

Promising Practices to Build Human Resources Capacity in HIV Strategic Information

December 2009

The Capacity Project authors:

Wanda Jaskiewicz

Laura Fitzgerald

Linda Fogarty

Amanda Huber

Greet Peersman

Stephanie Schalk-Zaitsev

Reena Sethi

Maya Tholandi

Steve Yank



The views expressed in this document do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

ACKNOWLEDGMENTS

The Capacity Project team is grateful to the PEPFAR Monitoring and Evaluation Technical Working Group (TWG) for its guidance and support in the development of this resource. We give particular thanks to TWG member Tom Perdue of USAID/Washington for strategic insights and his persistence in mobilizing key informants. We would also like to express our sincere gratitude to the hundreds of individuals who contributed their valuable time to share their views and experiences and provide detailed information on promising practices via e-mail, phone and in person. This collection of promising practices for building human resources capacity in strategic information would not have been possible without their many thoughtful contributions.

The authors would like to acknowledge Udaya Thomas, Alishea Galvin and Emma Kofa Mtiro for their programmatic and technical support, as well as Susi Wyss, Jamie Wolfe, and Chris Klotschkow for designing, editing and formatting the collection of promising practices into an attractive and user-friendly resource. Claire Viadro provided further valuable editing and revision of the document.

We appreciate very much the time and attention the following individuals so generously committed to review and provide feedback:

- Tom Perdue, USAID
- Vanessa Brown, OGAC
- Elisa Ballard, USAID
- Laura Porter, CDC
- Lois Schaefer, USAID
- Estelle Quain, USAID
- Anne Wilson, The Capacity Project
- Jim McCaffery, The Capacity Project

TABLE OF CONTENTS

Acronyms	v
Executive Summary	viii
PART ONE: Narrative	1
Introduction	2
Promising Practices Documentation	6
Methodology	7
Results by HRH Action Framework Area.....	8
Conclusions and Recommendations	18
PART TWO: Promising Practices by HRH Action Framework Area	20
Planning a National HIV Strategic Information Management System in India	21
Other Notable Practice	22
Developing a New Cadre of Data Capturers in South Africa.....	24
Institutionalizing a New Cadre of Health Informatics Technicians in Ethiopia.....	26
Integrated Analysis and Advocacy in China	28
Establishing a Nongovernmental Organization Dedicated to Monitoring and Evaluation in Zanzibar	30
Virtual Leadership Development for Monitoring and Evaluation of Global HIV Programs.....	32
UNAIDS Initiative for Global Monitoring and Evaluation Human Resources Capacity-Building.....	34
Enhancing Surveillance through Field Epidemiology Training	36
Improving Understanding and Commitment to Monitoring and Evaluation at the Provincial Level in Vietnam.....	39
Partnerships to Strengthen Community-Based Monitoring and Evaluation Reporting System in Kenya.....	43
Other Notable Practice	45
The Positive Impact of Joint Missions on HIV Monitoring and Evaluation Partnerships.....	46
Mukuru on the Move: Geographic Information Systems Mapping of Community HIV Prevention in a Kenyan Slum	48
Partnerships for Effective Use of Geographic Information Systems Technology for HIV/AIDS Interventions in Africa	50
Strengthening Regional Monitoring and Evaluation Systems through Partnership in Ukraine.....	52
Enhancing HIV Surveillance and Decision-making across Sectors in Mozambique.....	54
Using Data Triangulation for Comprehensive Analysis in Vietnam.....	56
Strengthening Human Resources Financing Capacity in Peru	58
Funding of District AIDS Coordination Advisors for Monitoring and Evaluation in Zambia.....	60
Performance Support to Improve Health Management Information System in Uganda	62
Joint Supervision Missions and Training for District Monitoring and Evaluation Officers in Indonesia	64
Other Notable Practices.....	65

Developing a New Cadre of Monitoring and Evaluation Officers in Botswana	67
Other Notable Practices.....	69
University of Pretoria Short Course on Monitoring and Evaluation for HIV Programs	70
Other Notable Practices.....	71
Three-week Evening Certificate Course on Monitoring and Evaluation at the University of Zambia.....	72
World Health Organization Collaborating Centre for Capacity-Building in HIV/AIDS Surveillance in Croatia.....	74
Surveillance and Epidemiological Profile Training in Haiti.....	76
Building Skills in HIV/AIDS Management and Monitoring and Evaluation Skills of Program Managers in China	79
Geographic Information Systems Training for HIV/AIDS Health Professionals in Ethiopia.....	81
Regional Training to Improve Routine Health Information Systems Performance in Francophone Africa	83
Adaptation of a Regional Monitoring and Evaluation Training Course to the Kenyan Context	85
MSc in Health Monitoring and Evaluation in Ethiopia.....	87
Forums for Strengthening Routine Health Information Systems and Data Use.....	90
Other Notable Practices.....	91
Community-Owned Monitoring through the Use of Low-Literacy Tools in India.....	93
Progressive Courses to Advance Strategic Information Capacity in South Africa	95
Building Practical Program Evaluation Capacity from a Distance	97
Capacity-Building in Data Quality Assessments in Africa.....	99
Data Quality Assessment for PEPFAR-Funded Programs in South Africa.....	99
Training in Routine Data Quality Assessment in Kenya	99
Strengthening Monitoring and Evaluation Capacity through Data Quality Assessment in Tanzania...	100
References.....	102
Annex A: Self-Administered Nomination Survey	103
Annex B: Questions Found on Survey Monkey	104
Annex C: In-Depth Interview Guide.....	106
Annex D: Promising Practice Scoring Table*.....	108

ACRONYMS

AIDSTAR	AIDS Support and Technical Resources
AIMNET	HIV/AIDS Monitoring and Evaluation Network
APHIA	AIDS, Population and Health Integrated Assistance
ART	antiretroviral therapy
CACC	Constituency AIDS Control Committee
CBO	community-based organization
CDC	United States Centers for Disease Control and Prevention
CESAG	Centre Africain d'Etudes Supérieures en Gestion
CIDA	Canadian International Development Agency
COBPAP	community-based program activity reporting system
CSO	civil society organization
DACA	district AIDS coordination advisor
DASCO	district AIDS and STIs coordinator
DOH	Department of Health
DQA	data quality assessment
EIS	Epidemic Intelligence Service
ESI	Enhancing Strategic Information
FBO	faith-based organization
FETP	Field Epidemiology Training Program
GAMET	Global Monitoring and Evaluation Team
GAP	Global AIDS Program
GHWA	Global Health Workforce Alliance
GIS	geographic information systems
GPS	global positioning systems
HAF	HRH Action Framework
HFG	HIV-free generation
HISP	Health Information System Programme
HIT	health information technician
HIV	Human Immunodeficiency Virus
HMIS	health management information system
HPI	Health Policy Initiative
HR	human resources
HRH	human resources for health
HRMS	human resources management system
IBP	Implementing Best Practices
IRC	International Rescue Committee
I-TECH	International Training and Education Centers on HIV
M&E	monitoring and evaluation

MENTOR	Monitoring and Evaluation Network of Training Online Resources
MERG	Monitoring and Evaluation Reference Group
MESI	monitoring and evaluation system interface
MLG	Ministry of Local Government
MOE	Ministry of Education
MOH	Ministry of Health
MOTM	Mukuru on the Move
MSH	Management Sciences for Health
MTG	multisectoral technical group
NAC	National AIDS Commission
NACC	National AIDS Control Council
NACO	National AIDS Control Organization
NACP	National AIDS Control Program
NASTAD	National Alliance of State and Territorial AIDS Directors
NCAIDS	National Center for AIDS/STD Control and Prevention
NGO	nongovernmental organization
NIHE	National Institutes of Health and Epidemiology (Vietnam)
OGAC	Office of the Global AIDS Coordinator
PE	program evaluation
PEPFAR	President's Emergency Plan for AIDS Relief
PPMTP	Provincial Program Management Training Program
PRISM	performance of routine information system management
PSRI	Population Studies and Research Institute
RDQA	routine data quality audit
RHINO	Routine Health Information Network
RHIS	routine health information system
RRT	Resource Requirements Tool
SACS	State AIDS Control Societies
SDI	spatial data infrastructure
SI	strategic information
SIMU	Strategic Information Management Unit
TA	technical assistance
TSU	Technical Support Units
TWG	technical working group
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Programme
UNECA	United Nations Economic Commission for Africa
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNZA	University of Zambia

UPMB	Uganda Protestant Medical Bureau
USAID	United States Agency for International Development
USG	United States Government
VAAC	Vietnam Administration for HIV/AIDS Control
VLDP	Virtual Leadership Development Program
WHO	World Health Organization
ZAMEA	Zanzibar Monitoring and Evaluation Association
ZHAPMOS	Zanzibar HIV/AIDS Programme Monitoring System

EXECUTIVE SUMMARY

Countries addressing HIV epidemics must first lay the cornerstone for evidence-based planning and decision-making by gathering strategic information (SI) from national monitoring and evaluation (M&E) systems. While national governments and development partners have made significant progress toward building national HIV M&E systems to support an effective and efficient response to HIV, few countries have the human resources (HR) needed to comprehensively monitor and evaluate HIV programs. These organizations face a common challenge in locating the right people with the right skills and the organizational support to do their jobs well. One of the key lessons learned during the first phase of PEPFAR is that building national SI/M&E¹ capacity requires supportive human resources for health (HRH) policies, organizational and leadership development and individual technical capacity development.

As such, the PEPFAR M&E technical working group (TWG) asked the Capacity Project to identify and document promising practices to plan, develop and support national HR in HIV-related SI/M&E. This document adds to recent global M&E system strengthening guidance by compiling examples of promising approaches from a wide range of countries, and is intended for use in the creation of country plans to strengthen the workforce to support a fully functional, national M&E system to ensure strategic information for HIV/AIDS programming.

Promising practices have the potential to become *best* practices but are not yet supported by enough evidence as required to fulfill best practice criteria. We view the identification of promising practices as a critical first step toward closing the knowledge-to-practice gap and translating evidence into practice. The promising practices collected here, drawn from all regions of the world, cover the core components of SI (M&E; surveys and surveillance; and health management information systems, including geographical information systems) and span the six “action fields” of the *HRH Action Framework* (HAF). The HAF is a conceptual framework developed by the World Health Organization (WHO), the US Agency for International Development (USAID) and other development partners to assist HRH leaders and practitioners to develop and implement strategies to achieve an effective and sustainable health workforce (WHO, 2006). When applied to the SI/M&E arena, the six “action fields” of the HAF (policy, leadership, partnership, finance, human resource management systems and education) provide a comprehensive lens through which to strategically plan for and implement M&E workforce strengthening initiatives.

