are providing quality programs? [for example,] if we do food, how do we know what impact it is having on the children?"* Another example is related to the provision of animals as a part of livelihood interventions in which the results are not monitored to determine if the intervention actually generates income or other means of economic stability. USAID/PEPFAR requires information about the number of core program areas that children have access to. This data requirement emphasizes the importance of comprehensive programming - and, therefore, the quality of programming. Tracking access to those core program areas will be more rigorous with the proposed computer system that is currently being implemented. However, the data will provide information only on "access" to various services, so information about quality of the inputs will not be available.

Monitoring the well-being of the child is not being done through the current CBMIS. Members of the OVC committees and other community members are informally monitoring the needs of vulnerable children and their households. The extent and the adequacy of this support are unknown. This problem was not unique to Save the Children. FDC concurred that this was difficult for their communities to accomplish. As explained by an administrator, "*We know that we can serve 20,000 children, but what that means, we are discussing that internally. We need to know did we make any difference in each child's life. We don't know. [We'll] have to find a way of keeping track. We have a baseline for each child, including a psychosocial profile, illnesses, whether they are going to school…But then, every year, what happens? I know I've given exercise books to the child. Is that enough? What other services is the community giving? …*"

A copy of the Child Status Index (CSI) tool, distributed at the PEPFAR Implementers Meeting in Kigali in 2007, had since been translated by FDC into Portuguese though they have not yet attempted to incorporate it into community activities. The Child Status Index is a tool that has been initiated by PEPFAR to encourage communities to systematically monitor and improve the response to the needs of children. The status of children is measured on a regular basis with regard to the six core program areas. It is yet to be seen whether this tool can be introduced and used to ultimately enhance the positive support of children through community owned processes, or whether an unintended consequence of introducing a donor-developed tool to the community might be to undermine existing social support systems.

In Ethiopia, the project has made some attempts to capture data on quality and outcomes in children being served by the program. The CSI tool was piloted using the LQAS methodology where the community core groups chose small samples of children being served in their program to assess them on the CSI domains. The core groups are conducting this exercise which is being complemented by a pilot of the national OVC quality standards for each of the services being provided. Through this process, it is intended that the core groups will have an opportunity to better reflect on the work they are doing and ask critical questions about whether or not the children are doing better as a result of the program or whether or not the groups need to make changes in the way they are conducting business. This is in the beginning stages and was found to be a key gap in the OVC program by program administrators.

Linkages to District, Provincial and National Level Data Collection: Key to the sustainability of CBMI systems is the linkage of community data to district, provincial and national level data collection efforts. Except in the case of home based care, the researchers found limited linkages between these levels. This was in part due to the non-existence of national monitoring and evaluation systems to collect data on OVC as well as lack of capacity of MMCAS, the ministry responsible for orphans and other vulnerable children. There are efforts underway to develop such a system, as mandated by Mozambique's National Plan of Action. (see section below on Mozambique Framework for Action) In developing a national system, it will be important to consider the types of data that are already being collected at community level, that can feed into district-level systems, and ultimately to provincial and central level monitoring and evaluation systems. Likewise, in developing systems to collect data from communities, implementing organizations should take into consideration the data that is already being collected and/or data that would be useful to the communities. When considering information requirements of the entire system - from community leaders, to program-level community mobilizers, to provincial administrators, headquarters, and ultimately to the donor (and its link with potential government systems)- the whole system must be considered at once in order to maximize simplicity and reduce redundancy. Otherwise, community members and staff members are bombarded with multiple forms, some of which are redundant and many of which are not considered of use to the community in improving their response to vulnerable children and their households.

In Ethiopia, there are no such linkages in a systematic fashion with government reporting systems, although investments by USAID and other donors are moving towards this harmonization. However, the core groups, including traditional leaders and other officials, have more communication with lower level government officials than was observed in Mozambique.

B. National level

USAID/Mozambique: USAID/Mozambique was one of the first Missions to require that children be monitored in all core program areas. This was in line with the national government policy that OVC be provided all six services by partners, government and other organizations. Partners are required to report on OVC access to all six indicators in addition to collecting the following information:

- Number of households, in addition to number of OVC, who receive support
- Age breakdown of the children served.
- The type of vulnerability of the child (e.g. maternal orphan, paternal orphan, double orphan)

In order to coordinate the data collection process from the various partners, USAID/Mozambique has introduced a database developed with Microsoft Access that is intended to track beneficiaries on an individual basis. The database assigns unique identifiers to children receiving services through PEPFAR funded programs. Information to be collected about the children includes: name, geographic location, age, gender, orphan status, as well as access to services and the provider of those services. The database recognizes that services can be provided by a multitude of actors, including communities, faith-based organizations, and NGO partners.

The database captures access, though there is no definition of what “access” means. In addition, there are not yet clear guidelines on how to complete the database. It was suggested that the records for the child be updated whenever there is a change. It is not clear, however, if the database will allow program partners to assess change over time of each child enrolled in the programs. Moreover, there are no plans to use this system to collect data on the quality of the services. USAID/Mozambique representatives acknowledged the limited information that is available on the quality of services to OVC and the impacts of services on the well being of children. Lastly, the database is limited to providing information on the types of services provided through PEPFAR funding, and does not include resources provided by the community.

In order to respond to USAID/Mozambique reporting requirements, SUH partners submit quarterly reports to Save the Children/USA according to the indicators required by USAID/Mozambique. A form developed by Save the Children/USA is completed by all partners and displays information according to the strategic objectives and intermediate results of the program. Though this form is uniformly used by all program partners, each has different systems to collect data.

