

**JOINT WHO-UNICEF-UNAIDS- PEPFAR
CAPACITY-BUILDING WORKSHOP:**

**STRENGTHENING REPORTING AND MONITORING IN THE
HEALTH SECTOR FOR THE AFRICA REGION**

Johannesburg, South Africa

27 – 30 September 2010

FINAL, 9 December 2010

Workshop Report



WHO Library Cataloguing-in-Publication Data

Joint WHO-UNICEF-UNAIDS- PEPFAR capacity-building workshop: strengthening reporting and monitoring in the health sector for the Africa region, Johannesburg, South Africa, 27-30 September 2010: workshop report.

1.Delivery of health care - organization and administration. 2.Data collection. 3.Program evaluation. 4.National health programs. 5.Africa. I.World Health Organization.

ISBN 978 92 4 150132 3

(NLM classification: W 84)

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Acknowledgements

Although we cannot thank and mention every single person who contributed in the preparation or implementation of this workshop, or both, we wish to make a particular mention to some key stakeholders who have been made this workshop a success.

We are grateful to all country national participants who came from 13 countries and contributed to the success of this workshop through their preparation and intense involvement during the 4 days of this workshop. We thank the national Authorities from South Africa who opened this workshop, and the WHO South Africa Country Office who was instrumental in hosting this workshop as well and in contributing to the closing and concluding steps and words.

USAID and CDC have supported this workshop technically from the very beginning that this workshop was planned, and also financially and we are grateful to their involvements, as well as technical contractors (MEASURE Evaluation). Other partners that made it happen on a short notice has been the UNAIDS Regional Support Team from East and South Africa who has facilitated the logistics arrangements in Johannesburg in coordination with WHO Offices. UNICEF provided as well the support through its HQs and UNDP as Principal Recipients for the Global Fund against HIV/AIDS, TB and Malaria. The Global Fund contributed to the preparations and inventory of country needs based on the review of current efforts with the Principal Recipients. The World Bank contributed to the early discussions around the components of M&E systems with exchanges between USAID and WHO.

Finally, we thank all WHO Country Offices and sub-Regional and Regional Offices where instrumental in their contributions as well.

Our special thanks go to Alois Doerlemann, Consultant, who prepared background materials for this workshop, as well as this report with inputs from WHO, and to Cyril Pervilhac who managed this process throughout with the various partners and teams at WHO/ HQ and in the Region.

Yves Souteyrand
WHO, HIV/SIR Strategic Information Coordinator

1. Background

Global initiatives such as the UNGASS commitments, Universal Access to HIV prevention care and treatment and Millennium Development Goals as well as bilateral programs such as PEPFAR *cum* Global Health Initiative (GHI), have created a plethora of reporting demands for participating countries. The reporting requested by international agencies and donors, if rationally and systematically developed, can improve health systems with impact beyond the narrow domains defined by individual disease programs. WHO, UNICEF, UNAIDS with bi- and multi- lateral institutions are working to develop capacity in countries to refine existing monitoring systems and improve underperforming systems. At the same time, these entities are exploring opportunities for reporting systems to cross disease specific boundaries and create greater efficiencies for the health sector. With the last few years, investments by donors and national governments in Strategic Information (S.I.), including development of guidance for Monitoring and Evaluation and Surveillance, countries have improved their capacity to produce strategic information (S.I.) to inform and assess national programs. The collected data can be better used to monitor the national responses and performances against national objectives or targets.

The broad array of programs has created a need for cross-cutting health systems strengthening (HSS) efforts. These include the collection, analysis and use of data related to outcomes and impact of health programs. Global partners (USAID/ CDC/ GF/ UNAIDS/ WHO/ UNICEF/ the World Bank and others) are investing major efforts to improve the quality of data collected and reported from the health sector, both HIV-specific and related to other diseases, with benefits accruing to the overall national monitoring and reporting system.

As a visible and positive development of expansion of S. I. collection, an increasing number of countries have reported over the past 3 years (2007 to 2009) on their Health Sector Response in the context of Universal Access (UA) to HIV prevention, treatment and care using a joint tool developed for this purpose (WHO, UNICEF, UNAIDS Secretariat, "*A Guide on Indicators for Monitoring and Reporting on the Health Sector Response to HIV/AIDS*").

Among many countries, the vast quantities of collected data are often insufficiently analysed and used while, in some countries, information related to health outcomes and program impact are still scarce. The organization and logistics of S. I., a component important to Health Systems Strengthening, are insufficiently addressed in many countries.¹ It is essential to create and support an enabling environment with institution building to strengthen national reporting systems at country level.² Coordination among different health groups, creation of standards for electronic systems to share data, and many other steps are required to improve countries' ability to report quality health data. These broad stroke efforts do not obviate the technical considerations, the effective

¹ Joint WHO-UNICEF Technical Support Missions for 2010 Universal Access (UA) and UNGASS Reporting on the Health Sector Response to HIV/AIDS, May 2010

² C. Potter and R. Brough, "Systemic capacity building: a hierarchy of needs, Health Policy and Planning, Health Policy and Planning, 19, 5, pp. 336-345, and the World Bank Institute, "Characteristics of Institutional Capacity Factors that can be Targeted for Change" (unpublished, 2010)

dissemination of data collection methods and use of tools to strengthen monitoring and reporting, and assess outcome and impact.

As a way forward to fill in the existing gaps described above, and as a step to further support in-country and global information systems, especially in data quality, use and analysis, the organization of this sub-regional workshop involving key country players reinforces the monitoring of the health sector response with a joint venture among technical agencies. The workshop complements other on-going efforts such as the PEPFAR-sponsored meeting on health information systems, monitoring and evaluation and surveillance in August, 2010, data quality assessment and adjustment (WHO/IER, Oct 2010), UNAIDS Secretariat. M&E and national staff training (UNAIDS, Oct.-Nov. 2010), upcoming UNDP/ GF/ Principal Recipients regional workshops planned in the Africa Region (early 2011).

2. Aim and outputs

2.1 Aim

To build capacity among national authorities and technicians (MoH/NACP and NAC) to gather and analyze Strategic Information in relation to global reporting in the health sector (e.g. UA, UNGASS), and use for national health sector reporting.

The workshop focused on strengthening health services statistics to monitor in particular ART and HIV/TB and PMTCT, as well as, HIV testing and counseling (HTC), and drug supply/stock-outs through the Procurement Supply Management/ Health Systems Strengthening (HSS/PSM), and on presenting a few key related tools related to those.

2.2 Outputs

- Improved know-how, and basic skills on the latest normative materials and tools.
- Succinct essential practical and immediate action plan to strengthen the national health sector's own progress report (or the equivalent) with existing tools, and the in-country data collection, analysis and use in the health sector for upcoming reporting, encompassing the bottlenecks to be overcome on the long term to be addressed in the M&E system.
- Advocacy plan by the joint country team to mobilize the political support for joint country-based activities and strategies from the new set of priorities identified during the workshop, the in-country, and if necessary out-of-country, technical assistance for the end of 2010 and early 2011 towards improving the supportive environment by the various partners and attracting their support.

3. Participants

13 English speaking (including 1 Lusophone) countries from Africa (*South Africa, Zimbabwe, Botswana, Lesotho, Swaziland, Malawi, Uganda, Zambia, Mozambique, Tanzania, Kenya, Ethiopia, and Nigeria*) participated with 27 representatives from Ministries of Health (with expertise in programmatic areas of PMTCT, ART, HTC, HSS/PSM and/ or M&E in charge of monitoring and

reporting those), and National AIDS Commission (NAC); these were further accompanied by 12 WHO HIV focal point staff, and 10 Regional/ sub- regional and HQ staff, and finally, 15 partner agency technical staff contributed as well (CDC, USAID, GF, UNAIDS, UNICEF, UNDP - World Bank could not participate). (Annex A, List of participants)

4. Structure and Content

As a preparatory step for the workshop, a desk study compiled the key findings related to the indicators reported in the 2010 the Universal Access Progress (encompassing some essential UNGASS indicators related to the health sector), and queries and answers related to those, as well as some additional health information and reporting systems assessments realized over the last two years. The results were presented and discussed the first day and helped to document the background to the workshop and identify some of the current bottlenecks. The stage was set early on how the use of a systems approach with the 12 components of a functional M&E system to overcome bottlenecks on the long term, and using a country ownership and institution building approach. The present effort was presented as part of the country health systems surveillance (CHeSS) platform broader efforts.

The workshop focused on data related to PMTCT, ART, HIV Testing and Counselling (HCT) programs and HSS/ Procurement Supply Management (PSM), as one component of Health Systems Strengthening (HSS) which were covered on day 2 to day 4 (Annex B, Workshop agenda).

Each country participated by compiling and presenting its own findings for each of the thirteen countries for UA reporting in 2009 and 2010 based on a generic template (Annex C) sent to each of the country teams before the workshop. Countries presented based on their observations and questions related to their own country report forms, the key elements, challenges and solutions experienced within their national reporting system.

Normative materials were distributed and made available to participants (USB stick), and several of those were distributed as hard copies (Annex D).

In addition to plenary sessions presenting some of the key updates for each programmatic area, interactive sessions took place with working groups (group discussion, interactions and cross-fertilization between countries) in a problem-solving approach to address questions related to data quality for each programmatic area and ultimately to develop follow-up action and advocacy plans (Annex E). Using country data banks and various assessments, reporting, and reacting to country experiences brought in from the countries, helped reviewing quality of reported data already discussed in national committees.

In addition, 6 recent tools in M&E related to improving data quality were presented and discussed that participants could elect to attend as market places:

1. *IMAI: Three Interlinked Patient Monitoring. Systems for HIV care/ ART, MCH/PMTCT (3ILPMS) and the Annual Patient Monitoring Review (APMR) for both data quality and quality of care*

2. Information Technology (national and district updates)
3. M&E of MARPS
4. Data quality (e.g. RDQA): ex of Tanzania
5. M&E 2009 MERG tools (12 components M&E System Strengthening tool, Guidance on Capacity-Building for HIV M&E)
6. M&E Male Circumcision (special session- non routine reporting-relevance for 12/ 13 countries participating)

In summary, the mix of approaches used, workshop contents, and tools presented helped improving the understanding of strategic information specific to the programs for the participants and all partners. In addition, the workshop had several indirect benefits (country interactions, networking, south- south technical support and the 'feeling of not being alone with the same or similar problems' made participants conclude 'our next report will be better'). The workshop evaluation summarizes the participants' views (Annex F).

5. UA reporting processes and lessons learnt

The workshop aimed to contribute to improving reporting by reflecting on current country processes and challenges and by coming up with a country list of priority short and long term activities to address those.