We collected “tried and true” promising practices as well as those that were new, innovative or little known outside their immediate setting. Using a modified snowball interviewing approach², we solicited promising practice nominations and names of experts, and contacted them directly through phone, e-mail and face-to-face meetings or indirectly through the RHINO and AIMNET online listservs. We ultimately contacted over 500 sources from a variety of

¹ Different terms are used to refer to the set of activities that make up a fully functional national-level system to track disease-specific information. Here we use the abbreviation SI/M&E to refer to the comprehensive set of strategic information activities included in developing and implementing M&E systems; establishing standardized surveillance and surveys; and building health management information systems, including geographic information systems.

² The snowball interviewing technique starts with key known informants from whom additional relevant informant names are collected. This continues until a sufficient list of relevant informants is obtained to serve the study’s purpose.

organizations and representatives (e.g., PEPFAR M&E TWG, host country institutions, international cooperating agencies, local nongovernmental organizations, civil society organizations, US government SI liaisons, UNAIDS M&E advisors). We also reviewed abstracts from the 2007 and 2008 PEPFAR Implementers' Meetings and noted relevant initiatives.

We initially collected over 150 promising practice nominations, and then culled this to a list of 50. Using in-depth field guides, we conducted in-person or telephone interviews with key informants representing each of the interventions on the reduced list. Using the data collected from the interviews, we scored each practice by considering whether its objectives had been achieved, the resources required for implementation, the extent of local ownership and replicability within country, as well as the potential for transferability to other countries. We used the scoring table as a guide to organize discussion about the practices and their merits. This process resulted in the final selection of 36 promising practices and 11 notable practices.

Our final list of practices shows a prevalence of interventions in the education action field. The partnership area has the second highest number of practices, illustrating the vital role of partnerships in strengthening HR for HIV-related SI/M&E. Although smaller in number, the few practices we include in each of the policy, leadership and HRMS action fields reflect the strides that some countries are making in these key areas. With only two entries, the finance section includes the smallest number of promising practices, perhaps because the general understanding of capacity-building often does not include a finance component.

The 36 promising practices included in the compendium provide ideas for those searching for solutions to M&E HR capacity-building challenges. By examining the experiences in detail, reviewing available results and supporting materials as well as considering the implementation context, users of the compendium may be able to identify approaches worth testing in their own countries. Implementers must select initiatives in alignment with national health priorities and strategic plans, guided by frameworks such as the HAF and the UNAIDS/M&E Reference Group (MERG) *Organizing Framework for a Functional National HIV Monitoring and Evaluation System*. While the list of practices in this compendium is by no means exhaustive or representative, it does provide an important starting point upon which to build a more comprehensive learning resource for human resources capacity building for effective HIV M&E systems and strategic information.

PART ONE: NARRATIVE

INTRODUCTION

Countries addressing HIV epidemics must lay the cornerstone for evidence-based planning and decision-making by first gathering strategic information (SI) from national monitoring and evaluation (M&E) systems. National governments and development partners have made tremendous progress toward achieving “the three ones”—one national HIV strategic plan, one national HIV coordinating authority and one national HIV M&E system—to support an efficient response to HIV. However, gaps remain, particularly in building comprehensive, national M&E systems that function across the national, subnational and service delivery levels (Peersman et al., 2009).

One of the key lessons learned during the first phase of PEPFAR is that building national SI capacity requires supportive human resources for health (HRH) policies, organizational and leadership development and individual technical capacity development. Moreover, the foundation and sustainability of a country’s HIV SI and national M&E system are heavily dependent on the availability and capacity of the implementing workforce. As development partners and national governments work to strengthen national M&E systems and the SI needed to inform HIV program planning, they face a common challenge in finding the right people with the right skills and the organizational support to do their jobs well. For example, only 5% of 66 countries surveyed reported having the human resources (HR) needed to adequately monitor and evaluate HIV programs (United Nations General Assembly Special Session, 2006).

For these reasons, the PEPFAR M&E Technical Working Group asked the Capacity Project to identify and document promising practices to “plan, develop and support” the individuals and teams working in HIV-related SI/M&E³. This document compiles examples of promising approaches or interventions from a wide range of countries that can be used by those creating country plans to strengthen the workforce to support a fully functional national-level M&E system and other SI activities for HIV⁴.

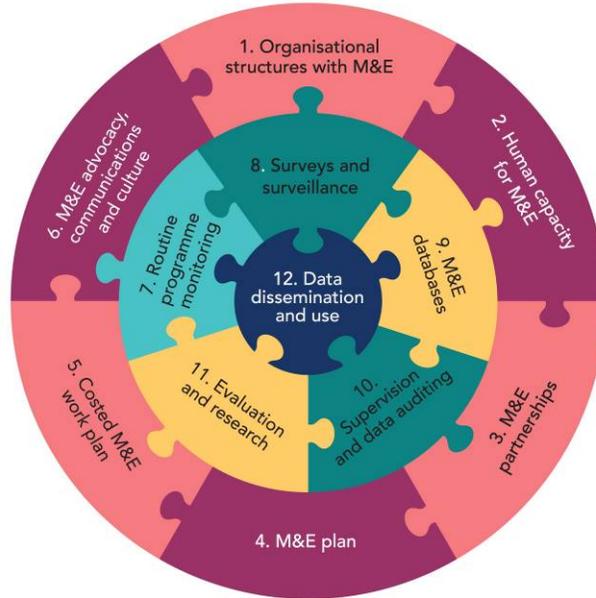
To guide national M&E system strengthening, country and development partners agreed on a common understanding of a functional national HIV M&E system, the *Organizing Framework for a Functional National HIV Monitoring and Evaluation System* (Joint United Nations Program on HIV/AIDS and Monitoring and Evaluation Reference Group [MERG], 2008). The framework describes 12 components necessary for a comprehensive, fully functional national M&E system. One of the components is human capacity for M&E (see Figure 1, component 2). Companion documents provide guidance and tools on how to assess and build M&E capacity within each of the 12 components of the system, including interventions at the system, organizational and individual levels, the different M&E positions needed at national, subnational and service-delivery levels and the specific competencies needed to ensure good job performance (Joint United Nations Program on HIV/AIDS and Monitoring and Evaluation Reference Group, 2009a, 2009b,

³ Different terms are used to refer to the set of activities that make up a fully functional national-level system to track disease-specific information. Here we use the abbreviation SI/M&E to refer to the comprehensive set of strategic information activities included in developing and implementing M&E systems; establishing standardized surveillance and surveys; and building health management information systems, including geographic information systems.

⁴ Although this collection focuses on M&E for HIV, the examples may be applied to other health areas.

2010). Together, these documents provide important guidance for countries building and maintaining comprehensive HIV-specific M&E systems.

Figure 1. Organizing Framework for a Functional National HIV M&E System: 12 Components



Source: *Joint United Nations Program on HIV/AIDS and Monitoring and Evaluation Reference Group, 2008*

Globally, the health sector has made concerted efforts over the last decade to address workforce gaps in low-resource settings, not just in the SI/M&E workforces, but in the entire health sector (Joint Learning Initiative, Global Health Workforce Alliance). The World Health Organization (WHO), the US Agency for International Development (USAID) and other development partners responded in 2006 with the development and publication of the *HRH Action Framework* (HAF), which offers a comprehensive approach for analyzing health-related human capacity challenges (WHO, 2006). The HAF was designed to assist HRH leaders and practitioners to develop and implement strategies to achieve an effective and sustainable health workforce. The HAF model conceptualizes six interrelated “action fields” (policy, leadership, partnership, finance, human resource management systems [HRMS] and education) within the phases of the action cycle (situational analysis, planning, implementation and M&E) that can provide focus and context for HR analysis and intervention (see Figure 2). Using a comprehensive approach, the HAF helps decision-makers address staff shortages, uneven distribution of staff, gaps in skills and competencies, low retention and poor motivation, among other challenges.

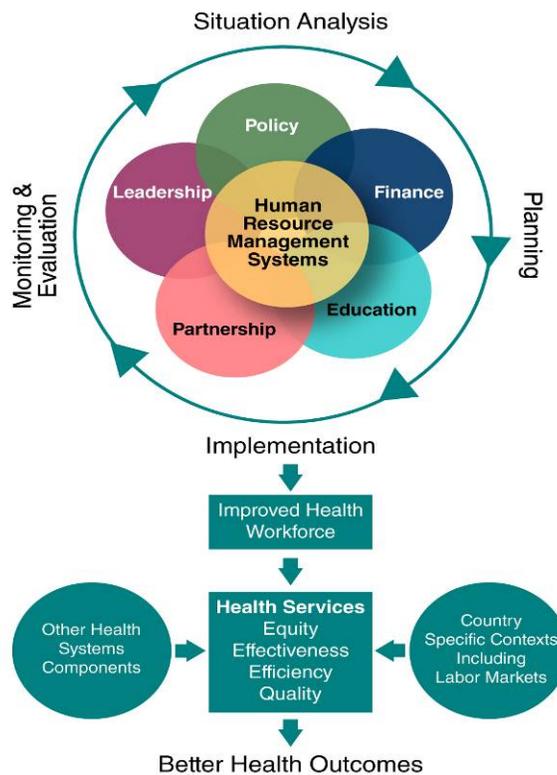
When applied to the SI/M&E arena, the six action fields of the HAF provide a comprehensive lens through which to view workforce strengthening initiatives. Most efforts to develop the M&E workforce have focused on the education action field. Typical interventions consist of workshops, short courses and pre-service and graduate programs. However, the other five action fields are also essential to support a well-functioning, sustainable national workforce. These include HRMS to support the staff, leadership to advocate for funding and priority

attention to M&E, policies and plans to guide strategic workforce development, financial planning to allow investments in workforce development and strategic partnerships to work across sectors and donors.

Purpose

The collection of practices presented here complements the work already done by the MERG and other groups that describes the components necessary for a fully functional M&E system, and the essential knowledge, skills and competencies for the M&E and SI-related workforce. The collected examples of how programs and countries have managed to build a workforce to run national M&E systems reflect a range of promising approaches—including innovative, new and untested approaches, as well as some that are well established and reliable. The collection encompasses examples from all SI components: M&E, surveys and surveillance, health management information systems (HMIS) and geographic information systems (GIS) as well as the HAF’s six action fields and all regions of the world.

