## Lessons Learned Document

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| **Thematic Area** | Monitoring and Evaluation (M&E) |
| **Description** | This Lessons Learned document focuses on routine monitoring of iCCM, referring to the ongoing processes of data collection, analysis, interpretation and use to gauge performance, identify areas for improvement, trigger corrective actions, and contribute to evaluation of iCCM and broader learning. |
| **Organizations documenting Lessons Learned** | Save the Children, International Rescue Committee (IRC), PSI, Malaria Consortium, MCHIP, UNICEF |

**Background**

iCCM programmes are expanding rapidly in many low- and middle-income countries, particularly in sub-Saharan Africa, yet monitoring systems to routinely gauge performance are often weak and characterized by:

- Lack of a national plan for monitoring and evaluating iCCM, including theory of change, indicators and targets;
- Limited integration and coordination with other programmes/interventions implemented by community health workers (CHWs) or other stakeholders at the community level;
- Parallel systems for data collection and reporting;
- Complicated registers and reporting tools that fail to meet users' needs;
- Inadequate human resource capacity to ensure timely and quality data collection, reporting, management, analysis and use;
- Suboptimal capacity of information systems (Health Management Information Systems (HMIS) and Logistics Management and Information System (LMIS)) to meet needs for data management, analysis, visualization, sharing and learning;
- Fragmented use of information communication technology and mHealth solutions; and
- Weak linkages to processes for decision-making and corrective actions.

It is assumed that strong monitoring systems, in which iCCM data are integrated within national HMIS and LMIS and used to identify issues and make appropriate adjustments, will help improve programme performance and thereby impact child health.

**Process for documentation**

Data sources included discussions with M&E focal persons at agencies supporting iCCM implementation in sub-Saharan Africa and documents and tools related to M&E of iCCM. Informants were asked to share information on: development of frameworks and indicators for iCCM; experiences related to integration of community treatment data into the national HMIS and LMIS; approaches to strengthen data quality and use; periodic assessments to triangulate data from routine monitoring systems; and strengths and weaknesses of routine monitoring approaches. Based on documents reviewed and discussions with key informants, we compiled lessons learned and identified some of the most promising approaches and tools.

**Strategies that worked well**

The following were identified as strategies that improved monitoring and evaluation of iCCM programmes.

- **Interagency technical working groups led by the Ministry of Health are critical to identify common indicators and design monitoring tools and processes** for iCCM within the context of the CHW platform as a whole. Coordinated efforts are essential to prioritize and harmonize data needs across donors and implementing partners, balance reporting requirements with system capacity, limit development of parallel systems and promote pooling of resources to strengthen the national system.

- **Early involvement of a representative mix of end users in the development of monitoring tools and systems** contributes to better design and use (e.g. involving CHWs, especially those with lower levels of education/literacy, in the development and testing of registers and reporting tools; involving district managers, facility staff and CHW supervisors in the design of paper-based reports and electronic tools such as data entry screens, graphic user interfaces and data visualization dashboards). Integrating use of the tools within initial and refresher trainings and supervision, with sufficient time dedicated for adequate skill-building, is also important.

- **The District Health Information Systems** (DHIS 2; www.dhis2.org), a free and open source software package, **is a promising platform used by a growing number of countries to integrate community information into national HMIS and LMIS.** Integrated systems allow programme managers at various levels to look at treatment data disaggregated by point-of-service to better understand the contribution of iCCM, compare cases treated against expected cases and identify underserved or underperforming areas.

- **Triangulating routine data periodically with a mix of rapid quantitative and qualitative assessments** to assess concordance with routine data, fill critical data gaps on knowledge and behaviors of caregivers, assess the strength of implementation, monitor the removal of bottlenecks, document context and further explore quality of care is important to improve interpretation of monitoring data. These assessments need to be strategically targeted and conducted at an appropriate frequency so they are useful for decision-making and not another data collection burden on an already overstretched system.

- **Rapid audits of data quality** are an effective mechanism to help identify gaps in quality and formulate strategies for improvement and can lead to increased confidence and use of routine data.