The first day was used to clarify objectives and expected outputs of the workshop. Key presentations introduced the different technical areas to be discussed during the workshop and highlighted lessons learnt from previous UA reporting, including UNGASS as it relates to health sector reporting. Participants from South Africa and Nigeria presented their overall experiences in UA and UNGASS reporting, in particular their challenges and measures identified to improve the situation (next).

<p>Nigeria</p> <ul style="list-style-type: none"> - Standard tools and registers in use - Standard reporting tool - Both passive and active data collection - Regional meetings to validate the data, at times used to collect the data - Data flow: HF to Local Govt Authority to State-National <p>Challenges:</p> <ul style="list-style-type: none"> ✓ Coordination of partners ✓ Funds for active f/up of data ✓ Low capacity for data management at the lower levels <p>Measures to help improve the situation:</p> <ul style="list-style-type: none"> ✓ Conduct an impact study on loss to follow up ✓ Merge Registers 	<p>South Africa</p> <ul style="list-style-type: none"> - National Electronic M&E System under development - Scale up of critical programmes such as ART and PMTCT can exacerbate an already overburdened health system - Parallel services inhibit necessary integration (i.e. TB and HIV collaboration) <p>Challenges:</p> <ul style="list-style-type: none"> • Data accuracy, data quality audits, routine supervision, use of collected and available information, culture of M&E still underdeveloped • Low reporting rate, large swings, impacted negatively by lack of data capturers in many of the facilities • UA reporting: Age group categories not similar to the country ones <p>Measures to help improve the situation:</p> <ul style="list-style-type: none"> ✓ Increase the functionality of the SANAC Secretariat (legal status, funding, staff) ✓ Transform HIV/AIDS information into HIV/AIDS intelligence (SANAC M&E unit) ✓ Prioritize national indicators set to a maximum of 20 indicators and direct efforts towards collecting and using available data ✓ Develop one data collection tool and one central database to collect, aggregate and store information on the national response ✓ Utilise provincial, district, and local Aids Councils to collect, verify and disseminate data on national indicators
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All thirteen countries presented their UA access reporting using a similar structure (highlighting the challenges, and identifying measures to improve future reporting, using the same presentation template (see Annex C). These findings and discussions were steered by the resource participants in the various working groups (3-4 countries/ group) that took place daily (day 2 to 4).

The main challenges and queries (box, next) related to these in country processes are:

- the number of indicators whose definition does not always match the ones used in the national information systems
- the weaknesses of the national information systems to provide timely, reliable and complete data due in part to the lack of quality M&E plans
- the lack of adequate infrastructure, staff and budget for M&E and low spending for data quality assurance
- the multiple partner information requirements related to specific donor driven interventions slowing the process towards a countrywide unique reporting system.

Some queries repeatedly expressed by participants from different country health systems

‘Multiple vertical programs with specific information and reporting requirements’

‘National data not representative by lack of private sector data’

‘Data reported from health facilities are delayed, incomplete and inaccurate’

‘Disaggregation required for UA and UNGASS reporting not compatible with national NHIS tools’

‘Data accuracy: Overestimation of number of patients actively on ART due to weak systems currently in place to identify patients lost to follow up’ ,

‘We have to take what we get’ (data availability and quality)

‘Absence of efficient early warning systems to avoid breakdowns in commodities management’

Appropriate use of 5-10% of PRM for M&E, involving local and international partners (WHO)

National M&E plan that includes an impact measurement framework (design & implementation), an indicator matrix (multi-year targets), a costed action plan and a data quality assurance strategy

Monitor implementation of M&E plan using the MESST (Monitoring and Evaluation System Strengthening Tool)

National M&E systems taking into account human resources capacities (quantity & quality), improvement of infrastructures, equipment and IT, data management (collection, transfer, analysis, use, storage, dissemination) and data quality assurance and control.

M&E Self Assessments should be part of program reviews and include strengthening measures as part of strategic plans, operational plans, work plans & budgets.

Development partners using different databases often do not share information among themselves. Therefore the National Program need to facilitate further the data/information sharing among partners while it is working to harmonize and create a single national database.

WHO supports national monitoring and reporting processes giving timely feedback on completeness and plausibility of data addressing the focal point in each partner country. UA reporting should concentrate on relevant minimum indicators/data set. Reporting on MARPs is generally weak in the Africa region, and underlying barriers need to be further understood and dealt with.

The Global Fund to fight AIDS, Tuberculosis and Malaria (GF) suggests (ref box "Recommendations of the GF") a limited list of M&E requirements and one national M&E plan for HIV and encourages countries to allocate 5-10% of grant

funding to M&E covering the costs of the M&E framework, data collection, data quality assessment, data dissemination, evaluation and research activities, data management (storage and use), capacity building and coordination.

The new orientation of USG development cooperation was presented informing on the shift from attribution to contribution under strong country ownership. Under the second round of PEPFAR (known as PEPFAR II), the program puts emphasis on a country led process, and aligns with the global indicators.

The UNAIDS TSF (Technical Support Facilities) provides specific TA on country request including support to partnership building processes. The harmonization of different reporting mechanisms is under way: the WHO and UNICEF reports have already been merged, and the UA and UNGASS reports are to be further aligned in the near future.

In 2006, WHO member states Health Ministers Assembly asked WHO to prepare annual reports on the progress of the Universal Access (UA) to HIV services in the health sector. At that time UNICEF was also preparing what was called PMTCT and Pediatric HIV Report Card. Since 2009, however, these two reports have been merged and prepared as UA progress report. UNAIDS is coordinating the bi-annual UNGASS reporting. To streamline global reporting on progress in fighting the epidemic three measures are under consideration:

- Merging the two reports (UA and UNGASS) into one report
- Supporting countries to ease the workload in writing the reports – establishing and sharing with countries a system where the reports are prepared in a relatively easy way
- Supporting countries in data analysis, elaborating their own UA national reporting that should then be integrated into the global UA reporting (for ex. Ethiopia: could reduce the total number of health indicators to 108 for the whole sector and concentrate on a few (19) core indicators for HIV related issues).

6. PMTCT

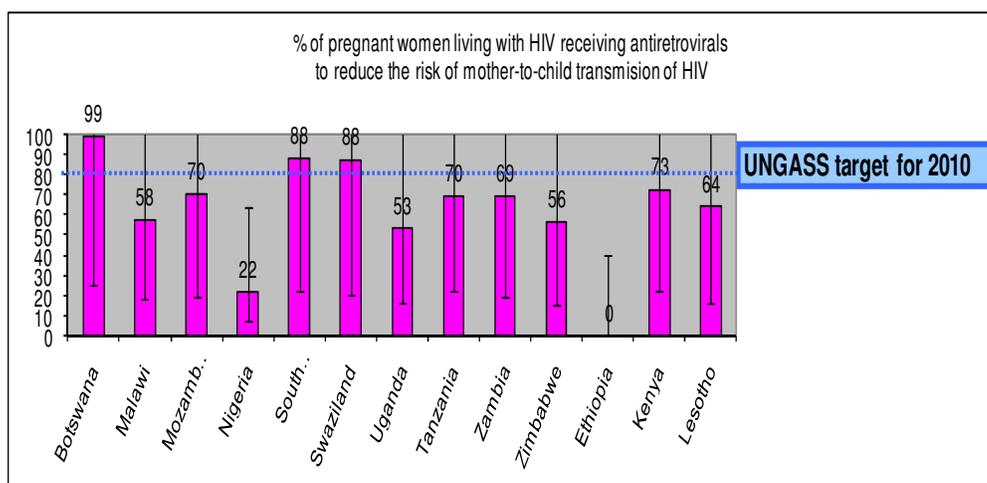
The prevention of mother to child transmission (PMTCT) program was discussed on the second day of the meeting. Over the day Tanzania, Swaziland and Zambia presented their perspectives in regards PMTCT data collection, data systems and data use. Zambia presented their electronic health information systems called “SmartCare” and client held cards that contain health data. These cards, called “SmartCards” can be used in approximately one third of Zambia’s health facilities. This system requires additional emphasis on training and human resources development. In Tanzania, patient level data in addition to the aggregated data is reported to the national level. Confidentiality is an ongoing issue that should be addressed.

Three countries presented essential aspects of their UA reporting process (Zambia, Tanzania, Swaziland) in terms of major bottlenecks and solutions envisaged in 2011.

<p>Tanzania Major bottlenecks</p> <ul style="list-style-type: none"> ➤ Untimely reporting from health facilities ➤ Incomplete & inaccurate data ➤ Inconsistency in reporting data between Govt and partner's reporting frameworks ➤ Lack of programme ownership at LGHAs ➤ Language barrier <p>Short and long term solutions</p> <ul style="list-style-type: none"> ✓ Strengthen supervision & mentoring of HCWs ✓ Build capacity on M&E to supervisors at LGHAs(RHMT& CHMT) ✓ Translate the M&E tools and training materials into Swahili ✓ Scale up the e-database to all the districts and regions ✓ Improve the paper based system at facility level ✓ Integration of PMTCT M&E framework into the HMIS 	<p>Swaziland Major bottlenecks</p> <ul style="list-style-type: none"> ➤ Nursing personnel overloaded by tools ➤ No post natal care data, poor infant feeding data ➤ Minimal analytical skills ➤ Minimal data use ➤ Continued introduction of new data elements ➤ Poor reporting from private sector <p>Solutions to improve the 2011 monitoring and reporting</p> <ul style="list-style-type: none"> ✓ Harmonize all Health Sector data collection ✓ Put a data quality assessment process in place ✓ Develop M&E plans across program areas ✓ Improve mentoring and supervisory activities ✓ Use surveys to ease overload on routine systems ✓ Build capacity building in M&E across all levels 	<p>Zambia Major bottlenecks</p> <ul style="list-style-type: none"> ➤ Increase in service demand not matching with infrastructural development ➤ Patient files sometimes kept in different places due to lack of space ➤ Shortage of adequate staff (number and capacity) ➤ Limited access to infant diagnostic techniques ➤ Data quality requires improvement ➤ Difficulties in reporting non-routine data ➤ New service delivery demands and changes in guidelines outpaces M&E systems response capacity <p>Solutions to improve the 2011 monitoring and reporting</p> <ul style="list-style-type: none"> ✓ Intensive orientation and training of new Information officers in MOH districts with regular supervisory visits ✓ Sustained roll out of smartcare (electronic smart card) ✓ Functioning M&E TWGs to harmonize data ✓ Investment in other modes of data collection ✓ Regular data audits at provincial level for all districts ✓ Regular data triangulation
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UNGASS/UA Global Reporting for PMTCT: Overall challenges to data collection and areas for improvement

Using the example of the following PMTCT indicator data quality was discussed, as well as UNGASS targets.



Some of the key findings pointed generally to an improvement in the reporting even for the difficult to report indicators and ultimately countries deciding which indicators are important for them.