Figure 2. HRH Action Framework



Source: HRH Action Framework

This document presents descriptions of 36 promising methods used to develop and maintain a strong workforce to support a fully functional national M&E system for SI on HIV. By examining these experiences, available results and supporting materials, and considering the implementation context, readers can identify approaches that may be worth testing in their own countries to meet workforce development needs. The examples are not intended to present the level of detail necessary for step-by-step replication, but rather to provide ideas for

those searching for solutions to SI/M&E-related HR capacity-building challenges. Interventions must be selected in alignment with national health priorities and strategic plans, guided by organizing frameworks such as the 12-component system and the HAF.

Intended Users

This compilation is intended for use by those involved in developing or strengthening M&E systems and other SI-related activities and solving identified workforce gaps, whether at the national, subnational or service delivery levels. This includes those in government responsible for developing multiyear strategic M&E plans and annual workplans for M&E implementation. Intended users also include US government country teams and staff of other development partners or international organizations supporting SI and national M&E system strengthening. The collection would also be of use to technical advisors from local, regional, and international institutions or organizations called upon by governments to help strengthen current M&E systems and other SI-related activities.

How to Use This Document

The document is divided into two parts. Part One provides a brief description of the methods used for identifying, selecting and summarizing the promising practices, and a general discussion of the findings. Table I in Part One lists the promising practices along with their HAF categorization, PEPFAR SI area and geographic region. Readers can use this table to find examples of particular interest (for example, practices used in Africa; interventions used to develop HR management systems; or interventions to strengthen surveillance).

Part Two presents descriptions of the promising practices, each produced as a stand-alone brief. A number of the promising practices case studies are supplemented with brief paragraph descriptions of additional related notable practices. The promising practices are organized by the six HAF categories and appear in the following order: policy, leadership, partnership, finance, HRMS, education. Each practice is color-coded with three tabs to represent HAF category, region and SI area, so that readers can quickly identify examples in their areas of interest. Each brief presents background information to set the context for the intervention, provides a description of the intervention, presents available outcomes (or initial results or early anecdotal information if the activity is a new or burgeoning activity) and states conclusions, lessons learned or recommendations for the approach. Each promising practice also provides contact information to allow interested readers to pursue deeper conversations for program development and implementation.

Some promising practices list “Supporting Materials Online⁵.” These can be found in an online resource, which is a companion digital collection of tools and additional information to support implementation of individual approaches. Supporting materials include training curricula, training schedules and outlines, supervision guides and checklists, performance support assessment tools, training evaluation forms and reports. The online resource is hosted on MERG’s Global HIV M&E Information website at http://www.globalhivmeinfo.org/CapacityBuilding/Pages/SI_HR_PromisingPractices.aspx

⁵ Resources and supporting materials could not be obtained for public sharing online for all promising practices.

Please note that this document **does not** provide an inventory of all SI/M&E workforce-strengthening efforts or a representative sampling of that work, and is not intended as a showcase for country or program capacity in general in relation to their M&E systems, their ability to manage and report on HIV data, conduct surveys or surveillance or other SI-related functions. Nor does it address the broader area of capacity-building, such as developing organizational structures or strengthening infrastructures necessary to support M&E systems. Instead, the compendium is intended to elicit the activities, interventions or strategies being used to build “human” capacity for SI/M&E. This document focuses on ways to develop the capacity of the individuals and teams needed to run a national M&E system and carry out SI-related activities, and provides wide-ranging examples of HR strengthening activities, particularly those available in low-resource settings.

PROMISING PRACTICES DOCUMENTATION

The Implementing Best Practices (IBP) initiative, established in 2005 by the WHO, USAID and the United Nations Population Fund (UNFPA), seeks to analyze existing programs against established criteria, so that evidence-based best practices can be reliably differentiated from other, less successful practices (IBP, 2009). Identifying best practices requires a close examination of program-related data to ensure a causal link between a given intervention and positive outcomes. Ultimately, through the replication of best practices, new programs can avoid prolonged, isolated trial-and-error approaches toward program development. Sharing best practice strategies results in cumulative benefits for all groups working toward the same goal.

In the absence of universal definitions that distinguish best practices from promising practices, there is a need for a commonly understood classification system. Supported by the highest level of evidence, best practices are considered the “gold standard.” They are defined as specific sets of actions exhibiting quantitative and qualitative evidence of success as well as demonstrated abilities to be adapted, transferred and replicated (Advance Africa Best Practices Compendium, 2009).

Even though the ultimate aim of health care programming is to scale up *best practices*, in the absence of solid evidence to establish a set of best practices in a given area, it is also useful to promote strategies with best practice potential. Innovations that fall into this latter category are termed *promising practices*. Promising practices are not supported by enough evidence-based data required to fulfill best practice criteria—perhaps because these practices are still young and cannot show the consistent positive results over time that are needed to garner best practice status or have not been consistently documented or evaluated. Even so, promising practices have a role to play in moving toward quality, efficient and effective service delivery. Identifying promising practices is a critical first step toward cultivating communities of practice to create, share and apply knowledge within and across professional fields to improve practice. For these reasons, the term *promising practices* is the most appropriate for the examples presented in this document.

METHODOLOGY

Process

The team cast a wide net to collect promising practices that were both “tried and true” as well as those that are new, innovative or may not yet have been well-tested or widely publicized. During the first phase of this activity, team members employed several techniques to gather promising practice nominations. These included contacting key people from the PEPFAR M&E TWG, USAID, the US Office of the Global AIDS Coordinator (OGAC), the Centers for Disease Control (CDC), MERG, and the Global Monitoring and Evaluation Team (GAMET) to solicit their initial nominations of practices as well as recommendations of key experts in the SI/M&E field to contact for suggestions of effective interventions. The project team particularly targeted in-country US government SI liaisons and UNAIDS M&E advisors in PEPFAR focus and non-focus countries to learn more about promising practices applied in a range of countries. Many PEPFAR partners such as host country institutions, international cooperating agencies, local NGOs and civil society organizations contributed nominations as well. In total, the team communicated with over 500 individuals via phone, e-mail and face-to-face meetings. Conversations were open-ended; the intention was to gather an extensive list of potential promising practices, along with brief descriptions, that could be explored in more depth during the second phase of information gathering and selection of practices for inclusion in the final document. Individuals also offered promising practice nominations via an online survey advertised on the RHINO and AIMNET listservs (see Annex A: Self-Administered Nomination Survey). Lastly, Capacity Project team members reviewed abstracts from the 2007 and 2008 PEPFAR Implementers’ Meetings and noted relevant initiatives. These collection strategies resulted in over 150 promising practice nominations.

The project team culled this to a list of about 50 by considering each practice’s relevance and outcomes; distribution of practices across the HAF action fields, PEPFAR SI areas, and geographic regions; and completeness and triangulation of information. Using an in-depth questionnaire (see Annex B) to capture similar information across all practices, team members then interviewed key informants for each promising practice. Interviews were conducted by phone or in person. In many cases, the original key contacts referred interviewers to additional informants with greater knowledge about implementation of the promising practice, or partners whose perspective would assist the interviewer to better understand the practice. In instances where a country had several promising practices to pursue, a field visit was considered. Over the course of the activity, team members traveled to Ethiopia, Kenya, Zambia and South Africa to gather information.

During the data gathering phase, key informants also gave permission to post supporting documents, tools and other resource materials to the Online Resource that serves as a companion to this compendium. The Online Resource is intended for use by individuals and programs interested in implementing a given practice. Unfortunately, the team was not able to obtain supporting resources for all practices.

To further refine the selection of promising practices included in this collection, the team developed a scoring table (see Annex C) that considered the practices according to the

following criteria: objectives achieved, resources required, local ownership, replicability within country, and transferability to other countries⁶. This scoring table was used to stimulate and guide discussion about the different promising practices (based on notes from the in-depth interviews) as opposed to dictating selection of a practice based on total score. For example, a practice that had not yet been replicated or one that relied on external resources might receive a low score yet be included in the compilation because it represented a new and innovative strategy. In making the final selection, the team reevaluated the practices within the context of the other practices within the same HAF category to avoid duplication. This process resulted in the selection of 36 promising practices that are documented in full form here, as well as 11 “other notable practices” documented in shorter form.

Limitations

We recognize there are potentially many more promising practices being implemented around the world that would have been suitable for inclusion in this document. However, the nature of the data gathering process presented us with some limitations. First, the snowball interviewing technique does not elicit an exhaustive search, but instead depends on the appropriateness of the contact recommendations given and the response rate of individual contacts. The dependence on self-reporting as well as the lack of access to relevant informants, documents, reports and proceedings from meetings or conferences limited the amount of information and the number of additional practices we could pursue.

RESULTS BY HRH ACTION FRAMEWORK AREA

Because many people outside the HRH strengthening sector may be unfamiliar with the HAF, this section presents a definition of each of the six action fields and relates them to the SI/M&E arena. We have also included a brief description of the various practices corresponding to each of the HAF components. A full listing of the 36 promising practices and 11 other notable practice mentions, categorized by HAF action field and PEPFAR SI area as well as their geographic region, is presented in Table I. The more detailed descriptions of each promising practice are included in Part Two of this document.

⁶ The team used an AIDSTAR ONE GSP Rating Form as a model and modified as necessary.