- **Providing simple tools for data visualization** (such as dashboards) and training on data analysis and use for CHWs, health facility staff and district managers promotes improved data quality, enhanced visibility of iCCM services and timely identification and implementation of local solutions to address issues. To be effective, approaches need to focus on a small set of indicators with agreed upon targets and actionable responses and engage programme managers in critical thinking to identify bottlenecks and root causes.

- **Mobile technologies for CHW reporting** can contribute to improved timeliness and availability of data. The most effective examples are those designed jointly with Ministries of Health, focused on elements requiring timely response (e.g. availability of iCCM medicines) and linked with platforms such as DHIS2.

**Strategies that did not work well**

The following were identified as strategies that hindered the effective monitoring and evaluation of iCCM programmes.

- **Monitoring systems that require CHWs to document and report exhaustive details about iCCM services.** These burdensome approaches dilute data quality and can demotivate CHWs. Similarly, systems that require indicators that are dependent on the availability of data at the individual CHW level (e.g. percent of CHWs that were supervised in the last three months) force additional data entry and management investments that drain limited resources. Instead, indicators better suited for collection through routine systems should be used for ongoing programme management purposes (e.g. number of CHWs supervised each month out of the total number of active CHWs).

- **Relying on a single source of information to monitor programme performance.** Experience shows this is particularly relevant for monitoring quality of care and medicine availability, as data captured through supervision checklists or CHW reports tend to paint an overly positive picture compared with more structured assessments.

- **Health information systems that integrate community and facility data but do not report treatment data separately by source.** Disaggregated data are necessary to understand the contribution of and demand for iCCM services.

- **Parallel systems for data collection, management and reporting** designed to meet individual agency information requirements. While in early pilot stages this approach may be necessary, in the longer term it can undermine government ownership and oversight.

- Investment in development of software or mHealth systems that **fail to meet the data needs of managers at all levels.**

**Lessons Learned**

Building systems to effectively monitor iCCM implementation is complex, involving data collection from thousands of multi-tasked CHWs, who in many cases are volunteers with limited education levels. Further, iCCM monitoring data must be integrated within often weak and overstretched health information systems. Sustained and coordinated efforts, considering the lessons below, are needed to establish robust M&E structures and processes to guide iCCM implementation.

- **Coordination and leadership** by Ministry of Health to develop an overarching framework and rational plans for M&E is necessary to prevent parallel systems and optimize available resources.

- **Prioritization of a limited number of indicators** that reflect the determinants for achieving high coverage and are tied to specific targets and actions is an essential step for a functional routine reporting system. The selection and definition of indicators should be informed by global recommendations and the underlying structure and capacity of the health information system (e.g. frequency of reporting, levels of aggregation).

- **Integration of community treatment data** into HMIS and LMIS is rarely straightforward and can be a lengthy process involving many partners. DHIS 2 developments are an important contribution to this process.

- **Placing end users at the centre of tool development and testing** is often overlooked, leading to sub-optimal or non-functional data collection systems. Simple, user-friendly tools contribute to data quality and use. Adequate time and resources for tool development, training and the supervision of data collection are crucial as programmes scale up.

- **Use of existing resources and standards** can help avoid the tendency to re-invent indicators, reporting tools and other M&E system elements that others have already developed and tested. Standardized indicators and tools (e.g. registers and reporting tools for low-literacy CHWs) are available and can guide countries on what works best in what context.

- **Triangulation with other data sources** and data quality audits should be built into M&E plans to guide interpretation of routine data. Failure to assess quality of routine data early on can lead to false assurances of programme performance.
- **Building capacity for data use** by CHWs, health workers and programme managers requires concerted efforts and culture change Further work is needed to better integrate data use skill development into existing training and supervision plans.
- **Innovations such as rapid SMS for CHW reporting should be coordinated** through the Ministry of Health and linked to plans for integrating iCCM treatment data into HMIS or other platforms. Many small, resource-intensive projects can be a distraction rather than a contribution.
- **Areas for further development** include:
  - Approaches to better use existing data sources to capture demand for iCCM services and services gaps or barriers to use;
  - Scalable approaches to monitor use and quality of private sector treatments; and
  - Simple approaches for routinely monitoring equity of iCCM services.