Based on the discussion the following points were brought up:

- The need to harmonize the indicator definitions especially denominators between national and global levels
- The need to minimize the number of indicators to be reported on
- The need to investigate further why reporting of some indicators is poor across a number of countries
- There are still challenges in getting the denominator for pregnant women in need of ART
- The need to clarify instructions on disaggregation of the criteria for eligibility
- The need to ensure that the disaggregation adds up to the aggregates.

Translating the updated WHO PMTCT ARV guidelines (ref Annex D) for better data collection, quality and use challenges of integrating all the reporting requirements with other programs needs to be addressed. There is no scientific evidence that starting and stopping ARVs in this population leads to resistance. A public health approach principle and the benefit of reduced transmission seem to be more important. In terms of reporting, it is difficult to determine the denominator for pregnant women in need of ART. Open questions such as how to address reporting on the PMTCT drugs given in a visit based reporting systems in cases where HIV+ pregnant women are given NVP at first visit and assessed for eligibility to treatment for own health and found eligible for ART at a later date.

Ensuring that countries have a protocol for addressing over-counting and under-counting with PMTCT HTC and ARVs is important in understanding the true coverage of the PMTCT program. Such a strategy should be discussed at all levels of program implementations – from the facilities, to district level to the national level. Countries like Malawi have developed a retrospectively reported longitudinal register that only reports on each pregnancy once, therefore improving the chance for accurate data. . In addition, there is need to review how the ANC visits are structured and what is done reported at each visit.

There is need to explore linking Pediatric ART with IMAI. This will help to capture HIV exposed children who do not turn up at PMTCT when they get ill. It can also be used for monitoring after 6 weeks.

Concrete steps for improvement : based on the challenges identified, what are some concrete next steps and opportunities that can be proposed in your country to improve PMTCT data quality and use for PMTCT program improvement?

	LESOTHO	SWAZILAND	BOTSWANA	SOUTH AFRICA
Concrete steps & opportunities that can be proposed in country to improve PMTCT data quality & use for PMTCT program improvement?	Planned DQA, train health care workers in basic M & E. establish national M & E technical working group. Introduced quarterly reviews to promote data use and as feedback mechanism. Plan to integrate ART & HCT . Strengthening LAB data.	Training of the providers. On Tools & guidelines. Update electronic. Routine data quality audit. Develop staff capacity regarding data. PMTCT impact evaluation. Forster culture for data use	Improvement of data collection instrument. Collect data from the private sector. Involve developmental quarterly meeting. Approval to be done by the higher authority.	Team has been set to do a rapid data assessment. Preliminary report available of all provinces. WHO registers are customised for the country. Data capturer to be appointed. M & E officer appointed for PMTCT. 1 patient register is being planned.

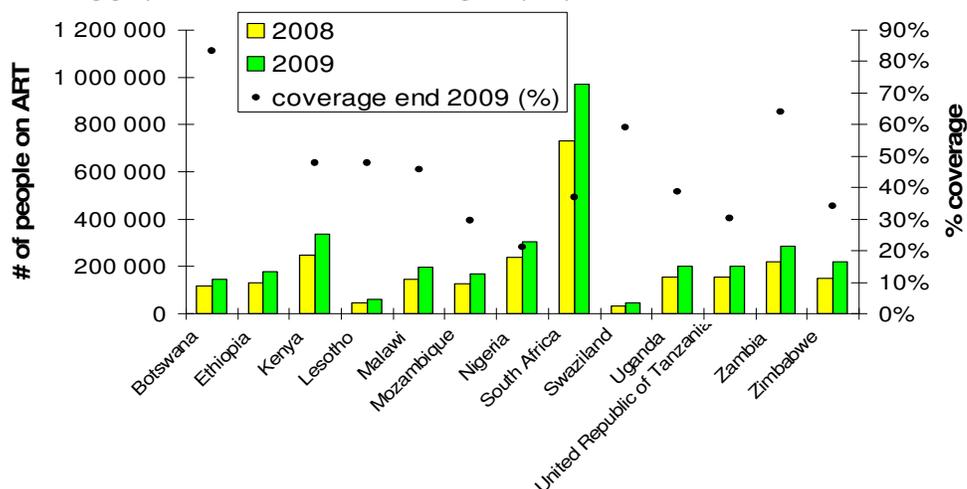
7. ART

Experience and lessons learnt from UA reporting process were presented by the teams from Ethiopia, Mozambique and Botswana.

<p>Ethiopia _ Reporting on ART Major challenges</p> <ul style="list-style-type: none"> ▪ Lack of up-to-date population-based survey to caliber ANC surveillance data. ▪ National HIS strategy is not finalized. ▪ The M & E system suffers from shortage of skilled personnel in information management at health facility level. ▪ Disaggregation for UA and UNGASS reporting is not compatible with the national HIS tools. ▪ Some data elements in the UA and UNGASS are not captured in the routine system, Eg. breastfeeding. ▪ Existing HIV/AIDS M & E system is not able to fully capture care and support implemented by partners. ▪ Incompleteness of data for UA and UNGASS reporting (MARPs, Nutrition, disaggregation). ▪ Lack of integrated and compatible national database system. <p>Solutions short and long term</p> <ul style="list-style-type: none"> ✓ Finalization of the HIS strategy. ✓ Capacity building for M & E officers and people who are engaged in data collection and reporting at all levels. ✓ Conducting MARPs survey – there is a preparation to conduct a national survey among MARPs (MOH, HAPCO, EHNRI, CDC, Ethiopian Public Health Association). 	<p>Mozambique _ Reporting on ART Major Challenges</p> <ul style="list-style-type: none"> ▪ Integration of the HIV and AIDS M&E subsystem (one national M&E system). ▪ Development of a national M&E Curriculum for training. ▪ Supervision from central to provincial and district level. ▪ Coordination of technical assistance. ▪ Data accuracy: <ul style="list-style-type: none"> - Weaknesses to identify ART patients lost to follow-up (over estimated number actively in ART); - Data incompleteness - No routine ‘Data Quality Assurance Activities’ ▪ Data consistency <ul style="list-style-type: none"> - Differences between the number of patients picking up their medicines and the number of patients on ART in the system; ▪ National representativeness <ul style="list-style-type: none"> - No reporting from the private sector <p>Solutions short and long term</p> <ul style="list-style-type: none"> ✓ Integration of the HIV and AIDS M&E in the MoH (one nat. M&E system). ✓ Development and implementation of a national M&E Curricula for training the district, provincial and central staff. ✓ Improvement of supervision from central to provincial and district level. ✓ Improvement of the coordination between the National system, private sector and NGO in the collection, use and dissemination of M&E data. ✓ Development of a strong comprehensive national M&E that serve the need of health sector reviews, disease programs and global health partnerships with the support of WHO, GFATM,GAVI and USG. 	<p>Botswana _ Reporting on ART Major Challenges</p> <ul style="list-style-type: none"> ▪ Data Consistency. ▪ Data on MARPS not collected yet. ▪ Access for ‘non nationals’ to ART services. <p>Solutions short and long term</p> <ul style="list-style-type: none"> ✓ Development of MARPS strategy. Mapping exercise and estimation. ✓ Non nationals especially refugees identified as MARPs. ART provision will be resolved after mapping and estimation. ✓ Evaluation of the NAC: membership and coverage of HIV related information.
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Usually it is difficult to involve the private sector in regular progress reporting. In Botswana, reports are obtained from private sector through the chair of Business Coalition organizations. In Mozambique, the Loss to Follow-Up (LTF) rate is high (25%) probably due to existing traditional alternatives to the services offered by governmental and private service providers. Strategies for capturing loss to follow up include home visits by Partners particularly Red Cross.

The following graph illustrates current coverage of people on ART



Presentation slide n° 4, Johannesburg September 27, 2010, WHO HIV department Geneva: Indicators related to HIV care (including TB) and antiretroviral therapy - Rationale and main challenges

The country experiences presented and the plenary discussion showed that indicator definitions as described in the UA indicators Guide are still interpreted differently by countries. As an example, an indicator requesting information on number of patients *Ever started* and those *currently on ART* as basis for estimation of ARV needs impacts on the appropriate use of drugs and drug wastages. Data on 'transfer-out' also implies 'transfer-in' which is often not included in the data presented by service providers.

7.1 TB and HIV interaction

ART coverage is significantly lower for TB patients than for the general population.

	TB/HIV on ART	ART Coverage
Nigeria	10%	31%
Kenya	23%	65%
Ethiopia	1.7%	53%
Global (2009)	17%	36%

The collaborative activity is generally low in the three countries:

- Separation of services (programmatic and physical at all levels)
- Low skills of the TB workers to also provide ART

- Ownership/source of data (Nigeria – ART centre, Ethiopia – TB, Kenya TB)
- 2 countries examples (ref above as per plenary presentations)

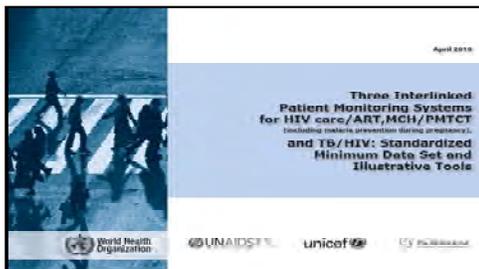
The following corrective measures can be identified:

- Integration of services (making TB centre to provide ART) to improve collaboration
- Standardize the sources of data
- Make TB clinic to capture the data on TB/HIV and ART M&E officer harmonize their data “monthly”(make the register to talk to each other)
- Use for patient outcome
- Harmonize the reporting system of the two programmes from facility upwards
- Capacity building
- Logistics

Further clarifications and discussions were pursued around the following key domains.

7.2 Patient Monitoring Systems

Patient Monitoring Systems (PMS) are essential for data gathering on patient oriented services. The three interlinked PMS for HIV care/ART, MCH/PMTCT is a combined partners’ approach to ground the PMS as per presentation and discussion during that session (illustration next).



Facilitator training guide and Participant training manual for the 3 ILPMS

Integrated electronic register- in development

Annual Patient Monitoring Review

WHO longitudinal patient monitoring systems: country adaptation guide
On IMAI EZ collaboration site

Countries have still difficulties to ensure effective monitoring of patients. Several Information Technology (IT)-based PMS are in place but still weak because of capacity gaps and lack of trained staff and adequate equipment.

The PMS supports the integration of PMTCT into interventions with MCH, family-based care, follow up of mother-infant pairs, facilitating the tracking of patient across services-in HIV/ART, TB,

MCH/PMTCT. It contributes to the elimination of duplication and improves the patient follow up and is useful to harmonize indicators for national/international reporting.