Table I. Promising Practices Categorized by HAF Action Field, SI Area and Geographic Region

#	Name of Practice	HAF Area						SI Area				Region				
		Policy	Leadership	Partnership	Finance	HRMS	Education	M&E	Surveillance	GIS	HMIS	Africa	Asia	Americas	Eastern Euro	Global
1	Planning a National HIV Strategic Information Management System in India	♦						♦					♦			
1A	Operationalizing Monitoring and Evaluation in Guyana: Strengthening the National Response to HIV	♦						♦						♦		
2	Developing a New Cadre of Data Capturers in South Africa	♦						♦				♦				
3	Institutionalizing a New Cadre of Health Informatics Technicians in Ethiopia	♦								♦		♦				
4	Integrated Analysis and Advocacy in China	♦							♦				♦			
5	Establishing a Nongovernmental Organization Dedicated to Monitoring and Evaluation in Zanzibar		♦					♦				♦				
6	Virtual Leadership Development for Monitoring and Evaluation of Global HIV Programs		♦					♦								♦
7	UNAIDS Initiative for Global Monitoring and Evaluation Human Resource Capacity-Building		♦					♦								♦
8	Enhancing Surveillance through Field Epidemiology Training		♦						♦							♦
9	Improving Understanding and Commitment to Monitoring and Evaluation at the Provincial Level in Vietnam		♦					♦								♦
10	Nongovernmental Organizations as Partners in Monitoring and Evaluation Capacity-building in Ukraine		♦					♦						♦		
11	Partnerships to Strengthen Community-based Monitoring and Evaluation Reporting System in Kenya			♦				♦				♦				
11A	Joint Supervision of Decentralized Monitoring and Evaluation Staff in Zambia			♦				♦				♦				
12	The Positive Impact of Joint Missions on HIV M&E Partnerships			♦				♦				♦				
13	Mukuru on the Move: GIS Mapping of Community HIV Prevention in a Kenyan Slum			♦						♦		♦				
14	Partnerships for the Effective Use of GIS Technology for HIV/AIDS Interventions			♦						♦		♦				
15	Strengthening Regional Monitoring and Evaluation Systems through Partnership in Ukraine			♦				♦						♦		
16	Enhancing HIV Surveillance and Decision-making across Sectors in Mozambique			♦					♦			♦				
17	Using Data Triangulation for Comprehensive Analysis in Vietnam			♦					♦				♦			

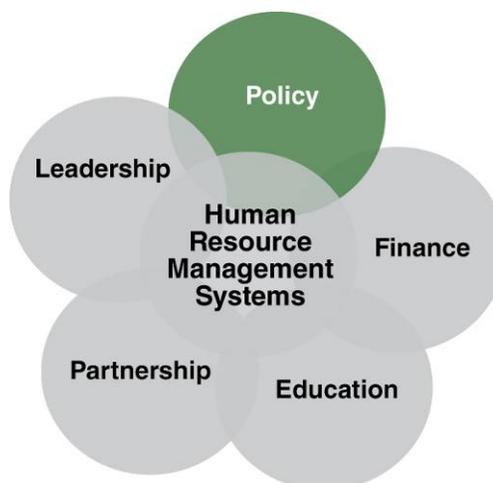
#	Name of Practice	HAF Area						SI Area				Region				
		Policy	Leadership	Partnership	Finance	HRMS	Education	M&E	Surveillance	GIS	HMIS	Africa	Asia	Americas	Eastern Euro	Global
18	Strengthening Human Resources Financing Capacity in Peru				♦			♦						♦		
19	Funding of District AIDS Coordination Advisors for Monitoring and Evaluation in Zambia				♦			♦				♦				
20	Performance Support to Improve HMIS in Uganda					♦			♦			♦				
21	Joint Supervision Missions and Training for District Monitoring and Evaluation Officers in Indonesia					♦		♦					♦			
21A	Supportive Supervision of HIV Monitoring and Evaluation Staff in Haiti					♦		♦		♦			♦			
21B	Mentoring and Supervision for Community Reporting in Zanzibar					♦		♦				♦				
22	Developing a New Cadre of Monitoring and Evaluation Officers in Botswana					♦		♦		♦						
22A	Hiring Nationwide Monitoring and Evaluation Staff in Rwanda					♦		♦				♦				
22B	Recruiting Monitoring and Evaluation Staff at Multiple Levels in Ethiopia					♦		♦				♦				
22C	Development of Monitoring and Evaluation Job Descriptions in Viet Nam					♦		♦					♦			
23	University of Pretoria Short Course on Monitoring and Evaluation for HIV Programs							♦				♦				
23A	Development of Regional Monitoring and Evaluation Training Capacity							♦								♦
23B	Nationally Accredited Monitoring and Evaluation Course in Botswana							♦				♦				
24	Three-week Evening Certificate Course on M&E at the University of Zambia							♦				♦				
25	WHO Collaborating Centre for Capacity Building in HIV/AIDS Surveillance in Zagreb, Croatia								♦					♦		
26	Surveillance and Epidemiological Profile Training in Haiti								♦				♦			
27	Building Skills in HIV/AIDS Management and M&E Skills of Program Managers throughout China							♦	♦				♦			
28	Geographic Information Systems Training for HIV/AIDS Health Professionals in Ethiopia									♦			♦			
29	Regional Training to Improve Routine Health Information Systems Performance in Francophone Africa											♦				
30	Adaptation of a Regional Monitoring and Evaluation Training Course to the Kenyan Context							♦				♦				
31	MSc in Health Monitoring and Evaluation in Ethiopia							♦				♦				

#	Name of Practice	HAF Area						SI Area				Region				
		Policy	Leadership	Partnership	Finance	HRMS	Education	M&E	Surveillance	GIS	HMIS	Africa	Asia	Americas	Eastern Euro	Global
32	Forums for Strengthening Routine Health Information Systems and Data Use						♦				♦					♦
32A	Listserv for USG-funded Program M&E Officers in Kenya						♦					♦				
32B	Online Monitoring and Evaluation Training Resources (MENTOR) from MEASURE Evaluation						♦									♦
33	Community-Owned Monitoring through the Use of Low-Literacy Tools in India						♦						♦			
34	Progressive Courses to Advance Strategic Information Capacity in South Africa						♦					♦				
35	Building Practical Program Evaluation Capacity from a Distance						♦									♦
36	Capacity-building in Data Quality Assessment in South Africa and Kenya						♦					♦				

POLICY

The policy action field is defined as the “legislation, regulations and guidelines for conditions of employment, work standards, and development” of the workforce. In the case of the **health** workforce, the policy action field includes interventions related to developing professional standards, licensing and accreditation; authorized scopes of practice for health cadres; political, social and financial decisions that affect HRH; and employment law and rules for civil service and other employers.⁷

These policy-related intervention areas are equally relevant to the SI/M&E workforce. Countries embarking on strategic HR development typically start by creating HR strategic plans. The plans assess current resources, specify the desired number and distribution of SI/M&E-related workers and identify the type of workers and skills needed at the national, subnational and service delivery levels.



Several documents provide guidance on managing the strategic planning process for HIV M&E efforts. First, according to the UNAIDS/MERG 12-component *Organizing Framework for a Functional National HIV Monitoring and Evaluation System*, countries require a national multisectoral HIV M&E plan and an annual costed national HIV M&E workplan—both of which include capacity-building strategies (UNAIDS, 2008). The *Guidance on Capacity Building for HIV Monitoring and Evaluation* (UNAIDS, 2009) and the 12 components M&E system strengthening tool (UNAIDS, 2009) are aligned with the *Organizing Framework*, and describe who should be involved in planning for capacity-building, what interventions or strategies should be considered and how to use the results of capacity assessments. The *Capacity-Building Guidance* also lists knowledge, skills and competency requirements for M&E positions at the national, subnational and service delivery levels, which are further specified for M&E leadership positions in the *Standards for a Competency-Based Approach to M&E Curricula and Training* (UNAIDS, 2010).

In some instances, action fields of the HAF may overlap with one another. This is the case with the policy action field and the human resource management systems (HRMS) action field. For example, policies or guidelines that identify scopes of practice provide information necessary for job descriptions, which are considered an element of a strong HRMS. Similarly, policies that make provisions for clear career ladders strengthen HRMS. Ideally, however, the policies and plans also stand alone as a coherent set of strategic ideas that focus on the broad goal of strengthening the entire system.

At the country level, policy support for SI/M&E HR has received less attention than, for example, training. Nonetheless, the promising practices described in the policy action field include dynamic examples of policy-related work in SI/M&E HR capacity-building, such as:

⁷ <http://www.capacityproject.org/framework/policy/>
Promising Practices to Build Human Resources Capacity in HIV Strategic Information

- In India, the national government and a wide range of partners engaged in a high-level strategic planning process to create a comprehensive, multisectoral SI management system for HIV based on the 12-component *Organizing Framework* and aligned with “the three ones.” The strategic plan resulted in provisions for staff—including epidemiologists, SI officers and M&E specialists—at the national and subnational levels, and availability and use of high quality data for annual action planning for each state.
- The summary from South Africa provides an example of more focused planning to improve an identified M&E system gap. South Africa developed a plan to use available human resources to recruit, train, deploy and support data capturer interns and, eventually, to transfer responsibilities to provinces and districts.
- Ethiopia also created a new cadre of health informatics technicians to meet M&E system needs. The project involved delineating terms of service, job descriptions and salary structure and developing a training curriculum that culminates in technicians’ licensure.

LEADERSHIP

The HAF defines the leadership action field as the “capacity to provide direction, align people, mobilize resources and reach goals; management includes capacity to plan, budget, organize, and guide people to achieve results.” Interventions specific to the leadership action area include: supporting HRH champions and advocates; building the capacity for leadership and management at all levels; enhancing the capacity to lead multisectoral and sector-wide collaboration; and strengthening professional associations to provide leadership among their constituencies.⁸



Effective leadership in key organizations at the national, subnational and service-delivery levels is necessary for an effective HIV M&E system (UNAIDS/MERG, 2008). The promising practices we highlight in this series illustrate some of the ways that countries are beginning to focus on SI/M&E-related leadership development, including:

- In Zanzibar, dedicated and motivated M&E professionals formed their own nongovernmental organization (NGO)—the Zanzibar Monitoring and Evaluation Association (ZAMEA)—to share their collective knowledge and build M&E capacity.
- The Virtual Leadership Development Program (VLDP) for M&E of HIV programs provides an example of an intervention that reaches beyond national boundaries to enhance the effectiveness of M&E teams worldwide, using online and remote trainings and exercises.
- UNAIDS has played a leadership role in a global effort dedicated to developing a systematic competency-based approach to M&E training and standards for M&E training

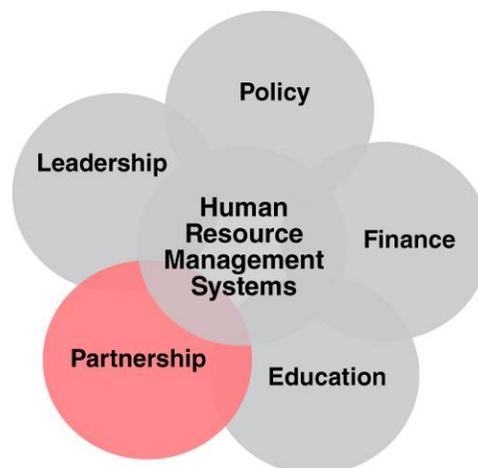
⁸ <http://www.capacityproject.org/framework/leadership/>
Promising Practices to Build Human Resources Capacity in HIV Strategic Information

curricula. The tools developed under this initiative will help unify M&E capacity-building efforts worldwide.