Government of Mozambique: Framework for National Action: The National Plan of Action (NPA) for OVC includes a mandate to develop a national system of monitoring and evaluation. The definition of vulnerability according to the NPA lists a range of vulnerabilities including poverty, children living on the street, children in conflict with the law, among others. There is currently no national system that requires specific data collection on vulnerable children. Organizations that work with orphans and other vulnerable children send information to the district level MMCAS representatives. However, there is no specific format requested by MMCAS. Some partners provide narrative information and others include tables of data. The district level representative, in turn, summarizes the information and sends a report to the provincial MMAS office, including narrative and tabular information that has been made available at the district. Systems differ for data collection by the National Institute of Statistics (INAS), which is housed within MMCAS. INAS is the government institute within MMCAS that provides benefits to support specific eligible populations such as the elderly and including children born to mothers who are HIV-positive. Data is collected on those beneficiaries who have registered and are receiving support in the form of small grants. Unlike MMCAS, INAS has financial resources to register and provide direct support to households.

There is a plan to have community level volunteers collect information on OVC once the national database has been developed. These volunteers would be placed at the district level and interact with the programs on the ground to gather registration data on OVC in their communities. This has not yet started and it was clear that MMCAS would still have to depend on organizations’ volunteers to collect these data and support volunteers either with financial or in-kind support.

Mechanisms for data collection by MMCAS differ significantly from those of the Ministry of Health (MOH), which has more comprehensive systems for collecting data. For example, MOH supports the home-based care program, which includes an extensive training program and oversight of the home-based care volunteers. Forms are developed by the National System of Health Affairs and distributed for the home-based care visitor to complete. Unique to the health information systems, data collected at the community level are fed into district, provincial and national level information systems. However, the data does not capture information on children in households with sick caregivers.

Support to National Level Efforts: At national level, there are efforts to increase the capacity of MMCAS by various stakeholders. STC/Norway, together with the Ministry, FDC and CARE, have identified common indicators and developed a database that has the potential to monitor and report on data on vulnerable children at specified time intervals. UNICEF is also developing forms to be used to collect data at various levels of government. USAID is working with UNICEF to support an advisor to MMCAS and is providing capacity building to MMCAS in monitoring and evaluation through the JSI/MEASURE Project. HACI is also providing support to MMCAS to increase their capacity to monitor and provide oversight to psychosocial interventions.

The Mozambique OVC Technical Working Group is a coordinating body that includes representatives from government, UN organizations, and international implementing organizations. This mechanism is operating at national and provincial levels, with plans to expand to district level. At the district and provincial levels, MMCAS has a coordinating and supervisory role in OVC interventions. SUH partners work with, and provide support to, MMCAS in various ways at the local level.

C. Scale Up Hope Partners

The Scale Up Hope Project in Mozambique includes Save the Children/US, in partnership with Save the Children/Norway, Save the Children/UK, and HACI/Mozambique. At national level, administrators from each of the partners were interviewed for this study regarding data collection and use of data at the community and national levels. The following sections describe the key findings from interviews with implementing partners under the SUH partnership.

Save the Children/US: In Gaza, **Save the Children/US** has mobilized fifty OVC committees in five districts to identify and provide support to OVC in their communities. In each of the five districts, a community mobilizer oversees and provides support to 10 village committees. Information about each of the children and their households is collected and recorded at the community level; the community mobilizer is responsible for aggregating data on the number of children receiving services for each quarter. The community mobilizer is also responsible for maintaining data on other activities that take place, such as meetings held and trainings sessions conducted. He/she also serves as a key intermediary between the communities and the project staff and other key stakeholders at district level. Documentation of activities assumes that the community mobilizer is present or is informed of all such activities. However, because he/she is responsible for ten communities, it is likely that there is under-reporting when the community mobilizer is not in attendance.

Challenges to collecting data, as explained by an administrator:
"In the past we have organized a training to partners…First thing a person should know to fill this instrument is to read and write, but in certain situations, you find that those people working with children that should provide the information are those people who do not read and write. We tried to design a simple process to help these people collect this information."

The original intention was to use the Community Action Cycle (CAC) approach as a guide to mobilizing the OVC committees. Based on the CAC process (refer to literature review), the community would be central in developing plans regarding the type of information that was important to the community to collect. They would collect and use the data to inform them on how well they were achieving their objectives and to reflect on how to improve their interventions. However, the pace of CAC must reflect the pace of the community in developing and moving toward a community-owned action plan. This generally takes a much longer time than was available when initiating the SUH project. As one of the administrators explained, "*The original mobilization had only one person on the ground…. The mobilization process was accelerated in the process to get the numbers. We had the money and we were* *told it is an emergency….there was not adequate funds or time for training*". In addition to communities deciding for themselves what data to collect, central to this methodology is that communities are able to use the data to improve their own situation through an evaluative process. The researchers found that the CAC seemed to stop at the mobilization process and failed to reach the "planning together", "acting together" and "evaluating together" stages, all of which are critical in the use of a participatory approach to CBMIS.