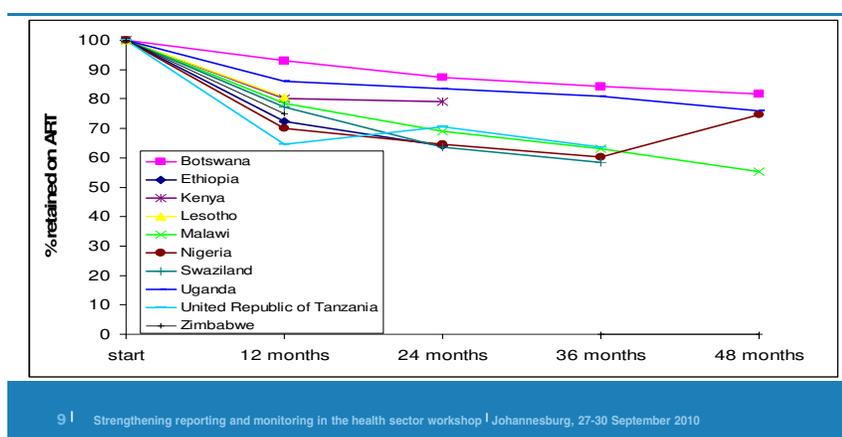
7.3 Retention on ART

Different countries use different methods to measure retention on ART. The overarching and most important element of progress reporting on ART is the performance and the accuracy of information systems. Some countries reported data on survival and not retention on ART.

Lost to follow up data (LTF) should be measured after a period of 3 months (90 days). Method of calculating the number of patients currently on ART using different cut-off points of 350 CD4 cells or 200 imply different corresponding denominators. There is a need to standardize this globally. It is recommended to use 350. An updated definition of 'Advance Disease' is currently in progress and will be presented by WHO in 2011. Discussion on LTF also includes transfer in and transfer out. There is a need to focus on monthly reporting on cohort studies for yearly progress report.

There is a general concern related to the challenges on where to get information on percent of TB-patients on ART. Collaboration and data networking by different national programs such as TB or HIV is still a challenge in all countries. ART-coverage of TB patients is still significantly lower than ART coverage of the general population.

Retention on ART reported in 2010



Presentation slide n° 9, Johannesburg September 27, 2010, WHO HIV department Geneva: Indicators related to HIV care (including TB) and antiretroviral therapy - Rationale and main challenges

7.4 Annual Patient Monitoring System (APMS)

The system presented created interest among all participants, as it provides also information on the availability of drugs and laboratory materials and can be linked to an 'Early warning system' which helps to prevent stock outs. It also provides timely and useful information to service providers as both, TB and HIV indicators are included. The discussion stated again that investment and fund allocation for patient monitoring and monitoring of program implementation processes are necessary. APMS allows for retrospective analysis of patient records and can be used for impact assessments of ART programs.

7.5 Measuring Impact using current available data

The approach to measuring impact using current and available data at country level is essential to see whether programs are having outcomes or impact, and for the justification of ongoing programs and of continuous funding towards reaching the MDGs in 2015. This approach shows the feasibility to gather information retrospectively to demonstrate impact (data mining). It is recommended to be proactive, dig for information and plan in the program budget for impact assessment. A general challenge is related to the performance of the basic health information systems which need improvement.

Methods

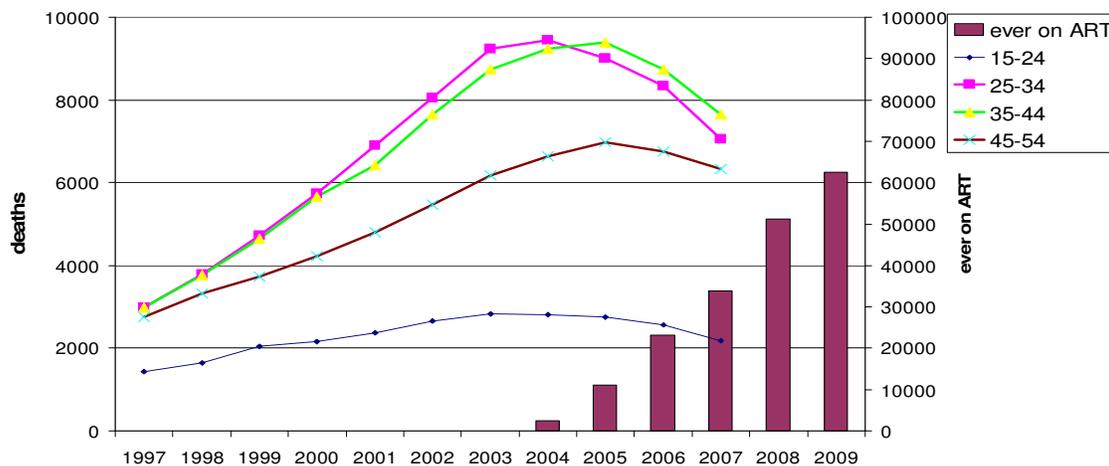
- Outcome data sources: programs
- Impact data from routine health surveillance :
 - Vital registration statistics
 - DHIS or HMIS-hospital morbidity and mortality
 - Census and demographic surveys
 - Program surveillance data (TB)

Examples: Malawi, Botswana, South Africa with UNAIDS, WHO, GF initiative with countries analyzing data from available systems to inform on impact at population level. Focus:

- ART impact on adult morbidity and mortality
- PMTCT impact on infant child mortality
- TB-ART impact on declines in TB incidence

Example South African Republic

North West province all cause mortality ages 15-54, 1997-2007 vs ART uptake through June 2009



Presentation by rand Stoneburner (UNAIDS): Approach to measuring impact using current health surveillance systems: preliminary results of UNAIDS/WHO/ GF investigations, slide n°

8. HIV Testing and Counseling (HTC)

Country experiences with bottlenecks and solutions were presented by Lesotho, Uganda.

<p>Lesotho</p> <p>Bottlenecks</p> <ul style="list-style-type: none"> • Submission rate low-late reporting and no reporting • Data reported not accurate –double counting • Weak linkage between HMIS and HIV M&E • Database analysis a challenge, not complete (exporting and importing and we are not linked to internet) • Linkages between the lab data and facility data a challenge <p>Solutions</p> <ul style="list-style-type: none"> ✓ Revise the monthly summary forms to avoid the problem of double counting ✓ Integrate HTC data into routine HMIS as well as laboratory data ✓ Conducting the quarterly routine data verification ✓ Constant supervision and mentoring(capacity building) 	<p>Uganda</p> <ul style="list-style-type: none"> • Age categorization, missing data - MARPS • Changes in HIV prevalence? Stable prevalence (6.4% adults and 0.7% in children UDHS 2004/05) Higher in women 12%, urban dwellers 10%, post conflict regions • Data accuracy? Inaccuracy e.g. the indicator on the % HF that provide HCT – 99%; Double counting – re-testers and repeat testers • Data consistency? Inconsistencies highly possible given that some partners do not report through HMIS, ? MEEPP • National completeness? PHP, NGO's/CBO's • Overstretched service levels <p>Short term solutions for 2011 reporting</p> <ul style="list-style-type: none"> ✓ Revision of HMIS Tools Integrate data elements needed for reporting; harmonized with the partners ✓ Engage with PHP and get them to report HCT data (Using umbrella organizations working with PHP) ✓ Capacity building at all levels: Pre-service, In-service ✓ Data sharing and feedback ✓ DQA <p>Long term solutions</p> <ul style="list-style-type: none"> ✓ Develop one M&E Framework for HIV/AIDS in the health sector. HCT Program M&E Plan aligned ✓ A single repository of data housed in the MOH/RC Database. Data ware housing (National HMIS strengthened – HR/Staff recruitment - CDC) Interoperability ✓ HR - Right skills and right numbers to manage M&E roles ✓ Advocate for adequate funding for M&E activities ✓ Process for the development of a country led NHIS Framework (Partners) ✓ Data quality: Data use at all levels, DQA
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Main challenges are related to timeliness, consistency, completeness and accuracy of collected data, avoiding double counting and including the linkage with HMIS and data quality verification exercises. Data collection and reporting should be integrated into the national HMIS, regularly revising the reporting tools and including data quality assessment exercises. As a general issue, human resources development and strengthening and advocacy for data quality assurance were mentioned at all times. In Uganda, specific challenges were related to the supply management of HIV testing materials resulting in low performance of HTC services in 2009. In addition, the efficiency of the Provider Initiated Testing and Counseling (PITC) approach should be evaluated.

The information systems put in place at national regional and district levels by different organizations are often not compatible, and programmatic and financial aspects are monitored by different systems without direct linkages to facilitate the analysis of data. It has to be clarified how to bring together HTC from diverse entry points and sectors.

Disaggregation of data is a general challenge of health systems in the Region. The data sources are often not indicated, it is unclear if the data on people tested include pregnant women as these are different national programs providing and supporting the services for different target populations. Often, data on HTC coverage represent tests done (including retesting) instead of people tested. When possible, data should be triangulated with population based survey data (i.e. DHS). Comparing country reports and country performance based on UA progress reporting should always take into account the different information systems in place, their specificities and weaknesses. WHO with partners has developed an updated draft guide on monitoring HTC. Several country teams have expressed interest to participate in the pilot testing the draft guide on monitoring HTC.

9. Health Systems Strengthening/ Procurement Supply Management (HSS/PSM)

The Zimbabwe team elaborated on recent experience related to reporting on ARV use.

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The majority of countries represented during the workshop indicated null (0%) stock outs of ARV during the years 2008 and 2009. This information given in the UA progress reports is not matching with the fact procurement and supply management for drugs and goods faces challenges in all developing countries. Nigeria presented some of its current challenges in PSM (next). Therefore, emphasis was put on drug supply management highlighting three major areas:

- a) Shortage: Percentage of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in the last 12 months
- b) Overstock (wastage)
- c) Quality of drugs.

PSM in Nigeria - Main challenges

- Multiple vertical programs with individual PSM systems
- Inadequate coordination of commodity procurement and distribution (including weak coordination between federal and state governments)
- Inadequate national quantification to inform resource mobilization and allocation
- Absence of efficient early warning systems for impending breakdowns in commodities management
- Non regular and weak supportive supervision
- Non-efficient use of resources
- No consistent indicators yet in place to measure actual pipeline delivery cycle times or quality of commodities delivered across the nation
- No methods in place to track system efficiency (cost and money)
- Requisition by facilities is widely reported at irregular times, making distribution planning unachievable
- Too many players are involved in making requisition (NASCP, NACA, CMS, Crown Agent) leading to confusion, delay and duplication of efforts
- The use of multiple reporting forms leads not only to avoidable mistakes and delays but an inability to track orders and monitor the pipeline cycle

Availability of drugs depends from different variables such as changes of treatment protocols, use of drugs, and performance of the drug supply management system which has to be monitored via an effective information system. Availability of timely and valid information related to PSM is necessary to ensure continuous access to quality services related to HIV.