PARTNERSHIP

The HAF recognizes the importance of the partnership action field in countries facing HRH shortages. Where resources are limited, stakeholders across various sectors must link together and work cooperatively to maximize the use of those resources. Partnership interventions can be both formal and informal, and may include: interministerial committees; health worker advisory groups; donor coordination groups; public-private sector agreements; or community involvement in care, treatment and governance of health services.⁹

The UNAIDS/MERG 12-component framework illustrates that the formation of partnerships “to plan, coordinate, and manage the HIV M&E system” is a key component of HR capacity-building. The partnerships may include both domestic and international stakeholders. The document further states that “to ensure that these partnerships become a practical part of the M&E system, it is important to establish a national M&E technical working group (TWG); develop a mechanism to coordinate stakeholders; establish communication channels among stakeholders; and define local leadership and capacity for stakeholder coordination.”



Partnerships must use a variety of mechanisms to be successful. Moreover, partnerships (like any relationships between individuals or organizations) require ongoing attention and support to promote change and make progress toward defined objectives. Although the establishment of a national M&E TWG is a key first step, the group is only useful if it meets regularly and serves a specific purpose. It is this commitment to a shared purpose that is most likely to guarantee a positive impact.

Real-world examples can help translate well-reasoned, but sometimes unrealistic, ideals into practice. The partnership promising practices included in this compendium illustrate ways in which partnerships can play vital roles in strengthening HR for HIV-related SI/M&E. Some examples include:

- In Kenya, the National AIDS Coordinating Committee called upon the collective knowledge and contributions of donors, government bodies and implementing partners to revise their community-based program activity reporting system, an M&E system that thrived only after these groups came together to design and support it.
- A notable practice in Zambia involved joint supervision of decentralized M&E staff to avoid duplication of efforts. The Zambian government, UNAIDS and US government (USG)-funded partners shared resources to conduct supportive supervision visits, resulting in increased M&E reporting.

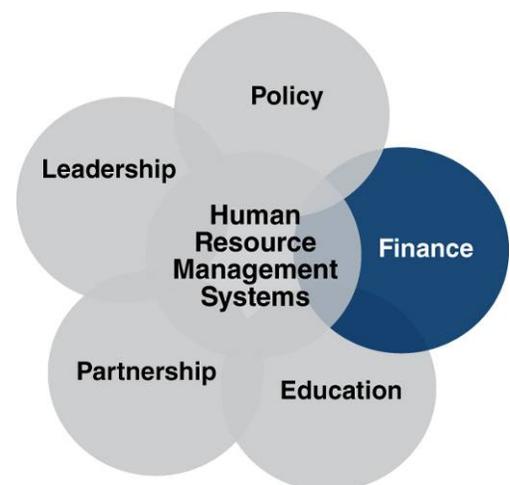
⁹ <http://www.capacityproject.org/framework/partnership/>
Promising Practices to Build Human Resources Capacity in HIV Strategic Information

- When multiple partners provided M&E technical assistance (TA) within the same country, partnerships among these organizations prevented fragmentation of efforts and promoted efficiency toward strengthening the national M&E system. To this end, key partners working in East and Southern Africa created joint missions for M&E TA.
- Mukuru on the Move, a project focused on community mapping in an urban Kenyan slum, served as an example of effective public-private partnerships.
- USG and UN donors convened a meeting of health and mapping sector experts from 30 African nations to maximize partnerships between these two fields. The workshop strengthened the ability of the two sectors to collaborate and share resources in the application of GIS to HIV/AIDS interventions.

FINANCE

The finance component of the HAF is described as “obtaining, allocating and disbursing adequate funding for human resources.” Areas of financial intervention for the health workforce include:

- Setting levels of salaries and allowances
- Budgeting and making projections for HRH intervention resource requirements, including salaries, allowances, education and incentive packages
- Increasing fiscal space and mobilizing financial resources (e.g., government, Global Fund, PEPFAR, donors)
- Using data on HRH expenditures (e.g., National Health Accounts)¹⁰



According to the UNAIDS/MERG *Guidance on Capacity-Building for HIV Monitoring and Evaluation* (2009), much of the responsibility for capacity-building efforts in the area of finance is housed at the systems and organizational levels. The 12-component *Organizing Framework for a Functional National HIV Monitoring and Evaluation System* (UNAIDS, 2009) also specifies that an important performance goal for a functional system is to “develop an annual costed national M&E workplan, including the specific and costed HIV M&E activities of all relevant stakeholders and identified sources of funding.” This goal can help ensure that adequate human, physical and financial resources are committed to implementation of the M&E workplan.

For ease of categorization and to avoid repetition within this document, the promising practices related to development and costing of national M&E plans are included under the HAF’s policy section. Our global scan to identify other capacity-building efforts and interventions within the broad context of finance for the SI/M&E-related workforce yielded limited examples, perhaps because the common understanding of capacity-building often does not include a finance component. We include two promising examples of finance-focused interventions:

¹⁰ <http://www.capacityproject.org/framework/finance/>

- In Peru, the Ministry of Health initiated a course to develop skills in costing and financing for the health sector. Participation in the course prepared health managers to test a new tool to determine the costs of implementing the country’s newly adopted universal health care package. Although the course was targeted to the health sector as a whole, the model has relevance for building finance-related capacity for HIV M&E systems.
- The other promising practice fits within the traditional scope of the Finance component of the HAF. It describes the funding of a cadre of professionals to carry out M&E duties at the district level in Zambia through a pooling of resources by different agencies.

HUMAN RESOURCE MANAGEMENT SYSTEMS

Efficient and strong human resource management systems (HRMS) are critical in efforts to ensure overall HRH performance and service quality. The HRMS action field is defined as “the integrated use of data, policy and practice to plan for necessary staff, [and to] recruit, hire, deploy, develop and support health workers.” The HRMS component of the HAF is influenced to some degree by all five of the other action fields. Interventions to strengthen HRMS generally focus on: recruitment, hiring and deployment; work environment and conditions; job satisfaction and career development; and different facets of performance management, including performance appraisal, supervision and productivity.¹¹



In the definition of the HRMS action field, the term “health workers” encompasses not only those who provide direct health-related services to clients but also those who carry out SI/M&E responsibilities. These staff need a sound HRMS to support them in performing well to deliver complete and accurate data for decision-making in the area of HIV/AIDS. The UNAIDS/MERG 12-component *Organizing Framework for a Functional National HIV Monitoring and Evaluation System* (2009) advocates for HRMS elements such as job descriptions and defined career paths for M&E staff, as well as routine supervision visits, including data assessments and feedback to local staff. These elements are important for ensuring organizational structures with HIV M&E functions (Component 1), developing human capacity for HIV M&E (Component 2) and providing supportive supervision and data auditing (Component 10).

Our scan for promising and notable capacity-building practices related to HRMS encompassed the broad array of interventions described by the HAF. Within these broad parameters, we identified a number of countries making strides in implementing various HRMS components to benefit M&E staff and the work they do. Some examples are:

- Two interventions focus on providing supportive supervision and mentoring for M&E staff. Mechanisms include a performance support approach in Uganda and joint supervision missions with finance and program staff in Indonesia.

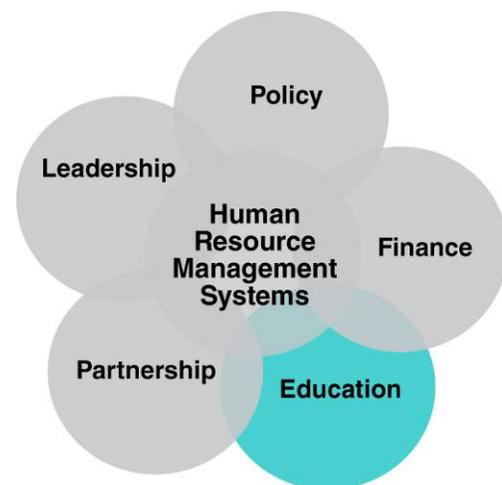
¹¹ <http://www.capacityproject.org/framework/hr-management-systems/>
Promising Practices to Build Human Resources Capacity in HIV Strategic Information

- Three notable practices (in Haiti, Zanzibar and Kenya) center on supervision and mentoring of community-based organizations to strengthen community-based HIV M&E reporting systems.
- A series of practices in Africa showcases the recruitment of new cadres dedicated to supporting HIV M&E efforts in their respective countries, including M&E officers in Botswana, data managers in Rwanda and data clerks in Ethiopia.
- In Vietnam the M&E Technical Working Group focused on the development of job descriptions and minimum competencies and standards for M&E staff at different levels of the health system.

EDUCATION

The education action field is described as the “production and maintenance of a skilled workforce.” Interventions specific to the education action area include “pre-service education tied to health needs, in-service training (e.g., distance and blended, continuing education), increasing the capacity of training institutions, and the training of community health workers and non-formal care providers.”¹²

The UNAIDS/MERG *Organizing Framework for a Functional National HIV Monitoring and Evaluation System* suggests that building and maintaining human capacity for HIV M&E requires “in-service training, mentoring, as well as standard curricula for organizational and technical capacity building.”



Within the context of strengthening HR in HIV SI/M&E, interventions in the education action field were the most prevalent among all of the promising practices. The promising and notable practices in the education area were categorized into one of the following five categories:

- **Certificate courses/short courses:** The vast majority of promising practices in education were certificate courses or short courses. Many of these focus on the fundamentals of M&E, including the two-to-three-week courses at the University of Pretoria, MEASURE Evaluation’s short courses offered globally with regional partners, a nationally-accredited M&E course in Botswana, and an evening certificate course in Zambia. Others focus on surveillance and epidemiology: the WHO Collaborating Centre for Capacity Building in HIV/AIDS Surveillance in Zagreb, Croatia; surveillance and epidemiologic profile training in Haiti; and an HIV surveillance/epidemiology fellowship program in China. Two more specialized short courses include a geographic information systems (GIS) course for HIV/AIDS professionals in Ethiopia and a course designed to strengthen existing routine health information systems in Francophone Africa. In addition, one of the promising practices is a regional M&E course adapted to a national context, in this case to Kenya.