Hope for African Children (HACI): HACI provides sub-grants to 14 local partners through SUH. The forms developed by Save the Children/US have been provided to the partners, and they are required to submit reports that are aggregated by HACI and then sent to Save the Children. Some local partners create their own forms to collect the required information. As explained by one of the HACI administrators, "*In fact, they have some problems filling in the forms. There are many pages. We have to insist for them to fill it out…this instrument [the required form] should be fed by others. For them, it is a problem to design instruments, and even the process to collect information to feed these things. Some of the organizations are very small, and they don't have expertise to do that…sometimes for them, collecting data is really a problem. If you have problems collecting data, you have problems filling this form…the data collection process they have does not facilitate the form. That is why we are organizing a training to provide technical support to design the data collection process…*"

To address this gap, HACI worked with its partners to design a tracking form for the volunteer to record the type of activities that he/she has provided. This form was to be given to the coordinators to fill in the information required by Save the Children. HACI worked with the partners to identify the various activities that they are conducting, so that they are included in the form. HACI trained its partners - first the coordinators and then the volunteers - on issues related to accounting for PEPFAR indicators, such as how to account for "direct" versus "indirect" beneficiaries, as defined by PEPFAR. Training included clarification on concepts such as the term "psychosocial" and its relationship to activities being conducted by the communities.

HACI also developed a database using EpiInfo, and is in the process of giving each of the partners a computer. Each partner works with multiple communities. One partner, for example, supports 18 communities. Volunteers will fill in the form with the local leaders. The partners will hire someone to help them input the data into the new computer system, preferably a student. In developing the data entry form, HACI consulted with all its partners. The local partners were encouraged to add any indicators that they felt would be helpful to describe their work. The only condition was that, at a minimum, the indicators required by USAID and PEPFAR were included. A major difference in the form, which addresses difficulties identified in other registration forms, is related to the six core program areas. The partners and the communities must still identify services provided to the children according to the six core program areas. However, the listing of the domains is further subdivided (through a pull-down menu in the computer program) to include the specific activities that the partners actually support. For example, under psychosocial activities, the following activities are listed as options to choose from: home visiting, counseling, etc. As the partners received the computer program, they were encouraged to review the forms and add anything that might be missing with regard to sub-categories of the six program areas. The final list is comprehensive, reflecting actual areas of intervention. In the intervention communities, a form has been developed which also reflects the breakdown of the six core program areas, with the intention of making the form more meaningful to the community. These forms are yet to be introduced for use in the communities.

HACI administrators noted that the data is not yet being used in the community, "*In fact, up to now, partners are*

> "*…One of the things we struggle with in monitoring and evaluation is that they look at it from Save the Children…because we want it, but not [because it] will be useful to them. I think it is a struggle and a challenge…*" (STC/UK administrator)

filling the forms just to respond to many issues…..people did things to show and not to satisfy themselves. We tell them now not to look at this for us, but just for you. We are doing this to support you. When you fill this form, when you go to the community, it is you that matters." HACI considers this level of community ownership to be an important area for their capacity building work that they will be conducting with communities.

Save the Children/UK works with OVC committees. The committees include separate groups of adults, children, and management groups of both children and adults. The groups identify sources of vulnerability within their communities. They conduct mapping of the community and identify available services and organizations working at the level of district and administrative posts. After identifying resources as well as problems, they examine ways to minimize the risk of vulnerability. District officials are invited to be a part of the process to address gaps in existing resources. This is a long process and can take weeks and even months.

As is true of the other SUH partners, Save the Children/UK is also completing the quarterly report provided by Save the Children/US with the required indicators for reporting to USAID/Mozambique and PEPFAR. To gather the required information at the community level, a simple book is used to list the OVCs, based on criteria set by the community that provides basic information about the children and is used for tracking services provided. However, one of the administrators explained, "*we do a lot of things that pass that we don't capture.*" Staff members who provide training keep track of the number of people trained for the quarterly reports. Case studies are also used to gather information on the activities that are conducted in the community. Save the Children/UK is contracting with a person whose job will be to manage the PEPFAR data.

Save the Children/UK is also supporting home based care volunteers who use a different system for data capture than the OVC program. Program administrators explained that the volunteers have a long training schedule, are closely supervised and have a great deal of input from the Ministry of Health. However, children in those households where the adults were receiving care were being overlooked and they were extremely vulnerable. Therefore, Save the Children/ UK has added a child-focused component onto the home-based care volunteers' activities.

Save the Children/Norway does not provide direct support, but works with district directorates or NGOs. Forms are filled out by the project manager, in conjunction with these organizations. According to Save the Children/Norway, the communities are not using the data from the forms. As explained by a program administrator, "*We fill it because we have to and we struggle a lot with our partners to do that*". At the end of the year, they conduct some small surveys that examine the situation of children in the community. For example, they are currently preparing a survey to identify the proportion of children who have knowledge equivalent to their class placement.

D. Other PEPFAR Implementers

The Fundação para o Desenvolvimento da Comunidade (FDC) is another partner – in addition to SUH - that implements OVC programs in Mozambique and is funded by PEPFAR. The organization utilizes five different models to support OVC and various approaches by which they collect data. In one of the approaches, the leadership of the community assigns volunteers to support the children. The community leadership does not provide data. Rather, community activists who can read and write and live in the community are chosen, upon the advice of the community leaders. They are paid by FDC. They supervise the volunteers and provide the data. The activists record the information that volunteers provide orally. Sometimes the leadership offers to collect the data. FDC found that if the NGO requests reports from the community, the community members perceive this as a request to do work for the NGO, and this leads to the expectation that they should be paid.