Zimbabwe presented one approach to harmonize the monitoring of the PSM system consisting of 12 indicators out of which 6 indicators are related to the early warning system to prevent drug stock outs. In order to ensure the effective functioning of the PSM

monitoring system, there is a need for:

- Capacity building of national professionals to track the performance of their PSM system,
- Implementation of PSM indicators in particular, the PSM Early Warning Indicators (EWI) to prevent stock outs and overstocks,
- Assessment of the impact of the PSM EWI on the performance of the PSM systems
- Revision of the PSM indicators if necessary.

Countries brought up many challenges in collecting data in a decentralized health system – (e.g. South Africa, Nigeria) - including issues around how the national level has difficulty in getting information from the provinces. Although the workshop focused on PSM under HSS, there were many other HSS issues that were raised e.g. lack of human resources to collect data accurately – e.g. over burdened nurses, introducing data clerks to improve reporting.

10. Innovative approaches related to M&E

Swaziland: has introduced a ‘community health information system’ which contains data collection tools that should help to improve the health information system and the use of analyzed data. As long as data cannot be used at service provider levels the quality of data reported at that level will always be low.

Tanzania: Training of health care providers on M&E is included in the activity plan and budgeted for. The country proposal of round 9 of the Global Fund contains an important budget for this training.

Zambia: Recently created new position at district level, the ‘health information officers’, mainly former nurses or clinical officers who had to be trained and reassigned on the new position within the public health system. In addition the county introduced Smart care _ smart cards (not only for HIV related issues) allowing ad-hoc availability of all relevant patient data and serves for M&E and reporting. All ART providing health facilities are working with these smart cards, are equipped accordingly. The sites are not yet connected via internet. This new system helps to improve completeness of data reported.

11. Evaluation Results

Participants were given the opportunity on the first day to exchange on their expectations with regard to workshop outputs and outcomes (as summarized next).

1	Exchange on best practices	54
2	Know M&E tools better	47
3	Exchange on bottlenecks related to M&E and reporting	39
4	Strengthening national policy and governance related to M&E	35
5	Know how to better analyze data	24
6	Know how to reduce workload related to M&E and reporting	24
7	Know how to use data	23
8	Identify TA needs in M&E and reporting	17
9	Know how to harmonize technical and financial support related to M&E	14
10	Know how to use M&E guidance	13
11	Know how to gain political and financial support for M&E and reporting	11

11.1 Evaluation related to the expected outputs

- *Improved know-how, and basic skills on the latest normative materials and tools*

According to the post workshop evaluation exercise, the workshop has met the personal expectations of the participants as well as the expectations related to the country needs (Annex F). The workshop was a forum for all participants to discuss and exchange their experiences in M&E and reporting on the health sector response to HIV, gave information on latest normative materials (Annex D) and tools that can contribute to strengthen the performance of national information systems and reporting processes. Resource people presented updates on key normative guidance and trends of various program areas. Participants were updated on the data quality issues within the health systems context.

- *Succinct essential practical and immediate action plan*

Prior to the workshop, countries identified some of their current challenges and solutions towards improving the monitoring of UA. During the workshop, however, despite some solid discussions surrounding those findings, and despite presenting the current gaps/ challenges/ issues and some solutions, countries (Table next) could not come up with the concrete Action Plans (Annex E) suggested. Insufficient time was given in the last day to identify concretely the priority under the

form of an action plan. Part of the successful outcome though is linked to the recommendations listed above which will guide the country teams to identify and program specific activities in order to streamline M&E and reporting on health sector response to HIV, and hopefully submit those plans in the next few weeks following the workshop.

COUNTRY ACTION PLAN: Botswana, Lesotho, Swaziland and South Africa

Improving M&E and reporting

Gaps/Challenges/Issue	Solutions
1.Lack of standardized National M&E system	<ul style="list-style-type: none"> • Implementation of Pre ART & ART registers • Capacity building • Mentoring and Supportive supervision • User-friendly electronic system • Quarterly meeting reviews (learning exchange)
2. Poor data capturing/quality	<ul style="list-style-type: none"> • Good record keeping system • Capacity building – <ul style="list-style-type: none"> - training on tools - Data verification/validation • Mentoring and Supportive supervision • Health care workers capturing the data • Conduct data quality assessment • Feedback mechanisms to the data collectors/reporters
3. Many indicators to report	<ul style="list-style-type: none"> • Develop electronic system
4. Under reporting and missed opportunities	<ul style="list-style-type: none"> • Strengthen TB and HIV integration • Harmonize the recording and reporting • TB/HIV working group and management team meeting to review and share reports

- *Advocacy plan by the joint country team*

Most of the country teams did not yet finalize their specific advocacy plans either, besides some general findings, as this will be a matter of a larger group within each country. Presentation of the desk study results on key challenges related to UA and UNGASS reporting from 2009 and 2010, the presentation of country specific challenges and experiences and the discussions within the working groups and during the 'market place' sessions on specific M&E tools laid the ground for the elaboration of the country advocacy plans. This plan is important as a follow up of the workshop to mobilize the political support to implement the action plan.

11.2 Specific results related to M&E and reporting on HIV related activities at country level

- All countries represented in the workshop go through similar general process to prepare and elaborate the yearly progress reports on Universal Access to quality services related to HIV.
- All countries are aware of the necessity to work on their information and reporting systems

- More investment is needed in the generation and use of strategic information to guide program planning.
- There is a general consent on the need for investment in M&E in order to allow for reliable reporting and consequently continuity of funding
- Demonstrating performance and results is necessary to sustain commitment of governments and donors.
- There is a felt need to reduce the number of harmonized indicators to report on at national and global level. 'Country ownership' means country specific selection of indicators for the national HMIS
- 'Country ownership' means country specific selection of indicators for the national HMIS
- Current data quality is uneven and lacking in critical areas, such as for populations at risk with data on MARPs rarely collected
- Systems to monitor patients remain critical to improve outcomes and evaluate impact.
- All countries work through multiple information and reporting systems which are related to specific vertical programs and funding which leads to work overload of service providers, under- or over reporting and lack of timely availability of reliable data
- NHIS and service providers are overloaded by parallel data collection and information systems, that provide rarely feedback for further planning and re-programming
- Private and NGO-run health facilities are often not reporting to the central registers
- Data validation exercises are still not done routinely
- Donors and implementing partners collect data directly from health facilities and numerators reported are different according to the institution asking for the data (example from one of the 13 countries: government gets lower, funding agencies such as GF get higher numerators)
- Key is harmonization of information systems combined with coaching/mentoring and regular and frequent supportive supervision of service providers (supportive supervision of service providers is still weak)
- Staff shortages in some countries and capacity gaps at service provider levels contribute to low quality of services and low quality of data reported.

12. Recommendations by field of activity

a) Country ownership and alignment

- ✓ Promote country ownership throughout service delivery and annual reporting on health sector response to HIV and efforts towards the integration of various information systems into national HMIS including availability of related budgets
- ✓ Promote training and improving supervisory activities /coaching /mentoring provided to strengthen the M&E of the health services

- ✓ Ensure participation and contribution of the private sector

b) Investment in HIS

- ✓ Support the transition from paper-based to electronic systems where needed with the update of Information Technology (IT) equipment if necessary
- ✓ Invest in specific data collection (that the routine HMIS may not capture) and operational research
- ✓ Use Routine Data Quality Assessment (RDQA) tools and data triangulation to improve quality (validity, consistency) of data
- ✓ Use active Impact Measurement exercises as specific active data collecting measures
- ✓ Ensure availability and use of the M&E budget (for ex. through GF grants), and support of key areas of needs (ex. based on M&E assessments, or data quality findings).

c) Guidance and tools

- ✓ Support further the Impact Measurement exercises to measure outcome and impact (by HQs / Regions and countries) towards an improved understanding of progress towards MDGs
- ✓ Review HIV related M&E tools (by HQs/ Regions) to capture missing data elements
- ✓ Further update (by HQ/ Regions) the guide for 2011 progress reporting on UA
- ✓ Provide systematic annual feedback (by HQ/ Regions) on country reporting and data quality.

13. Next steps

At country level

1. Ensure follow up of recommendations and measures identified by the countries
2. Narrow down some of the solutions and take action on those
3. Advocate to further support some of the above activities
4. WHO country focal points commit themselves to make it happen (e.g. National workshop to strengthen monitoring and reporting) and to follow up for countries to complete the proposed country action and advocacy plans identifying the needs for technical assistance for improving the M&E systems, in particular for UA
5. Discuss and disseminate findings of the workshop through M&E country thematic groups

At WHO HQ

1. Follow-up at country level the development of the proposed country action and advocacy plans
2. Take stock of this workshop to develop a similar one for Francophone Africa during the 1st quarter of 2011
3. Link-up with the respective agencies for the various Technical Assistance (TA) needed, in particular with PEPFAR and Global Fund

4. WHO (HQ/AFRO) to update the UA reporting guide based on country feedback

14. Annexes

Annex A: List of participants

Annex B: Workshop agenda

Annex C: Generic template on Lessons Learned from 2007-09 national and global reporting, strengthening reporting and monitoring in the health sector

Annex D: Key documents used during the workshop; List of Key Materials

Annex E: Draft country action plans

Annex F: Workshop evaluation (form and scores, and summary at glance)

Annex A: List of Participants**Joint WHO-UNICEF-UNAIDS-OGAC/CDC/USAID Capacity-Building Workshop:****Strengthening reporting and monitoring in the health sector for the Africa Region****Johannesburg, 27-30 September 2010****List of participants (29 September 2010)**

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Annex B: Workshop agenda

AGENDA FOR THE CAPACITY-BUILDING WORKSHOP 27-30 Sept. 2010: STRENGTHENING MONITORING AND REPORTING IN THE HEALTH SECTOR FOR THE AFRICA REGION (vers. of 30th Sept. 2010)

<i>Preli-minary</i> 26 th Sept. 3-6pm	TOPIC <i>Preparation</i>	<i>Facilitators, resource people: preparatory meeting</i>	Activity <i>Fine tuning</i>	All LEAD AGENCY <i>All facilitators/ presenters, resource people)</i>
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Day 1 27 th Sept.	TOPIC	CONTENTS	Activity	LEAD AGENCY (Facilitator/ presenter)
HEALTH SECTOR MONITORING AND REPORTING: A COMMON VISION				
Lead for session: WHO (A. Alislad), UNICEF (D. Burke), UNAIDS (W. Gill), GF (P. Mwangala), OGAC (P. Rao)				
8.15 - 9.00	Registration			
9.00 - 12.30	1. Introduction 2. Overview	1. Introduction, presentation of participants (45 mn) 2. Objectives and Outcomes. Agenda, structure, format of sessions (45 mn)		A. Alislad C. Pervilhac
10.30- 11.00	Coffee break 3. Evaluation	3. Expectations and evaluation of the workshop (baseline) (45 mn)		C. Pervilhac, A. Doerlemann
	4. Common vision national and global monitoring and reporting	4. Towards a common vision of strengthening data quality and use at country level through national monitoring and reporting: the political and institutional environment at country level to improve the systems towards results-based achievements. Perspectives and updates from USG/ G.H.I. and PEPFAR II, and the Global Fund, and views from beyond (UNAIDS Outcome Framework "Joint Action for Results" with UNGASS/ MDGs, UNICEF and WHO) (45 mn)		W. Gill D. Burke P. Mwangala A. Alislad P. Rao
12.30- 14.00	Lunch			