¹² <http://www.capacityproject.org/framework/education/>
Promising Practices to Build Human Resources Capacity in HIV Strategic Information

- **Postgraduate training:** While many training programs lead to a certificate, the one-year program at Jimma University, Ethiopia leads to an MSc in M&E.
- **Distance education/remote learning:** Three instances of remote learning are included in the education section of the HAF. The RHINO forum on data quality assurance was an online forum of global M&E professionals interacting with one another to improve their knowledge of data quality approaches. Similarly, in Kenya, a listserv on M&E connects professionals across the country and supports information exchanges and dissemination. And finally, MENTOR (Monitoring and Evaluation Network of Training Online Resources) makes available free training materials and tools on M&E, including a self-instructional interactive mini-course on M&E fundamentals.
- **Training in use of low-literacy data collection tools:** An innovative promising practice from India details how peer educators were trained to gather data using low-literacy data collection tools that use pictorial representations of services to track their day-to-day outreach activities.
- **Data quality assessment trainings:** Training courses specific to data quality assessment (DQA) are another type of education intervention. Three DQA trainings in South Africa, Kenya, and Tanzania that incorporated supportive supervision or mentoring are highlighted in this section.

CONCLUSIONS AND RECOMMENDATIONS

When most people hear the term “capacity-building,” they think of training or other knowledge and skills-building events. Additionally, the bulk of work in capacity-building has focused specifically in these areas. Thus, we found it difficult to broaden thinking beyond the education sphere when seeking nominations and pursuing in-depth data gathering.

However, by using interviewing techniques that probed the other HAF action fields and explored components of a comprehensive M&E system beyond routine monitoring and data reporting, we were able to uncover practices in each HAF and SI area. Likewise, we took efforts to represent a wide geographical sphere. Given a focus of donor-funded HIV programs, this logically means that the majority of the practices are implemented in Africa.

Overall, as the compendium of practices in Part Two of this document illustrates, countries use multiple and varied means to build human resources capacity to develop and strengthen effective M&E systems and SI for their HIV programs. The HAF provides a useful framework to demonstrate the importance of strengthening partnerships, promoting leadership, developing supportive policies, ensuring adequate and focused financing and strengthening HR management systems in order to build and support a highly functioning M&E workforce. The framework provides a wide lens through which one can define capacity-building in broad terms that go beyond training events. The education component for skills and knowledge development is undoubtedly critical, yet knowledgeable and skilled SI/M&E staff alone will not bolster a nation’s HIV information base for improved decision-making.

Instead, a full complement of favorable policies—such as India’s development of a national M&E system—are necessary to ensure SI/M&E is a priority and to plan for sufficient staff to undertake SI/M&E activities as described for South Africa and Ethiopia. This may require working in partnership with global and local counterparts to finance a new cadre of M&E staff,

Promising Practices to Build Human Resources Capacity in HIV Strategic Information

as was the case in Zambia. Too, a country must ensure that a comprehensive HRMS provides the support that M&E staff needs to perform well in their jobs through supportive supervision and mentoring, as seen in Uganda and Indonesia. Having highly skilled professionals in the field of SI/M&E is, of course, a very important ingredient to a functional national HIV M&E system. The university courses in Ethiopia and South Africa, and the short courses and training workshops in Vietnam and China, to name a few, are well considered.

While these are just a small sample of practices included, the compendium provides a range of tried and true—as well as new and innovative—activities or interventions that program developers and decision-makers can adapt or adopt to build their institution's SI/M&E workforce. We recommend that program planners, developers and other decision-makers contact the organization for further information if a promising practice appears feasible and relevant to their specific context; too, we suggest perusing the available supporting materials in the companion online resource library to prepare for adaptation and implementation. The UNAIDS/MERG *Organization Framework* and guidance document describing the competencies and capacity-building approaches for strengthening M&E human resources can be useful guides when transferring a practice or intervention to another country or institution. We note that it is important to ensure the effectiveness of the adapted practice by establishing a sound implementation monitoring system during the design and development phase.

As some of the practices are scaled up or adapted/adopted for use in other countries or regions, we suggest that this collection be updated to include the results of additional applied practices. We also recommend more systematic and rigorous evaluations to compile the evidence that will grow the practice from a promising one to a best practice. Best practices should be revisited regularly to see how they are sustained over time. Likewise, with the increased focus on HIV SI/M&E and the more unified approach towards building the “Third One” (i.e., one national M&E system), additional promising practices will surface.

Intensive efforts in several countries by development partners and international organizations that recognize the essential role of M&E have led to great strides in HIV SI/M&E in the past several years. Building and appropriately supporting a skilled workforce that can effectively implement and sustain a comprehensive and fully functioning national M&E system for the provision of accurate and timely strategic information takes time. A greater focus on documenting and sharing experiences, supplemented with the findings from formal evaluation studies, will help move this area forward efficiently and minimize mistakes. In this sense, while the list of practices in this compendium is by no means exhaustive or representative, it does provide an important starting point upon which to build a more comprehensive learning resource for human resources capacity-building for effective HIV SI and M&E systems.

**PART TWO:
PROMISING PRACTICES BY
HRH ACTION FRAMEWORK AREA**

PLANNING A NATIONAL HIV STRATEGIC INFORMATION MANAGEMENT SYSTEM IN INDIA

HAF area: Policy

SI area: M&E

Geographic region: Asia

Background

A national response to the HIV epidemic requires a single monitoring and evaluation (M&E) plan and system to direct the efforts of multiple stakeholders. During Phase II of India's National AIDS Control Program (NACP), the amount and types of information being collected grew substantially. However, much of these data were under-utilized due to the lack of staff and the need for more skills development for existing staff. It was also recognized that the multiple sources of data should be synthesized together to develop a more comprehensive and integrated understanding of both program results and their impact on the epidemic. During Phase III of the NACP, the national government envisaged an even greater level of expansion and identified strategic information (SI) management as one of the four key objectives of the Plan. An improved system for managing strategic information, which would encompass all aspects of program and financial data from key stakeholders such as civil society organizations, development partners, private sector organizations and other agencies, was essential.

In the spirit of the UNAIDS “three ones” principle and the 12 Components for a Functional HIV M&E System, the national government set up a working group involving all major internal and external stakeholders to develop a strategic information management system (SIMS). The purpose of the SIMS is to provide a common framework and information technology applications at national, state, and district levels. It includes operational guidelines and a manual, performance monitoring indicators (definitions and applicability), human resource requirements, and capacity building needs.

Description

A collaborative and transparent process—spearheaded by the National AIDS Control Organisation (NACO)—guided the redesign of India's SIMS for HIV. NACO emphasized the need for an effective, robust national system that would consolidate vertical systems and avoid double counting; cater to data monitoring and reporting needs at the national, state and district levels; be flexible enough to capture the M&E efforts of various agencies and networks; and make information readily available to stakeholders.

As a first step in the process, a national-level M&E group comprised of development partners met on a regular basis to discuss M&E issues. In addition, a working group was formed to identify input and reporting formats, consider data challenges faced by individual agencies and recommend additional inputs for inclusion in the national system. The working group also developed a list of core indicators, building on NACP II core indicators, activities envisaged under NACP III and considering global indicator frameworks such as the United Nations General Assembly Special Session, the Global Fund, and the President's Emergency Fund for AIDS Relief (PEPFAR).

Recognizing the need for a SIMS as part of the progression into Phase III of NACP, the Government of India created the national Strategic Information Management Unit (SIMU). The unit has five full-time staff with dedicated SI positions, including a senior person leading the M&E group and four deputies and program officers. The establishment of SIMU makes it possible to more clearly define staff roles and responsibilities and facilitates the availability and use of high-quality data. NACO also established Technical Support Units (TSU) at the state level to assist the State AIDS Control Society (SACS) in evidence-based strategic planning. The TSU also has a dedicated SI specialist to enable data analysis and use.

Results

The national government played a leadership role, and in collaboration with development partners, designed India's SIMS and strategically planned and advocated for additional human resources as part of the national HIV/AIDS strategic plan (NACP III). The information system platform, which is currently under development, will eventually service more than 50,000 reporting units. In addition to the full-time staff at the SIMU, SACS are hiring epidemiologists and M&E specialists for the District AIDS Prevention and Control Units. As states begin to implement evidence-based planning, they are using data generated by SIMS to prepare annual state-level action plans submitted to NACO, as well as using dashboard data to justify state-level budgets and proposed activities. SIMUs are expected to play a large role at the district level as well, given that districts are accountable for identifying gaps in the HIV/AIDS program response.

Conclusions

As described on the NACO website, the development of an HIV M&E system is a complex process that requires collaboration and transparency from the government and participating partner agencies. The concerted strategic planning effort led by NACO has resulted in the creation of a more cohesive HIV SI Management System, dedicated human resources, non-duplication of efforts, better utilization of data, and maximization of the impact of the NACP III response.

For further information, please contact the National AIDS Control Organisation
Ministry of Health and Family Welfare, Government of India
Website: <http://www.nacoonline.org>

Other Notable Practice

Operationalizing Monitoring and Evaluation in Guyana: Strengthening the National Response to HIV

In 2007, the Guyana Ministry of Health requested that a national M&E operational plan be developed to guide implementation of the existing M&E plan. With guidance from the 12-components framework and technical assistance from MEASURE Evaluation (made possible through financial support from the US Agency for International Development [USAID]/Guyana), a national M&E operational plan was completed in May 2008. The resulting plan (*National Monitoring and Evaluation Operational Plan for the Multisectoral Response to HIV and AIDS in Guyana 2007-2011*) guides the systematic collection of data that can be used to detect changes in the epidemic and in the efficiency and effectiveness of interventions. These data, in turn, can be used to strengthen coordination and inform and guide the national HIV response. The plan defines roles and responsibilities of M&E personnel and provides guidelines for human capacity-building for HIV M&E. USAID support for the capacity-building priorities outlined in the *National*

M&E Operational Plan is ongoing and has resulted in the placement of an M&E resident advisor at the National AIDS Program Secretariat to strengthen the capacity of the Secretariat's committed M&E team.

Supporting Materials Online

- Government of Guyana National AIDS Programme. National Monitoring and Evaluation Plan for the Multi-Sectoral Response to HIV/AIDS in Guyana (2007-2011) found at <http://www.hiv.gov.gy/doc.php?id=103>.