Pictorial forms have been developed by FDC on which the volunteers can mark with a "tick" when they visit a child. FDC has emphasized that the form is for the benefit of the community, to keep track of what they are doing, and not just for the benefit of FDC. FDC emphasizes that the information it collects is to help advocate for the community's work and to get them the help they need. The process of developing pictorial forms took three months. Originally, they gathered pictorial forms that had been used by other organizations. However, there were misunderstandings about the meaning of the pictures and, in some cases, the pictures were culturally inappropriate. For example, one of the forms they received from another organization used a picture of a coffin to symbolize death, which was not acceptable to the communities in which FDC is working. FDC decided to go back to the communities to find out what symbols could best be used to represent the 20 services that they were providing. Drama is widely used in the areas of implementation, so FDC took advantage of this by asking community members to strike a pose to represent the activities, until the others in the community could correctly guess what the pose represented. FDC then took a photograph and had a professional artist draw pictures of the poses for inclusion in the form.

With the help of a consultant, FDC is developing a database of the services provided to each child over time. The database is expected to provide a system by which care and support plans are more easily developed for the children. FDC currently finds it difficult to assess the needs and develop plans based on the thousands of forms they have, each representing one child. The database is expected to enable the aggregation of the data, as well as a more systematic method of tracking individual children.

According to an FDC administrator, community-owned processes have worked, but it takes time. For example, in one location, FDC helped the leadership of a community evolve into a committee that eventually took full responsibility for the needs of vulnerable children in their community. "*It took us three years to have this leadership achieve the target number for that community. Now they have doubled and the cost [to FDC] is almost none...They take responsibility of welfare of their own children. Last year, they said 'we don't need you [FDC] any longer'.*"

6. DISCUSSION

Data is collected at community level for various purposes, including:

- Monitoring for accountability
- Information for Planning and Decision making
- Monitoring the quality of interventions, to improve the quality based on results
- Monitoring and responding to the needs of children over time.

Donors require data to be collected from its grantees. In some communities, there is more than one donor or implementing organization, each requiring the use of different forms for data collection. In the communities that participated in this research, the forms being filled out at community level generally focused on the first bullet – monitoring for accountability to the donor and the implementing organization. None of the community committees reported involvement in the development of instruments used to collect data. In addition, no committee reported systematic analysis and use of data for decision-making. No monitoring of child status is currently being done, though community members repeatedly explained that they live with the children, they know them, and they know how they are doing.

In order to collect information that could be used to address the purposes listed in the last three bullets above, alternative means of data collection would need to be considered. For example, Save the Children/Norway utilizes special surveys to examine the situation of children in project areas. Research and special surveys can be designed to specifically examine particular topics of interest. Surveys and special studies can be developed to answer the questions that are most relevant to the partners and the communities that can ultimately make use of the data to improve local action. Thus, the results of these alternative methods of data collection have the potential for greater impact on the well-being of children in the areas of intervention. Involving local stakeholders in the development and implementation of the special studies may increase their relevance, as well as achieving greater local buy-in and commitment for future action that is based on the results.

The following are key considerations that consistently arose with regard to current data collection processes within and by the community:

- **Written versus oral data collection**
  - Many communities are already using oral reporting and information sharing
  - A large proportion of the population in the intervention area is illiterate and not oriented to the use of systematic data collection
  - Suitability of written data collection systems may vary according to:
    - Percentage of population that is literate
    - Visibility and existing relationships with children within the community: That is, when children are already in close proximity to adult visitors, who see the children on a regular basis, close observation and follow-up of children occurs spontaneously. As natural interaction between child and the adult "visitor" decreases, such as in an urban versus a rural environment, there may be increased need for written records and more systematic follow-up.
    - Number of children served: As the number of children increases, there may be increased need for written records in order to keep track of the targeted group of OVC.

- **Language Barriers:** There are multiple ways that language creates barriers to collection and use of data. One such barrier is described above in relation to the use of written versus oral data collection. Other barriers include the use of terms that are meaningless to the community, and the use of language that is accessible to the donor but inaccessible to the program implementers.
  - Communities are required to report on "psychosocial" and "advocacy" activities. Though communities and local program implementers may be conducting activities that fall within the purview of these categories of intervention, the terms are generally unfamiliar to them. One option to clarifying the use of the terms was exemplified by HACI, which worked with its partners to identify and list specific activities that the partners are conducting that could be included as "psychosocial" interventions. Another option would be to use terms that are more meaningful from the very beginning - identifying those terms that are actually used in the community. FDC, for example, is using a local term instead of referring to "psychosocial" interventions. Use of the term "advocacy" to describe activities that are reported to the donor is also not always understood by the community members or by the local staff that are working for the implementing organizations.
  - Local use of the results of data analysis and documentation that are produced outside of the sphere of action may be limited due to language differences. For example, reports that summarize data at headquarters are written in English, to be submitted to the donor. Similarly, data aggregation and analysis at the provincial level is written in Portuguese, which is not accessible to the communities where the local language is Changana.
  - In cultures where literacy in the local language is high,

> *"…you have PEPFAR saying I want numbers…You don't give us time to build this. Give us time and it will work…"*
> (Partner administrator)

there is potential to have robust systems of data collection. In Ethiopia, the community core groups visited appeared highly literate in Amharic. All the forms were translated into Amharic and were used by the core groups for reporting upwards. Therefore, the language barrier did not present itself in the same fashion as in Mozambique.