HEALTH SECTOR MONITORING AND REPORTING: COUNTRY UPDATES 2007-09				
Lead for session: Cyril Pervilhac, Pamela Rao, AFRO (tba)				
14.00 - 17.30	1. Country and global 2010 reporting 2. Update on Health Sector guidance Coffee break 3. M&E systems, management, policy	1. What are countries telling us? - UNGASS/ UA Health Sector monitoring and reporting for 2010 with 2 country experiences and update on current action plans (45mn) Monitoring and Reporting guidance (and update): - 2007-09 monitoring and reporting: rapid overview of trends, global and national progress, and bottlenecks (45mn)	Presentation	S. Afr. and Nigeria A. Abdikamal, AFRO/ESA Data Manager, M. Beusenberg D. Chamla, A. Doerlemann
15.30- 16.00		- Improving annual monitoring and reporting: summary of queries and using the updated Guide on Indicators for Monitoring and Reporting on the Health Sector Response to HIV/AIDS (30 mn) - Using a systems approach to long-term problem solving: Priorities in bottlenecks in systems approach (the 12 components of a functional M&E system) (30 mn) - Framework for country ownership and institution building and importance of including this component in any national M&E/SI action plan	Presentation	CDC WHO Pamela Rao, P. Mwangala C. Pervilhac Pamela Rao,
17.30 19.00	4. Country action and advocacy plans (working group prep.) End	What are the current action and advocacy plans for 2011 national monitoring and reporting? - Reviewing the current templates and updates if needed (30 mn)	Group work (intro.)	C. Pervilhac, others
		Reception (Cocktail)		

Annex B: Workshop Agenda

Day 2 28 th Sept.	TOPIC	CONTENTS	Activity	LEAD AGENCY (Facilitator/ presenter)
<p>HEALTH SECTOR MONITORING AND REPORTING: PMTCT Lead for module: Chika Hayashi, Danielle Burke, Rachel Blacher, PMTCT M&E AFRO & M&E for ESA and W. Afr.</p>				
<p>8.30-12.30</p> <p>10:30-11:00</p> <p>12.00-13.30</p>	<p><i>Country Experiences (8:30-9:30)</i></p> <p><i>Data collection and Reporting (9:30~10:30)</i></p> <p><i>Coffee Break</i></p> <p><i>Looking Ahead (11:00~11:45)</i></p> <p><i>(11:45~12:00)</i></p> <p><i>Lunch</i></p>	<p><i>Session 1: 3 country experiences (1hr)</i></p> <ul style="list-style-type: none"> • <i>Country 1 (Zambia) – 15 minutes</i> • <i>Country 2 (Tanzania) – 15 minutes</i> • <i>Country 3 (Swaziland) – 15 minutes</i> • <i>15 minutes discussion</i> <p><i>Session 2: UNGASS/UAGlobal Reporting for PMTCT: Overall challenges to data collection and areas for improvement (1 hr: 30 min presentation, 30 min discussion)</i></p> <p><i>Session 3: Translating the updated PMTCT ARV guidelines for better data collection, quality, and use (45 minutes)</i></p> <ul style="list-style-type: none"> • <i>Summary of Updated PMTCT ARV Guidelines and Possible Global Targets</i> • <i>PMTCT M&E Adjustments from 2010 onwards: Routine Data Collection/Reporting and Impact Measurement</i> • <i>PMTCT Data Quality (IATT Thoughts), PEPFAR Reporting</i> <p><i>Introduction to Group Work</i></p>	<p><i>Presentat. & Discussion Swaz., Zamb., Tz.</i></p> <p><i>Presentat.& discussion</i></p> <p><i>Presentation</i></p>	<p><i>To be identified</i></p> <p><i>C. Hayashi and D. Burke and (WHO/UNICEF/PEPFAR)</i></p> <p><i>Tin Tin Sint Chika Hayashi Rachel Blacher</i></p>

HEALTH SECTOR MONITORING AND REPORTING: PMTCT (end)				
13.30-17.00	Group Work (13:30-16:00)	Session 4: Group Work A separate sheet will be prepared outlining the key questions to be discussed during the group work. Countries should come to the meeting with a copies of their national indicators, summary reporting forms, registers and patient cards.		CDC, USAID, WHO HQ/AFRO UNAIDS UNICEF, GF
15.30-16.00	Coffee Break 16:00-17:00	Session 5: Report back from group work: - Reporting and discussion (2-3 countries) of working groups (1 h)		
17.00	End	(At least 1 country -to be identified)		Idem.
17.30-19.00	RECOM-MENDED: ADDITIONAL 5 sessions with 3 market place: 3 parallel update on key tools (1/ of 2 sessions) , and 1 W.G. C&T	1. IMAI: Three Interlinked Patient Monit. Systems for HIV care/ ART, MCH/PMTCT (3ILPMS) and the Annual Patient Monitoring Review (APMR) for both data quality and quality of care 2. Information Technology (national and district updates) 3. M&E of MARPS 4. HTC Session: Review of Couples/Partner and Re-testing HIV Testing and Counseling indicators (prep to Day 4)		1. Sisay Sirgu 2. J. Richards 3. C. Pervilhac 4 C. Hayashi

Annex B: Workshop Agenda

Day 3 29 th Sept.	TOPIC	CONTENTS	Activity	LEAD AGENCY <i>(Facilitator/ presenter)</i>
HEALTH SECTOR MONITORING AND REPORTING: ART (including Paediatric) and HIV/TB Lead for module: Abdi Alislad, J.M. Tassie, CDC (TBA), Technical Officer/HIV/AIDS S.I. C. Afr.				
8.30 - 9.30	Country experiences	- 3 country experiences and update on current action plans (1h) <i>(Presentations throughout the workshop emphasize data collection, data quality (key issues), data analysis and use presenting either new or unique experience and/ or specific problems and troubleshooting)</i>	Presentat. & Discussion Botsw., Moz., Eth.	To be identified
9.30-10.30	National and global reporting	- UNGASS/UA reporting in ART: the evolution of trends - Rational and main challenges for monitoring these indicators (1h) - Survey on ARV use and changes in guidelines in the Afr. Region	Presentat.& discussion	J.M. Tassie
10.30- 11.00	Coffee Break			
11.00- 12.30	Data analysis and use	Hands-on data analysis and use of results: - Data analysis and use (from the Annual Patient Monitoring Review/ APMR perspective) - Improving outcome and impact monitoring and use of results: (ex. Malawi, S. Afr. and Botswana) * from HIV cohort to population data * analysis of impact for ART/TB: mortality, incidence	Presentat.& discussion	S. Sirgu R. Stoneburner
12.30	Lunch			

HEALTH SECTOR MONITORING AND REPORTING: WORKING GROUPS: ART (including Paediatric) and HIV/TB (end)				
14.00-16.00	Working Group	- Working group UA health sector reporting and UNGASS health sector data reporting: 3-4 countries/ group (4 groups) for each country: -each country presents quickly country findings 1) how are ART/TB data from the health sector analysed and used in each country? Can we do better? What is needed? (country data) 2) discussion and feedback on the monitoring of 2009 ART/ TB data: data generation, aggregation, analysis, use, national and global reporting of data for 2010: identify 3 main issues gaps and related solutions to improve national monitoring and reporting with a follow-up action and advocacy plan for 2011 (2h)	Group work	CDC, USAID, WHO HQ/AFRO UNAIDS UNICEF, GF
16.-16.30	Coffee Break			
16.00-17.30	Reporting and discussion	Reporting and discussion (2-3 countries) of working groups (1 h) (At least 1 country -to be identif.- brief 10 mn presentation/ session)		
17.30	End			
18.00-19.30	RECOM-MENDED: ADDITIONAL 4 sessions with 3 market place: 3 parallel update on key tools (part 2 of 2 sessions), and 1 clinics/ country (upon request) and 1 W.G. on C&T	1. Data quality (e.g. RDQA): ex of Tanzania 2. M&E 2009 MERG tools (12 components M&E System Strengthening tool, Guidance on Capacity-Building for HIV M&E) 3. M&E Male Circumcision (special session- non routine reporting-relevance for 12/ 13 countries participating) 4. HTC Session: Special session on HIV Testing and Counseling indicators		1. Dawne Walker, Futures Group (MEASURE partner) 2. Wayne Gill 3. Kanyanta Sunkutu (Zamb.) 4. C. Hayashi

Annex B: Workshop Agenda

Day 4 30 th Sept.	TOPIC	CONTENTS	Activity	LEAD AGENCY (Facilitator/ presenter)
<p>HEALTH SECTOR MONITORING AND REPORTING: HTC AND HSS/ PROCUREMENT SUPPLY AND MANAGEMENT (PSM) Lead for module: Rachel Blacher (CDC) and Buhle Ncube (WHO) for HTC, J.M. Tassie (HSS/PSM, WHO)</p>				
8.00-10.00	1. HTC	<ul style="list-style-type: none"> - Presentation 1: 2 country experiences <ul style="list-style-type: none"> • 2 Countries: 10 minutes each • Discussion: 15 minutes -Presentation 2: UNGASS/UA reporting in HTC findings-summary (15 min ppt, 15 min discussion) Round tables (in plenary) 45 minutes: - Presentation of Round Table Questions - Countries in round-tables identify their own 2-3 top priority actions and advocacy plans for 2011 in their country (35 mn) - 2 countries report (10 mn) Items to be potentially discussed (based on what the group deems to be the most important issues) <ul style="list-style-type: none"> HTC Data Collection: Current Strategy and Issues <ul style="list-style-type: none"> • Couples counselling indicator/ Repeat testing indicator ☒ Data disaggregation on sex ☒ Reporting data from mobile clinics ☒ Goal is to have countries develop ways to improve their data quality Health Systems Strengthening (HSS)/ PSM: - 1 Country experience and update on current action plans (30 mn) 	<p>Lesotho, Uganda</p> <p>Presentation</p> <p>Round tables</p> <p>Presentation Zimbabwe</p> <p>Presentation</p>	<p><i>Rachel Blacher</i></p> <p><i>C. Hayashi</i></p> <p><i>CDC, USAID, WHO HQ/AFRO UNAIDS UNICEF, GF</i></p> <p><i>Forward Mudzimu, MoH</i></p> <p><i>J.M. Tassie</i></p>
10.30-11.00-13.00	Coffee Break	<ul style="list-style-type: none"> - UNGASS/UA reporting in PSM in 2010: findings-summary (30 mn) - Supply Chain Management Systems (SCMS) 		
13.00	2. HSS/ PSM	<ul style="list-style-type: none"> - Working group UA health sector reporting and UNGASS health sector data reporting: 3 countries/ group (4 groups): discussion and feedback on 2009 reported data for 2010 and improving reporting with a follow-up action and advocacy plan for 2011 (30 mn) 	<p>Group work</p>	<p>"</p>
13-00-14.00	Lunch	<ul style="list-style-type: none"> - Reporting and discussion (by round tables) (30 mn) 		