DEVELOPING A NEW CADRE OF DATA CAPTURERS IN SOUTH AFRICA

HAF area: Policy

SI area: M&E

Geographic region: Africa

Background

In South Africa, policy-makers increasingly recognize that the quality of data at the central level is determined by the quality of data captured at the grassroots level, before the data flow upward. To meet the need for a well trained monitoring and evaluation (M&E) workforce at South African health care facilities, policy-makers developed a plan to attract, train and deploy a new cadre of “data capturers.” In April 2007, the South African director general of health supported and approved a data capturer internship program to build national M&E capacity and address inadequate opportunities for career development in the public sector. The Department of Health organized the data capturer initiative through an Expanded Public Works Program subprogram. Originally mapped over a three-year period (2008 through 2011), the plan provides for training and deployment of 3,535 data capturers in public health facilities, including clinics and community health centers. Contingent on funding for program continuation, three waves of interns will serve terms of 12 months each.

Description

The Department of Health coordinated a multiorganizational collaborative effort to plan for the creation of a new cadre of data capturers and develop an internship program to fill the positions. The Department of Labor supports the recruitment and selection of applicants. To implement and manage the program, Provincial Departments of Health set up provincial steering committees, identified priority facilities for intern placement and organized facility readiness workshops. The Provincial Departments of Health also created the data capturer posts and funded the positions.

Program designers targeted intern recruitment among unemployed postmatriculation students with basic math and English skills, but without the financial resources to go directly to college or university. The one-year internship provides these individuals with valuable work experience and practical training. Following internship completion, the top-performing ten percent of each wave of interns will receive scholarships to pursue a health-related degree at an institute of higher learning. Ideally, the other 90% will be able to apply for permanent employment as data capturers in their provinces. During the 12-month internship, data capturers:

- Ensure proper management, storage and security of patient records and files
- Ensure ongoing data capture from patient records into databases with attention to time sensitivities and accuracy
- Identify, resolve or query missing data and errors observed during data entry
- Report missing data and errors to facility managers
- Communicate and distribute data to facility managers.

The plan also involves a process for formal certification. The Health Information Systems Data Capturer Programme is certified by the University of Pretoria under the auspices of two academic departments (School of Public Health and Department of Information Science). Certification has contributed significantly toward establishing the data capturer position within the national and provincial departments of health. As an indicator of the importance of certification, workers who are external to the data capturer initiative but share responsibility for capturing health facility data are now requesting certification as well.

South Africa's Human Resources Strategic Programmes and the M&E Directorates General spearhead oversight of the data capturer project. A consortium that includes the University of Pretoria (Continuing Education), Health Systems Trust and the Health Information System Programme (HISP) leads the 21-day training for interns. The University's Continuing Education program also provides post-training support with mobile learning technology and free airtime for learners. The HISP manages a hotline that provides similar support.

Results

In 2008-09, 1,100 data capturer interns were recruited, trained and deployed at health care facilities across South Africa. Plans are now under way to build the capacity of the Provincial District Information Office by developing provincial-level trainers capable of training data capturers at regional training centers. Eventually, training responsibilities will be transferred to the provinces and districts.

The collaborative group, consisting of the University of Pretoria, Health Systems Trust and HISP, received funding for the training costs and post-training support. HISP received funding to cover training costs, while the government covered all other program expenses for the first round of intern recruitment and deployment. However, the government cut funding for Years 2 and 3 of the program due to budgeting issues at the national level. Program planners are now in the process of obtaining supplemental funding for program continuation from other donors.

Conclusions

The data capturer internship project demonstrates that the creation of a new health cadre requires central-level policy change. To establish the cadre of data capturers and develop a sustainable career path for them, efforts directed toward locating and funding permanent positions are essential. Additionally, facility-level roles and responsibilities should be clearly defined at the time of data capturer deployment. Simultaneous training of supervisors would be beneficial to ensure that data capturers receive adequate support and guidance. On the operational level, feedback from trainers suggests that the 21-day training would be more effective if divided into several shorter segments distributed throughout the program year. Although more costly, this more gradual approach would likely enhance cumulative, applied learning over time.

**For further information, please contact Dr. J (Lieb) Liebenberg, Project Director
Health Information Systems for Data Capturers (HISDC) Programme
Website: <http://www.hisdc.co.za> E-mail: lieb.liebenberg@up.ac.za Telephone: +27825649668**

INSTITUTIONALIZING A NEW CADRE OF HEALTH INFORMATICS TECHNICIANS IN ETHIOPIA

HAF area: Policy

SI area: HMIS

Geographic region: Africa

Background

In 2007, at the request of the Ethiopian Ministry of Health (MOH), Tulane University conducted a survey of health informatics needs. The survey results showed that 60% of districts in Ethiopia did not have anyone on staff to fill this need, and estimated that around 7,700 health informatics technicians (HIT) would be needed by 2015 to meet the information requirements of Ethiopia's health sector.

To address this human resources gap, Tulane collaborated with the MOH and the Ministry of Education (MOE) to strategically plan for and develop a new cadre of health informatics technicians. As part of the process, the three partners developed a diploma course to support the training of the new cadre, and institutionalized the technicians' job description and role in the health sector.

Description

With support from Centers for Disease Control/Ethiopia, Tulane (in close collaboration with the MOH and MOE) developed an accredited curriculum to train licensed health informatics technicians at the diploma level. Although the diploma course is designed to be completed over a two-year period, students who have previously completed a two-year certification in information technology have the option of doing a one-year accelerated program. Most of the students come from federal and regional hospitals in Addis Ababa.

In addition to helping carry out the needs assessment and develop the curriculum, Tulane provided technical assistance to the MOE and MOH to select 21 Regional Health Science Colleges to offer both the full-term and accelerated training programs. Applicants are expected to apply at the regional level for tuition assistance and a regional position with the MOH following their graduation.

Results

The first cohorts of two-year students started their diploma programs in September 2009. The two-year program enrolled 80 students for their first semester at Harari Regional Health Science College. In October 2009, more than 900 students were enrolled around the country in 16 regional health colleges and technical and vocational education and trainings.

While planning the training course, planners acknowledged the need to institutionalize the new cadre to ensure recognition of the HIT diploma graduates and put in place an appropriate salary structure nationwide. The MOH and other stakeholders have taken two steps to help ensure institutionalization of HIT graduates. First, the MOH has included the new cadre in its recently

completed *National Human Resources for Health Strategy*. Second (and perhaps most importantly), both the MOH and the Regional Health Bureaus have made budget allocations to employ the HIT diploma graduates.

Conclusions

Meaningful and ongoing collaboration between the two in-country ministries (MOH and MOE) and Tulane University was critical during all three stages of the project (i.e., needs assessment, curriculum development, selection of teaching institutions). Securing the buy-in and support of these key government partners has helped ensure a successful training program for the new HITs as well as long-term institutionalization of a cadre vital to the needs of Ethiopia's health care system.

For further information, please contact Wuleta Lemma
Assistant Professor and Country Director for Tulane/Ethiopia
Tulane University, New Orleans, LA, USA
E-mail: wlemma@tulane.edu

INTEGRATED ANALYSIS AND ADVOCACY IN CHINA

HAF area: Policy

SI area: Surveillance

Geographic region: Asia

Background

Asia's unique patterns of HIV transmission as compared with other regions such as Africa can be traced to significant transmission among injecting drug users (IDUs), and differences in transmission among other at-risk groups. These differences require a response tailored to regional needs. The Integrated Analysis and Advocacy Project (A²) is a regional initiative to build local capacity in data analysis and advocacy for evidence-based decision making to direct programs and resources toward the factors driving the HIV epidemic. Beginning in 2005, the A² methodology was implemented in Guangxi province, which has the second highest cumulative number of reported HIV infections in China.

Description

The A² Project was funded by USAID and implemented through a partnership between Guangxi Center for Disease Control and Prevention (CDC—part of the Chinese government, not the US agency), the Guangxi Health Bureau, Family Health International (FHI), the East-West Center and the Health Policy Initiative.

The A² methodology uses two models that provide planners with a means to evaluate the effectiveness of past and current responses, project epidemiological trends and resource needs and calculate the cost and impact of different interventions. The Asian Epidemic Model (AEM) projects future epidemiological trends, and the Goals Model measures resource use linked to program goals. Using these models, it is possible to project different scenarios based on the implementation of preventive programs aimed at different groups.

The methodology was implemented through four steps in Guangxi province:

1. Train and support the local Chinese CDC team to gather and analyze existing data, identify key trends in HIV behaviors and responses and pinpoint gaps in data.
2. Use the AEM to develop a local model of the epidemic that shows where effective programs should be focused and projects future needs for antiretroviral therapy.
3. Evaluate the impact of different program choices and resource allocation decisions using linked AEM and Goals modeling.
4. Turn strategic information into action by providing the findings from the different scenarios to formal and informal decision-makers and policy-makers, obtaining stakeholder feedback and advocating for appropriate programs.

Results

FHI and the East-West Center provided training to four Guangxi provincial staff on use of the AEM and Goals models. Based on their analysis in 2006 that identified a growing problem of

HIV among men who have sex with men (MSM) in Guangxi province, the project then conducted a senior policy symposium to advocate for government program-led preventive measures. Although local decision-makers knew little about the MSM population and expressed surprise at the results of the projections, the symposium resulted in budgeting for preventive interventions among MSM for the next five years. A² policy and cost-analysis scenarios of resource needs also prompted one county in Guangxi to increase funding for HIV prevention and control and increase the number of staff working in HIV/AIDS. The interventions in Guangxi's Five-Year Action are projected to decrease the number of new HIV infections from almost 16,000 (original projection) to 7,400 (with intervention), compared with 10,800 in 2005.

Conclusions

An evaluation of A² found that the Chinese provinces achieved “full technical absorption of the models by local staff.” Trained staff will serve as resources for national Chinese CDC efforts to expand the use of A² to a total of ten provinces. External assistance to the process has ended with no plans for renewal, because capacity has successfully been created in Guangxi province.

Supporting Materials Online

- What is Analysis and Advocacy? The Philosophy and Tools of A²
- Analysis and Advocacy (A²) Project in Guangxi, China: Key findings and Impact
- An Evaluation: Implementing the A-Squared Project in Bangladesh, China, Thailand, and Vietnam

<http://www.healthpolicyinitiative.com/index.cfm?ID=publications&get=pubID&pubID=835>.