- **Collecting and using data as part of a comprehensive and participatory process of community mobilization and action:** The community action cycle (CAC) and other participatory approaches include monitoring and evaluation systems as one of many components of a participatory approach to enhancing community ownership and action. The level of community involvement in the process of identifying the needs within the community, deciding how to address those needs, and implementing action using their own resources (financial and human) will influence community ownership in monitoring and evaluating the result of community action. Using a participatory approach, the community is more likely to develop indicators to monitor their own objectives, collect information to inform them of progress, and to reflect on changes that need to be made to achieve their objectives. When the initial stages of the cycle are not participatory and the community views the interventions as externally driven, then collecting data is more likely to be perceived as work that is required in order to continue to receive funds from the external donor. However, truly participatory processes take more time than is generally available in the attempt to quickly implement and scale-up activities that reach large numbers of OVC with donor funding. The tension between mobilizing sustainable community-owned efforts and quickly reaching large numbers of children has a direct impact on the potential for community owned management information systems.

- **Frequency of change in data collection processes and forms:** Changes in data collection processes and/or forms necessitate increased resources (time and funds) to provide training in the use of the new systems. The change also creates confusion and frustration among those responsible for collecting the data. Therefore, it is important to carefully consider the system in its entirety, including the key considerations listed above, to initiate a system that will require minimal modifications in the future. From their initiation, systems that are developed at local level should ideally take into consideration the data requirements at district, province, and national level and vice versa.

- **Linking Data across sectors:** Tracking the outcomes of OVC activities encompasses multiple sectors that may - or may not - already be collecting data related to the well-being of children. For example, education sector interventions may already collect information on whether the child is attending school and grade-level learning achievements; child survival interventions collect data on immunization or child growth. Linking with these data collection systems has the potential to better inform OVC programs, while decreasing redundancy.

In summary, the following are various levels of data collection, used by program implementers to plan and monitor their interventions:

1. Population-based: Describes the situation of children in the area. May include:
    a. Overall description of the situation of children
    b. The total number of children who are orphans and/or otherwise vulnerable
2. Intervention-based: Describes services or other support provided. May include
    a. Number of children reached
    b. Types of interventions provided
    c. Number of services rendered
3. Individual-children: Describes information specific to the individual child:
    a. Registration information - intake forms

b. Number and types of services given to the child or the child's family
c. Monitoring the child's well-being over time,

National level efforts are being initiated to measure the population-based level, according to Mozambique's National Plan of Action for OVC. The information obtained by the researchers from programmers and from the community representatives focused on the second level - aggregating intervention inputs across the communities and across partners. In an attempt to monitor the situation of individual children and their households, programmers were struggling with how best to collect and use data on the third level. All the communities that were visited had registration forms for children who were receiving care. Some had developed forms to measure the number of services provided to children and their households. However, monitoring the well-being of children over time was not reflected in a systematic, written format, though communities are doing this on an informal basis. Indeed, PEFAR has recognized the gap in OVC programming in general in monitoring the child's well-being over time and providing quality and coordinated interventions. PEPFAR initiated efforts, such as its quality assurance efforts for OVC programming, its plans to develop new indicators, computerized information systems, CLIPR, and the child status index are all attempts to address the need to better measure and ensure responses that will result in improved well-being of children who receive PEPFAR supported interventions.

7. RECOMMENDATIONS

A. Community Level

Forms should be simple and easy to use at community level - for use by community committees and for reporting to the rest of the community. Data collection forms should be simple and accessible to all community members (even those who are illiterate). Currently, the forms are being filled out by one of the few literate members of the community committee. The information is inaccessible to community members unless they are able to read Portuguese. Moreover, programs can assist communities to display certain information in visual form that could help all community members track their own success. For example, the SECI model, piloted in Bolivia, used chalk boards placed strategically in the community that were regularly updated to record change over time. Such visual display can serve as a source of motivation for the community committees and other volunteers. However, the information for display should be carefully chosen so as not to create further stigma and discrimination of program beneficiaries. Such information could, for example, include aggregate numbers of people served.

Changes in the forms should be at a minimum. As one community mobilizer explained, whenever they change the forms, it requires that the household be revisited to gather the information. Usually, the information is the same and some communities have been resistant to the continuous registration of children, especially if they have not received substantial support. As another mobilizer commented "*the communities want to know why they are giving this information again and they look at us with distrust*." In addition, it requires additional training in the use of the new forms which is time taken away from program implementation.

Communities should have the flexibility to request the type of support that would enable them to take responsibility for their children. External organizations are providing things such as educational materials, shelter, food, clothing, among other material goods. The researchers found that because this support was coming from the outside, it actually served to dis-empower communities to examine the availability of resources that might be available from within the community. An alternative would be to provide support to community initiated efforts that have the potential for more long-term support. For example, many of the committees interviewed were formed around an agricultural activity, the proceeds from which could help them provide support to OVC and selected households. As one committee member noted "*give us the farming implements and the skills in better farming techniques and with the productivity of the farms, we can purchase these things ourselves.*" Many of the OVC committees requested this type of support, explaining that this would help decrease the need for external aid for material support.

B. Program Level

In order for CBMIS to truly be participatory and community-owned, programs must involve communities in its development. Programs working to build community capacity should make sure that they help communities to track information that is useful to them. Many communities did not understand the forms - especially the use of foreign terms such as "psychosocial" support. FDC provided an alternative example by working with communities to develop the form and to include in it all the activities that the community found necessary to track. This is similar to the HACI model, which engaged communities and local partners to define the key categories of interventions, such as "psychosocial" interventions. It is also important to find local words to replace terms that may otherwise be confusing to community members.