GLOBAL REPORTING, KEY FINDINGS AND RECOMMENDATIONS, , WAY FORWARD, CLOSING				
14.00-16.00	14.00-14.30	Universal Access Report 2010: post launch- summary release of global data with emphasis for the Africa Region		Y. Souteyrand
	14.30-15.00	- Overview of key findings and recommendations		A. Doerlemann
	15.00-15.30	- Evaluation of the workshop - Special award: 3 winners' workshop (S. Africa 2010 World Cup)		A. Doerlemann C. Pervilhac
	15.30-16.00	- Way forward: country, global - Closing Remarks: WHO, WR, South Africa		P. Rao P. Mwangala W. Gill Y. Souteyrand S. Anyangwe

Annex C: Generic template on Lessons Learned from 2007-09 national and global reporting, strengthening reporting and monitoring in the health sector

Country generic Presentation 2010 reporting: the process at a glance

- How was the 2010 reporting process in-country organised?
- Lessons learned from 2008-09 reporting?
- Technical committee (UA with UNGASS)?
- Use of technical guidelines?
- Quality assurance of data reported?
- Major achievements and bottlenecks?
- Present **data analysis and use of data** with 2010 reporting?

Country generic Presentation 2010 reporting: the process at a glance

- How was the 2010 reporting process in-country organised?
- Lessons learned from 2008-09 reporting?
- Technical committee (UA with UNGASS)?
- Use of technical guidelines?
- Quality assurance of data reported?
- Major achievements and bottlenecks?
- Present **data analysis and use of data** with 2010 reporting?

What are the long term solutions in the context of Systems Building?

to be addressed in details during the working groups in the workshop

Source (in attachment): Concept module "Using a systems approach to long-term problem-solving: Priorities in systems approach"

- Which are the systems bottlenecks for quality reporting (using the 12 basic components of HIV M&E system)?
- Within those and using the "WHO Health System Framework" what are the system building blocks to be addressed?
- What is the follow-up advocacy plan (what, who, when?)?

Country generic Presentation 2010 reporting: the process at a glance

- How was the 2010 reporting process in-country organised?
- Lessons learned from 2008-09 reporting?
- Technical committee (UA with UNGASS)?
- Use of technical guidelines?
- Quality assurance of data reported?
- Major achievements and bottlenecks?
- Present **data analysis and use of data** with 2010 reporting?

What are the solutions/ short term plans to improve the 2011 reporting?

to be addressed in details during the working groups in the workshop

- In light of the bottlenecks just identified what are the **2 or 3 urgent priorities** to address?
 - How to resolve those?
 - When?
 - Who (partnerships)?
- How are some of these bottlenecks addressed (or not) already in the existing national M&E plans/frameworks (in light of definition of indicators, quality of data, HIV/AIDS reporting in the broader HIS context, data analysis and use)?

INSTRUCTION SLIDE (to be erased)

- Select country presentations focus (as per proposed table)
- Discuss meeting preparation and follow-up around existing UA health sector reporting and UNGASS reporting technical group (beyond the workshop to implement action and advocacy plan short and long term)
- Select participants to meeting based on profile needed (see summary outline)
- Prepare with WHO, UNICEF, CDC technical focal points in-country the contribution with slide(s) presentation for the meeting
- Prepare, review, bring the materials requested to the meeting
- Link up with workshop organisers/ consultant as needed

Annex D: Key documents used during the workshop; List of Key Materials

**CAPACITY-BUILDING WORKSHOP 27-30 Sept. 2010:
STRENGTHENING MONITORING AND REPORTING IN THE HEALTH SECTOR FOR THE AFRICA REGION**

Documents LISTING for Johannesburg - PRINTED

See Key Materials on USB flash disk

NORMATIVE M&E

- A guide on indicators for monitoring and reporting on the health sector response to HIV/AIDS (50 copies)

http://www.who.int/hiv/data/ua10_indicator_guide_en.pdf

- WHO, UNICEF, DRAFT-Monitoring and evaluating the prevention of mother-to-child transmission of HIV A Guide for National Programmes (10 copies)

- WHO, UNICEF, UNAIDS, CDC, Macro DHS ..., DRAFT-Guide for monitoring and evaluating national HIV testing & counselling (HTC) programmes (30 copies)
and Appendix 1: Minimum data elements to be collected and reported for HIV testing and counselling (HTC) programmes

- Antiretroviral therapy for HIV infection in adults and adolescents (50 copies)

http://whqlibdoc.who.int/publications/2010/9789241599764_eng.pdf

- Antiretroviral drugs for treating pregnant women and preventing HIV infections in infants (50 copies)

http://whqlibdoc.who.int/publications/2010/9789241599818_eng.pdf

- Antiretroviral therapy for HIV infection in infants and children (50 copies)

http://whqlibdoc.who.int/publications/2010/9789241599801_eng.pdf

- Harmonized monitoring and evaluation indicators for procurement and supply management systems (60 copies)

- WHO, UNAIDS, UNICEF, "Towards Universal Access Scaling up Priority HIV/AIDS interventions in the health sector", Progress Report 2009

(see WHO HIV web site, and upcoming Progress Report 2010, release Sept 29 2010)

- UNAIDS, UNGASS Guideline on Construction of Core Indicators 2010 Reporting

(see UNAIDS Secr. web site)

SPECIFIC M&E

- WHO, UNAIDS, UNICEF, The Global Fund, Three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT (including malaria prevention during pregnancy) and TB/HIV: Standardized Minimum Data Set and Illustrative Tools (30 copies)

http://www.who.int/hiv/pubimai/forms_booklet.pdf

QUALITY OF DATA

- WHO, partners, Data quality assessment and adjustment For annual health statistical reporting April 2010
- Data quality assessment at a glance for the monitoring and reporting of national and global HIV data (50 copies)
- WHO et al., Strengthening country health sector reviews and MDG progress monitoring Workshop on data quality assessment and analysis, Kenya, Apr. 12-16 2010

CASE STUDIES

- Country experiences in implementing patient monitoring systems for HIV care and antiretroviral therapy in Ethiopia, Guyana and India (50 copies)
http://whqlibdoc.who.int/publications/2010/9789241599009_eng.pdf

OTHERS

- WHO, UNAIDS, UNICEF, Towards Universal Access Progress Report 2009 (50 copies)
http://www.who.int/hiv/pub/tuapr_2009_en.pdf
- Data quality assessment tool (RDQA): available on USB stick
- Health Metrics Network (Assessments of M&E) available under "Country Support" at:
<http://www.who.int/healthmetrics/support/en/>

OTHERS ADDITIONAL (PROGRAMMATIC, etc.)

- PMTCT strategic vision 2010-2015 (50 copies)
http://www.who.int/hiv/pub/mtct/strategic_vision.pdf
- HIV/AIDS Programme HIGHLIGHTS 2008-2009 (50 copies)
http://whqlibdoc.who.int/publications/2010/9789241599450_eng.pdf
- Transactions prices for antiretroviral medicines and HIV diagnostics from 2008 to March 2010 (60 copies)
http://www.who.int/hiv/pub/amds/GPRMsummary_report_may2010.pdf
- A guide to indicators for male circumcision programmes in the formal health care system (40 copies -via air)
<http://www.who.int/hiv/pub/malecircumcision/indicators/en/index.html>
- UNAIDS, MERG 12 Components Monitoring and Evaluation System Strengthening Tool
http://www.globalhivmeinfo.org/AgencySites/MERG%20Resources/MERG%2012%20Components%20OME%20System%20Assessment_Guidance%20Document.pdf
- UNAIDS, MERG Guidance on Capacity Building for HIV Monitoring and Evaluation
<http://www.globalhivmeinfo.org/AgencySites/MERG%20Resources/MERG%20Guidance%20for%20Capacity%20Building%20for%20HIV%20OME.pdf>

Annex E: Workshop evaluation

**JOINT WHO-UNICEF-UNAIDS-PEPFAR CAPACITY-BUILDING WORKSHOP: STRENGTHENING
REPORTING AND MONITORING
IN THE HEALTH SECTOR FOR THE AFRICA REGION**

Johannesburg, South Africa

27 – 30 September 2010

Evaluation of the workshop: POST-EVALUATION FORM AND SCORES

COUNTRY where you are working: _____

AFFILIATION (circle): MoH, NAC, Intern. Org., Other (specify): _____
(15) (1) (11)

GENERAL

- Has the workshop met my personal expectations (formulated the 1st day) or not? If not, why not?

Yes no why not
(27)

- Have my expectations for the country I represent been met (formulated the 1st day) or not? If not, why not?

Yes no why not
(26)

As a reminder:

	Ranking of expectations of participants documented the 1st day	dots
1	Exchange on best practices	54
2	Know M&E tools better	47
3	Exchange on bottlenecks related to M&E and reporting	39
4	Strengthening national policy and governance related to M&E	35
5	Know how to better analyze data	24
6	Know how to reduce workload related to M&E and reporting	24
7	Know how to use data	23
8	Identify TA needs in M&E and reporting	17
9	Know how to harmonize technical and financial support related to M&E	14
10	Know how to use M&E guidance	13
11	Know how to gain political and financial support for M&E and reporting	11

1. Relevance of the workshop for my work?

high - medium - low

(27)

Comment:

- Gotten feedback on country reporting
- Shared experience

2. Relevance of topics (e.g. ART, PMTCT, HTC, HSS/PSM, others)

high - medium - low

(27)

Comment:

3. What were the top 3 sessions during the workshop I liked best?

Comment:

- Using routine data for impact assessment: (16)
- PMTCT: (10)
- Presentation of country experiences: (8)
- ART and cohort monitoring: (7)
- HSS/PSM: (7)
- HTC: (5)
- Market place: (4)
- Group work: (3)
- Presentation from USG on GHI: (2)
- Patient Monitoring systems: (1)

4. What were the 3 sessions during the workshop I liked least?

Comment: none: (21), PMTCT: (1), opening session: (1), IT: (1), ART (1)

5. What was missing in this workshop, or would have been more useful for me in my present position in order to strengthen the data quality in monitoring and reporting?