Programs should ensure that data flow is two-way. It is essential to incorporate a feedback mechanism once the data has been collected. Currently, it appears that once the community sends the information to the community mobilizer and the community mobilizer sends it upwards to the provincial coordinator and ultimately the national M&E officer. However, communities do not receive any feedback. This means that they are not able to monitor their own successes and do not have information that is necessary to make changes to achieve better outcomes. The feedback mechanism is essential to completing the community action cycle in which communities learn together, act together and evaluate together.

On the other hand, communities were able to show that they did do some internal self-reflection, noting that "*We live with these children. We visit them all the time. We always try to find out from them (how they were doing)*" and further that "*We also use the data to remind the community about the situation they are in. and when somebody is sick then we become glad that they are better. And we become happy that they have sought services. People are going to the hospital more to get checked up. Since we began there has been death in the community but it is now reducing because of the information we are sharing with the community.*" However, it was not clear that they used the data they collected to make these conclusions. The process of data analysis was more intuitive than systematic because they "*lived with these children*".

Programs should ensure that community level data collection systems can be linked to government level systems for sustainability. Currently, the programs are sharing information with the district and provincial representatives on an ad hoc basis. There is no systematic data sharing from OVC partners. Government offices consistently showed the researchers the data that was collected by the food security programs, but for OVC programs, this information was not available. Since the government has plans to develop a national database to capture information on orphans and vulnerable children, programs such as Scale Up Hope should be able to link their data collection to the government systems. This way, the communities would not only be collecting information that is useful to the partner organization, but it would also be useful for their own government. For this, the researchers noted that the health information systems may provide lessons on how best to effectively link information systems at the various levels.

There is a caveat, however, to the potential of linking community data collection systems for OVC to the national systems. Because it is multi-sectoral, the "OVC sector" relies on data from a number of different sectors to record the inputs to a particular beneficiary. This would necessitate strong coordination among the various sectors to provide the necessary and comprehensive information. In addition, without unique identifiers, the process of linking information and minimizing double-counting would be extremely difficult.

If programs need to collect data to fulfill donor requirements, consider alternatives to relying on community volunteers to collect the information. Currently, the number of forms being completed at community level requires the time and commitment of a full time person. Community volunteers who are expected to collect this data are not paid, yet programs have very high expectations of them. For example, volunteers who care for children at the CBCCs, and also maintain and update CBCC data collection, complained that they were neglecting their own children to do the work of the communities. Community committees have not supported these volunteers with community resources. Therefore, programs should consider these burdens.

A potential solution is to engage communities in determining their own role in responding to donor requirements. Another potential solution is to ensure that volunteers can also benefit from some of the support that they are currently providing to other households. Programs would need to budget for this support. Africare, for example, is a PEPFAR partner in Mozambique that has been able to budget for such support to their volunteer service corps program. The service corps volunteers receive a stipend to work with the community committees to collect and report on their activities on a monthly basis. At the same time, community committee volunteers are linked to income generation activities for the purpose of providing incentives.

Implementing organizations should attempt, where possible, to consolidate efforts for data collection. With the push for coordinated care mechanisms at the community, data collection systems should also be better coordinated at the community level. The number of changes in the forms - given new interventions or new partners intervening in the same geographic areas - has led to a huge effort in training, time that could be better used to help communities achieve their larger objectives. New partners should be required to use existing data collection mechanisms to capture data for their own programs, as opposed to putting in place yet another form which increases the burden on community members.

C. Global Level

Create balance between reporting for the purposes of accountability to the donor and contributing to improved efforts at community level. The PEPFAR guidance for HIV and AIDS programming places a heavy emphasis on collecting target numbers for reporting to Congress. In some cases, projects respond to these requirements by instituting a process at local level to collect these data in a way that has contributed to disempowering communities, rather than strengthening communities to “own“ their data and to use it to improve the response. Data collection systems at the community level should encourage local responsibility for increased quality and sustainability. At global level, PEPFAR has emphasized the importance of focusing on improved quality as it moves toward reauthorization and its next phase of support to HIV and AIDS programming. In addition, PEPFAR is reconsidering indicators to be used in all areas of programming. Therefore, now is an opportune time to consider how best to collect necessary data in a way that also contributes to strengthening quality and sustainability of local activities.

Encourage local efforts to monitor and respond to overall wellbeing of children. Currently, the data collected by the communities for PEPFAR reporting are limited to numbers of children served. These data do not provide information about the impact that the interventions and services are having on the child, household or community. The donor and implementing organizations should place an equal focus on child wellbeing in order to assist the communities to understand and track outcomes for children. Currently, there is no way to tell if a particular service is leading to the intended outcome. For example, the communities maintain records on educational materials that have been distributed, but information was not available on whether or not those children were enrolled or progressing in school. In order to create effective programming, data collection should be linked to achievement of the intended outcomes for children.

Develop national information systems that contribute to improved well-being of children. National level efforts to collect OVC data should emphasize the use of these data for programming and other policy level discussions. Currently, discussions in Mozambique center around the development of a national database for OVC. However, it is unclear whether this database would simply house national OVC data or be used by government ministries for planning purposes. The researchers recommend that such a database be decentralized for planning purposes at district and provincial levels. The Ministry of Women and Social Action at this level should be encouraged and supported to work with local partners and communities to gather relevant data and plan resources efficiently.

OBSERVATIONS AND LESSONS LEARNED

Oral versus Written documentation: The issue of oral versus written forms of documentation repeatedly came up during the interviews with the OVC committees. All of the communities were rural farming communities. The use of oral tradition to capture data and report on the status of a child may, in fact, be a reliable way of monitoring and readily responding to the needs of vulnerable children and households in these communities. It is unclear how such a system would work in an area where there is greater migration of households coming into and leaving the community - where community members are not automatically aware of the condition of children in all households. This would more likely be the case in urban areas, or other areas where the population is large and/or more transient than the communities included in this research.

Lesson Learned: Communities reflect on their own experiences and way forward without necessarily writing these reflections down. It is part of an oral process in which communities gather, plan and discuss what they are doing. For example, *"If they find a problem they go directly to the president...The volunteer lives around the children. Volunteers feel responsible for children and monitor the situation...they have a system to visit and keep track of the kids. Maybe we say they don't have a system, but they do it orally and it is useful for them.* However, with the introduction of the program, one community noted that they are now "more organized" and that the inputs of Save the Children were able to solve some of the problems they had noticed but were unable to do anything about. As one community mobilizer stated *"… Before Save the Children, social networks were there. We tried to push them to be more organized, to have more systematic follow-up of the kids. They used to take care of the kids before we started but it was not systematic. They didn't have the referral systems before but now they do…."*

Requiring communities to write down the support they provide may take away from their ability and indeed willingness to do things that are done naturally, such as home visiting and the provision of emotional support. This codification of social relationships is having certain unintended consequences in the communities. In addition, it may actually lead to a high degree of underreporting, given that some of the activities are more difficult to capture than, for example, distribution of school materials. This is not to say that communities are not able to recognize and acknowledge the importance of all types of assistance that they provide. However, it may be that this information need not be captured on forms, and program reporting could potentially rely on the largely oral process of information sharing that is already happening in the communities. Programs should consider what information is needed; what can occur through an oral process; and what can be recorded through written communication.

Engaging Communities in Self Reflection: Committees did not report engaging the broader community or being engaged themselves by the program staff in the development of the data collection forms nor analysis and feedback of the data that was collected. This lack of reflection results in missed opportunities for community members to deliver improved services of high quality or better target their support to children under their care. It was also important that committees be oriented to the data requirements for program reporting and to understand the terms that are used. The research showed that communities often found the forms difficult to understand, including terms such as "psychosocial care and support."

Lesson Learned: While developing CBMIS to collect community data, it is necessary that the data be understood by communities/beneficiaries so that they can use the information to improve their response. Representatives from FDC explained an alternative process of developing data collection forms. The organization worked with communities to define a range of services and concepts that the communities felt could and should be provided to children in need. These services included "hard services" such as food and material distribution but also "softer services" such as counseling, home visiting, etc. The communities then worked together to devise pictures that represented the various services. This pictorial form was used at the community level by volunteers who could not read. However, the process should not stop there. Once having collected the data, organizations should engage communities in the analysis of the data so that communities themselves can make appropriate decisions on how to respond to the information. In the villages that participated in the research, this process was left out, contributing to the fact that forms were either incompletely or incorrectly filled out.

Raising Expectations: Community members chose not to record data on households that might result in raising expectations that could not be filled. Thus, they chose not to fill in some of the items requested in the forms. For example, one of the forms requested information on stated needs of intended beneficiaries. In many communities, this column was left blank. When asked why, community members noted that this would raise unrealistic expectations of them to provide according to the stated needs of the person or household. Collecting data on "hand-outs" was easier to keep track of at the community level. Data collection was more rigorous when the services recorded were concrete, such as the distribution of material goods, including distribution of food and school materials. Data on specific home-based care services that are pre-determined by the MOH and listed on the data collection forms were also more consistently recorded.

Lesson Learned: When collecting data, it is necessary to ensure that the systems do not raise unrealistic expectations of intended beneficiaries. The researchers found that communities often provided ad hoc support in the form of material distribution (food or school materials) with the support of external organizations. However, it was unclear that this ad hoc support was actually provided according to the needs of the children or intended beneficiary. In order to ensure that the needs of children are met, a system would be needed whereby the needs of children and their households are accurately recorded and updated, and that resources, whether from the community, government, faith-base organizations, or other NGOs, are identified to respond to those needs – without raising expectations that cannot be met.

OBSERVATIONS AND LESSONS LEARNED (cont.)

Leadership: Leadership in the communities varied a great deal. In some communities, the secretary was uninvolved, sometimes explained by the respondents as due to the fact that there was no financial remuneration in exchange for his involvement. In other cases, the secretary was an active member of the committee. He (in all villages included in the research, the secretary was male) was involved in making decisions, carrying out the committee work, and advocating for the community's needs. The chiefs of the area are consulted and provide information about the children who are most vulnerable in the area.

Lesson Learned: The community mobilization process is key to the development of community based information systems. Engaging community leaders who are highly motivated and will continue to work with the broader community to solve the problems identified is important. Communities that are actively involved and mobilized from the beginning can mount a response with minimum incentives and, with good leadership, communities can leverage increased external funding and make measurable differences in the lives of children.

Empowering Communities: Though there was a great deal of difference in data collection practices across the committees interviewed (see section on research limitations), this is not unexpected - nor is it necessarily undesirable. In fact, in the development of CBMI systems, the optimal condition would be for communities to create and use their own systems. In a participatory approach to developing M&E systems that is funded by a donor with significant reporting requirements, it would be necessary to provide communities with the "bottom line" data collection requirements. They could then develop their own processes or modify any instruments that they are given as prototypes. Differences in the ultimate processes to measure and report on their efforts would reflect local differences.