Comment: none: (20)

1. Time allocated for group work/practical session was minimal
2. The issue of the integration of HIV M&E into HMIS was not fully addressed to enable us to assist our countries to deal with this challenge
3. Data analysis and dissemination
4. The countries bottlenecks to be discussed in detail
5. More TA for queries and answers and working groups by country

6. Was the workshop instrumental in:

- team building within country team members? Yes No
(24) (2)
- useful exchange with participants from of other countries? Yes No
(27)
- useful exchange with external partners? Yes No
(23) (4)

7. Did the workshop allow me to reach the 3 outputs expected: (based on the concept note)

7.1 Acquiring improved know-how, and basic skills on the latest normative materials and tools?

fully - o.k. - not really
(10) (17)

Comment:

- We were given websites of where to access more information
- Needed more time with the resource person

7.2 Developing a brief practical, priority activities to strengthen monitoring and reporting on HIV response?

fully - o.k. - not really
(13) (14)

Comment:

7.3 Developing an advocacy plan to mobilize political and financial support for investment in to these activities and supporting necessary TA if needed?

fully - o.k. - not really
(6) (13) (7)

Comment:

- Could easily be done at country level
- There was not enough time to fully formulate this

8. I have a clear understanding of how the post workshop follow-up at country level for the activities I wish to pursue will take place and my role to support the implementation of those?

fully - o.k. - not really
(10) (13) (2)

Comment:

- No discussion or planning on this, however we will work on this
- 9. The tools presented in the market places have been very useful for me and my work**

fully agree - not really - no - did not participate the sessions
(24) **(2)** **(1)**

Comment:

- MMC and MERG tools should be incorporated in mandatory workshop time or provided as poster presentation
- MERG tools (II)
- IT workshop

10. I will use the tools and workshop results by promoting those in my own institution/ organization.

Yes - No - Need more knowledge on the tools
(25) **(2)**

11. In-depth training is further needed to be able to use the tools and workshop results.

Yes No
(23) **(3)**

12. Please give a rating for of each of the 4 days from 1 (not well structured and informative) to 5 (very well structured and informative).

Day 1 – Introduction	1 (1)	2 (2)	3 (11)	4 (7)	5 (6)
Day 2 – PMTCT	1	2 (1)	3 (5)	4 (16)	5 (5)
Day 3 – ART	1	2 (2)	3 (6)	4 (14)	5 (5)
Day 4 – HTC and PSM	1 (3)	2	3 (8)	4 (11)	5 (4)

13. The workshop overall facilitation was?

very good - good - needs improvement
(9) **(14)** **(2)**

Comment:

- The program was too congested,
- 5 days would have been better
- Need to brief chairs adequately
- Consultants not open and flexible, should synthesize what participants have discussed and not his own views and convictions

14. The administrative, logistics support during the workshop was?

very good - good - needs improvement
(13) (12) (2)

Comment:

15. The accommodation was

very good - good - needs improvement
(13) (13)

Comment:

16. The conditions (e.g. plenary room, working rooms, others) for the workshop?

very good - good - needs improvement
(14) (11) (2)

Comment:

17. What would you recommend to improve future 3-4 days workshops on monitoring and reporting on PMTCT, ART, HCT, PSM, etc. at regional/international level?

1. The time table should not be congested
2. Review the number of objectives
3. Reduce the presentations from countries, give more time for group work
4. Be more focused on critical issues
5. Invite other/additional partners involved in M&E
6. To maintain the number of days
7. Reduce the content to allow for more practical sessions
8. Increase the number of days to 5: IIIII
9. Air port shuttle
10. Allow time for people to visit the city
11. The workshop should not exceed 17^{oo} hours, it was very difficult to concentrate and be fully productive after nine hours: II
12. More time with resource persons
13. Participants should be informed well in time so that they would be better prepared for their presentation
14. Limit country presentation in plenary
15. More time for in death country group discussions to share solutions on M&E challenges, i.e. sharing how HIV-M&E can be integrated into the national HMIS
16. Materials for countries to bring should be communicated in good time
17. Allow some more time for relaxation
18. Send documents ahead of time and more focus on what needs to be promoted back home
19. Inclusion of how to determine staffing requirements at country level for effective M&E
20. Reduction of number of indicators, concentrate on those essential for UA reporting (overwhelmed staff)
21. More practical activities on data analysis and use
22. Decrease the number of presentations and give more time for country experiences and challenges

23. Focus on discussing and coming up with recommendations (concrete) for country challenges in preparing the reports

18. What would you recommend for future 3-4 days workshops on monitoring and reporting on PMTCT, ART, HCT, PSM, etc. at country level?

1. Before: identify the M&E issues
2. Involve people in charge of M&E at all levels and programme managers
3. Define next steps and ensure follow up and monitoring of the recommendations
4. A one week workshop will be more appropriate
5. Involvement of partners
6. Guidance on preparation should be shared with MoH (II)
7. Such capacity building workshop at country level will be very useful
8. Program officers for each component to be invited as there are not handled by one officer (II)
9. Specific issues on gaps identified should be focused
10. Principles and use of M&E
11. M&E tools
12. Reporting and feedback
13. Data collection be part of the works
14. Make sure that we avoid constant revision of data elements and indicators (tools, training packages have to be revised, staff to be retrained, ...)
15. TA need to support organizing a similar health sector HIV M&E workshop at country level
16. Consider involvement of other UN agencies key in the health sector response from country level (UNAIDS and UNICEF)

19. Other comments: _____ (use verso if needed)

- Thank you very much, we appreciate it was an extremely informative workshop
- Resource persons should continue communicating with focal people at country level so as to gather information about progress being made in implementation of action plans

Workshop Evaluation (summary at a glance)

27 (half from national authorities) of the 39 participants from the 13 countries have filled the post evaluation form.

All respondents felt that their personal and their country related expectations have been met by the workshop. They felt that the workshop itself and the selection of the content areas have been highly relevant for their work, especially by getting feedback from consultants and experts from WHO, UNAIDS, CDC, ... and sharing their experiences with colleagues from other African countries.

Especially the sharing of experiences and technical inputs provided by experts on the use of routine data for impact assessment, the different M&E tools presented via the 'market place', the country and technical presentations and discussion of new developments in the 4 main areas treated during the workshop (PMTCT, ART, HTC, HSS/PSM), the 3 interlinked M&E system have attracted attention and interest among all participants, contributing to the capacity strengthening intended by the workshop.

37% (fully agree) and 63% (o.k.) of the respondents say that the workshop allowed acquiring improved know-how, and basic skills on the latest normative materials and tools related to the monitoring of the health sector response to HIV.

48% (fully agree) and 52% (o.k.) say that they were able to develop a brief practical list of priority activities to strengthen monitoring and reporting on HIV response in their respective countries (although concretely only 1 country provided that plan at the end of the workshop).

As a consequence, the development of an advocacy plan to mobilize political and financial support for investment in to these activities and to support necessary TA was not achieved either due to time constraints (as an outcome of the group work) and a quite tight time schedule of the workshop.

More than 90% of the respondents have a clear idea how to ensure the follow up of the workshop results in their respective countries. But action and advocacy plans are still to be delivered.

The same percentage thinks that the tools presented and discussed in the 'market place' are very useful for their work and that they will use the tools and promote the workshop results in their respective countries. However, the same percentage expressed the need for further training to be able to use these tools and workshop results. Documentation and web sites were useful.

The majority of the participants (average 63%) feel that the workshop was well or very well structured. The first day and the last day of the workshop were slightly confusing for half of the participants. Comments given by the respondents indicate that the number of topics treated during the 4 days workshop was too high and chairs of the different plenary sessions were not all well prepared for this task as they were nominated spontaneously at the beginning of each morning .

More than 90% feel that the workshop facilitation was good or very good. The same results came out for administration and logistics support, accommodation and physical conditions for the workshop (plenary room, break out rooms, etc.)

Main recommendations for future workshops

Recommendations to improve future 3-4 days workshops on monitoring and reporting on PMTCT, ART, HCT, PSM, etc. at regional/international level

Workshop preparation

Participants should be informed well in time so that they would be better prepared for their presentation, materials for countries to bring should be communicated in good time, workshop documents should be sent ahead of time. Involve people in charge of M&E at all levels and program managers

Structuring of the workshop

The time table should not be congested or the number of days should be increased from 4 to 5 in order to allow more discussion, exchange between participants and more practical sessions with consultants. Allow time for people to relax or to visit the city. Site visits is also to be considered. Better time management (keep time and finish on time).

Specific content relevant issues

More time should be allocated to group work and for in depth country group discussions to share solutions on M&E challenges and issues, e.g. sharing how HIV-M&E can be integrated into the national HMIS. Emphasis could be given to the identification of staffing requirements at country level for effective M&E and to concrete recommendations for country challenges in preparing the progress reports on UA.

Recommendations for future 3-4 days workshops on monitoring and reporting on PMTCT, ART, HCT, PSM, etc. at country level

Workshop preparation

Share all preparatory issues with the MoH and consider involvement of UN agencies key in the health sector response at country level (WHO, UNAIDS and UNICEF), and other agencies (e.g. OGAC/ USAID/ CDC, and the GF). Identify the M&E issues focusing on gaps identified and ensure involvement and participation of partners. Invite program officers for each component as M&E is not handled by one officer.

Structuring of the workshop

Increase the number of days to 5 and focus on key principles and use of M&E, on M&E tools, data collection, reporting and feedback. More time for group work and practical sessions, exchanges, and less overload in the schedule. More practical activities on data analysis and use. Working groups: need better guidance on structure and expected outputs.

Follow up of the workshop

Define next steps and ensure follow up and monitoring of the recommendations and make sure that constant revision of data elements and indicators (e.g. tools, training packages have to be revised, staff to be retrained ...) be avoided for countries to improve the quality of reporting. Need to pursue this further with capacity-building cascade workshops at country level, including all cadres from lower to higher levels. Continue communication at country level about progress made in the action plans.

Annex F

COUNTRY ACTION AND ADVOCACY PLANS WORKSHEET

COUNTRY: _____

HIV PROGRAM (to specify): _____

PARTICIPANTS: _____

UPDATE OF : _____

For data sources: see Annex (following)

For instructions, please refer to:

- Workshop working groups: draft key questions (Annex 2, of "Country Instructions for the Preparation of the Workshop")
- Any specific questions/ instructions submitted for the specific program/ session
- FOLLOW-UP: to be validated at country level within 1 month, and follow-up (status of progress) at 3, and 6 months.

Follow-up Actions 2 or 3 urgent priorities	Due Date	Responsible	Sources of financing/ budget	Status of progress	Advocacy Plan	Due Date	Responsible	Status of progress
1.								
2.								
3.								
Others								
Long-term systems approach* with 2 or 3 actions								
1.								
2.								
3.								
Others								

* please use Concept module "Using a systems approach to long-term problem solving: Priorities in bottlenecks in systems approach", and you may consider here as well evaluation/ research question(s)

ISBN 978 92 4 150132 3



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