Lesson Learned: The implementation of community-based management information systems requires a process of community mobilization, participation, continuous involvement and monitoring and evaluation. This process is often described in known methodologies such as the community action cycle and other methods such as participatory rural appraisal. In the research communities, committees were effectively mobilized to organize themselves around the issue of orphans and vulnerable children. However, after the formation of the community groups, the process neither engaged communities in a process of learning based on the interventions and desired results for children nor allowed them to evaluate their progress. The benefit of participatory CBMI systems, where effectively implemented, is that they have the potential to give communities an opportunity to learn by doing through continuous analysis and reflection. This learning by doing allows communities to make changes when required to continue to reach desired results. However, in the communities included in this research, the process of enabling communities to be engaged at this level faltered. The focus of data collection was on gathering the target numbers that were required by the donor. The process was not participatory, limiting collection of data that was meaningful to the communities.

8. RESEARCH LIMITATIONS

The research that was conducted in Mozambique provides a description of the way that some of the Scale Up Hope Partners and the OVC committees that they are supporting with PEPFAR funding are collecting and using information. Each of the community committees visited, all having been mobilized by Save the Children/US, was operating differently. Though all had been mobilized by the same organization and had been trained to use the same forms, differences in data collection were found throughout. The ability to generalize from one community to another is limited. Communities differ in context and leadership. Additionally, each partner has a different way of providing community-based support to orphans and other vulnerable children, so there is likely to be an even greater difference in information collection and use across communities when they are supported by different partners.

How representative are the villages included in this study is unknown. Villages that participated in the research were not chosen randomly. They were identified by Save the Children staff, who were asked to arrange interviews in some communities that had relatively strong CBMI systems and others that were relatively weak. All the villages that participated were rural; none were urban. Accordingly, there is no way to tell from this research how representative are the findings. At the same time, in Ethiopia, the researcher visited all urban or peri-urban settings and found some of the same issues in terms of the burden it places on communities to collect the data, lack of feedback systems, and misunderstandings of terms like psychosocial support, suggesting broader applicability of findings.

Some bias in the responses is likely to have been introduced by the fact that interviews were conducted by "outsiders". The villagers could not speak to the researchers without a translator, and the researchers were accompanied by Save the Children staff members - the community mobilizers who introduced them to the community. The researchers stressed in their introduction to the research participants that they were coming to learn from the community and that there were no right or wrong answers, but that is unlikely to have resulted in completely candid responses in all communities.

More time and greater access to key informants may have resulted in more comprehensive data. Between the two researchers, villages that participated in the research were limited to eight, and all were in the same province and were Save the Children/US partners. At central level, a few of the key informants had to cancel meetings due to time conflicts that came up at the time of the interviews. Others were out of the city when the researchers were in Maputo. Therefore, gaps in the intended information collection resulted.

The researchers do not expect that the findings can be generalized to other communities, partners, or other countries. However, some of the issues that were faced by the communities and the partners resounded throughout the interviews. It is those issues that were consistently raised during the interviews that are expected to be of benefit to policy makers and programmers as efforts to strengthen community support of orphans and vulnerable children continue to expand.

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APPENDIX 1: Schedule of Field Work

DATE	LOCATION	RESPONDENT	TYPE OF INTERVIEW
Monday, 9/10	Maputo Save the Children/US office	Nely	Orientation
Tues, 9/11	Xai-Xai Save the Children/US Provincial office	Mahumani	
	Xai-Xai	Provincial representative MMAS	
	Xai-Xai	Provincial representative CNCS	
	Xai-Xia	Julio	
Wednesday, 9/12	Bilene District Incoluane	Village OVC committee Secretario de Aldea	FG N=-8 IDI
	Bilene District Chitlango	Village OVC committee	FG N=14
	Bilene District	District representative MMAS	IDI
	Bilene District	Save the Children/US Community Mobilizer	IDI
	Chibuto District Guemulene	Village OVC Committee	
	Chibuto District	District representative: XXX	
	Chibuto District Eduardo Mondlane	Village OVC committee	
	Chibuto District	Save the Children/US Community mobilizer	
Thursday, 9/13	Manjacaze District Nwadjahane	Village OVC Committee	
	Manjacaze District Chalala	Village OVC Committee	
	Guija District Nhampunguane	Village OVC Committee	FG N=13
	Guija District Community		

	Mobilizer		
Friday 9/14	Xai-Xai Save the Children/US Provincial office	Mahumani	
	Xai Xai District Chipenhe	Village OVC Committee	FG N=9
Monday 9/17	Maputo	Save the Children/US Brenda Yamba Nely	
Tuesday, 9/18	Maputo USAID/ Mozambique office	USAID/ Mozambique Lucille Bonaventure Sidney Bliss	
	Maputo HACI office	HACI Celso Mabunda XXX M&E person	
	Maputo Office of Save the Children/UK	Save the Children/UK XXX Save the Children/Norway XXX	
Wednesday 9/19	Maputo JSI/Measure office	MMAS M&E advisor Maria joao Nazareth MMAS chief of XXX MMAS M&E XXX	
Thursday 9/20	Maputo	Katerina (cancelled)	
		UNICEF cancelled	
Friday 9/21	Maputo FDC office	FDC	
		CNCS cancelled	