For further information, please contact:

Dr. Zhu Qiuying

Deputy Director, HIV/AIDS Division

Guangxi Center for Disease Control and Prevention

E-mail: zhuqiuying@hotmail.com

or

Chen Yaohong

A² Country Coordinator and Program Officer

Family Health International/China

E-mail: chenaohong@fhichina.org Telephone: +86 13608845480

ESTABLISHING A NONGOVERNMENTAL ORGANIZATION DEDICATED TO MONITORING AND EVALUATION IN ZANZIBAR

HAF area: Leadership

SI area: M&E

Geographic region: Africa

Background

In 2006, the Zanzibar AIDS Commission trained a group of monitoring and evaluation (M&E) professionals to provide on-the-job training and mentorship to community-based organizations in the implementation of the Zanzibar HIV and AIDS Programme Monitoring System (ZHAPMOS). The trainers demonstrated such interest and commitment to the area of M&E that they decided to organize themselves into the Zanzibar Monitoring and Evaluation Association (ZAMEA).

Description

ZAMEA became officially chartered in 2008 as a nongovernmental organization (NGO) dedicated to promoting sound M&E practices in Zanzibar and around the world. ZAMEA is a member of the Africa Evaluation Association, and is governed by a five-member Board of Trustees.

ZAMEA's vision is to become a national center of excellence in M&E by creating and sustaining a culture and practice of M&E skills through capacity-building, consultancy, advocacy and networking. The organization's objectives are to:

- Build M&E capacity in Zanzibar
- Provide a platform for interaction and information-sharing among those interested in M&E
- Promote high-quality intellectual, ethical and professional standards in M&E
- Promote the development and adoption of M&E approaches and methods suitable to Zanzibar and the development context
- Advocate for transparency and accountability in M&E-related public policy and expenditures.

Results

Currently, ZAMEA has 15 members from varied professional backgrounds (including finance, law, administration, education, economics and social sciences). Members work in the area of M&E in different ministries or organizations, and provide consulting services via ZAMEA on a part-time basis. Members also meet weekly to discuss M&E practices and ideas, share experiences, develop and review workplans and prepare proposals for new projects and assignments.

All ZAMEA members are core trainers for ZHAPMOS, providing M&E training to HIV implementers from the community level to the national level. The AIDS commission also contracts with ZAMEA to provide additional support for a range of M&E efforts. These include training and mentoring NGOs and community-based and faith-based organizations on M&E and recordkeeping for HIV/AIDS programs; data auditing to improve the quality of data provided by civil society organizations; and development of reports.

ZAMEA can share credit for the successful functioning and high participation rate of community implementers in the ZHAPMOS, which gathers community-level information into a central database and produces compiled data reports for a given calendar period.

Conclusions

ZAMEA provides an example of an indigenous organization created in response to a perceived need for professional leadership and development. In the words of ZAMEA's chairperson, "Organizing an NGO was our own initiative...we decided to form this organization to make sure we would not lose the knowledge we were learning." Although ZAMEA has been able to maintain its operations through consultancy contracts and monthly member dues, the chairperson suggests that the organization's success can be directly linked to the fact that it was established for "a specific end—and not for the money. Because if you fail to get the money, survival is short. If you are doing it to contribute to your nation, then it can work."

Although ZAMEA began with a focus on HIV M&E, the organization recognizes that there are many other types of projects in need of M&E support. ZAMEA is now developing a marketing plan to expand its business reach to these other areas. As the chairperson confidently states, "ZAMEA is sustainable because we are going on after almost three years with no assistance, and we are planning for more progress."

Supporting Materials Online

- ZAMEA Constitution, 2006.

For further information, please contact Said Mzee, ZAMEA Chairperson
E-mail: kishkule@yahoo.co.uk Telephone: +255 777 435920

VIRTUAL LEADERSHIP DEVELOPMENT FOR MONITORING AND EVALUATION OF GLOBAL HIV PROGRAMS

HAF area: Leadership

SI area: M&E

Geographic region: Global

Background

Management Sciences for Health (MSH) developed the Virtual Leadership Development Program (VLDP) in 2002 in response to demand from public and private health care organizations for cost-effective, practical and accessible leadership and management development. The program is offered in many different technical areas, including family planning and reproductive health, HIV/AIDS, public-private partnerships, human resources for health, contraceptive commodity security and monitoring and evaluation (M&E). As of September 2009, the VLDP has reached over 2,200 health professionals from more than 280 teams in 52 countries and is available in Arabic, English, French, Portuguese, Russian and Spanish. To address the need to strengthen leadership capabilities in organizations with M&E functions, the VLDP was adapted in 2009 under the MEASURE Evaluation Project for the specific needs of M&E units.

Description

The objective of the 13-week Internet-based VLDP for M&E is to strengthen the leadership capacity of those involved with the collection, analysis and use of health data at all levels of an organization. The VLDP for M&E enrolls intact M&E teams, defined as four to ten individuals who work together on a regular basis to achieve a common objective or goal related to M&E. Through the program's experiential learning approach, M&E teams work online and in on-site face-to-face team meetings to develop leadership practices and competencies that help them work more effectively as a team.

During the program, teams identify an organizational challenge and develop an action plan to address this challenge. The teams then must implement the action plan within six months of program completion and produce improved organizational or service delivery results. VLDP facilitators follow up within those six months to review team progress.

The VLDP consists of seven modules:

- **Module 1: Getting Started.** Participants are oriented to the VLDP website and materials, introduced to the concept of team dynamics, schedule team meetings, and complete the Workgroup Climate Assessment, a pre- and post-program evaluation tool.
- **Module 2: Leadership in Health Programs and Organizations.** Through individual and group exercises, participants are introduced to a leadership and management framework and eight leadership and management practices.

- **Module 3: Identifying Challenges and Developing an Action Plan.** Teams identify an organizational challenge and develop an action plan using the Challenge Model, which helps teams to develop a vision; articulate a measurable result; identify gaps, obstacles and root causes; and determine specific actions to be taken.
- **Module 4: Leadership Competencies.** Participants assess and discuss their personal leadership competencies by completing the Leadership Assessment Instrument¹³.
- **Module 5: Communication.** In addition to targeted reading, participants complete the Strength Deployment Inventory®¹⁴ to assess patterns of motivation and discuss the assessment results with their teams.
- **Module 6: Managing Change.** Participants are introduced to the concept of change management and John Kotter's eight stages of change to implement in their action plan.
- **Module 7: Coming to a Close.** Participants reflect upon the program and complete the final program evaluation and a post-program Workgroup Climate Assessment.

Leadership and organization development specialists facilitate the program, providing support, feedback and follow-up to participants via e-mail, telephone and website postings. Experts in M&E assist the facilitation team as participants work on their leadership action plans.

Results

In 2009, the first VLDP for HIV M&E under MEASURE Evaluation was offered to 103 participants from 14 teams in ten countries. The demand for this first program was extremely high, with over 150 teams applying for 12 team positions. Participating M&E teams are currently implementing their action plans to address a range of M&E challenges, which included developing an effective internal M&E system to improve quality of services; ensuring quality M&E training; designing and using information systems during rapid organizational expansion; and demonstrating effectiveness in decreasing HIV/AIDS transmission and improving treatment. The Kenya team's challenge was to pilot an internal M&E system. Within a month of the end of the program, the team developed and was testing a new M&E tool and had hired a data assistant to develop a database. Follow-up results for all teams will be measured in January 2010.

Conclusions

The VLDP is a cost-effective way to strengthen the leadership geographically disparate teams, without the costs of travel or absenteeism. Since its inception in 2002, the VLDP has been successfully used in 52 countries to strengthen leadership and management capacity, improve teamwork and workgroup climate and help teams to address identified organizational challenges to improve service delivery and management systems.

Supporting Materials Online

- General VLDP brochure.

For further information, please contact the Virtual Leadership Development Program
Website: <http://www1.msh.org/projects/lms/ProgramsAndTools/LeadingandManaging/upload/VLDP.pdf>
E-mail: virtualprograms@msh.org

¹³ Linkage, Inc., *Leadership Assessment Instrument: Self-Managed Assessment*. Lexington, MA: nd.

¹⁴ Strength Deployment Inventory®, Personal Strengths Publishing. Carlsbad, CA: 2005.

UNAIDS INITIATIVE FOR GLOBAL MONITORING AND EVALUATION HUMAN RESOURCES CAPACITY-BUILDING

HAF area: Leadership

SI area: M&E

Geographic region: Global

Background

In a 2008 survey of 135 countries, 70% had conducted monitoring and evaluation (M&E) trainings at the national level and 46% at the subnational level¹⁵. However, there is no professionally recognized, standardized program of study to develop M&E practitioners, and the wide array of M&E trainings has sometimes led to duplication of effort and confusing, if not conflicting, messages. UNAIDS, in collaboration with its partners, is spearheading the development of a competency-based approach¹⁶ to M&E training.

Description

In May 2009, the M&E Division of UNAIDS (Geneva, Switzerland) and the Payson Center of Tulane University (New Orleans, USA) organized a workshop with representatives from global, regional and country-level organizations and experts in M&E training. The group agreed on the need to develop a set of core competencies for M&E leadership positions¹⁷ and standards for M&E training. Subsequently, a multiagency working group developed two tools: the *Competency Self-Assessment Tool* and the *Curriculum/Training Standards Tool*.

UNAIDS also leads the M&E Reference Group (MERG), the global standard-setting body for M&E in HIV. Under the auspices of the MERG, a series of guidelines and standardized tools have been developed over the past several years to support the strengthening of HIV M&E systems worldwide, including human capacity-building.

Results

The *Competency Self-Assessment Tool* addresses five priority competencies that focus on the technical aspects of job performance as well as managerial and interpersonal aspects: 1) M&E leadership; 2) data collection and data management; 3) evaluation; 4) data analysis, dissemination and use; and 5) general management. Each competency is defined by specific knowledge and skills components that individuals self-assess on a six-point scale (0-2: entry/novice; 2-4: proficient/skilled; 4-6: mastery/expert)¹⁸. The tool can be used by M&E professionals to identify critical areas that need improvement and determine concrete actions

¹⁵ Joint United Nations Programme on HIV/AIDS (UNAIDS). 2008 Report on the global AIDS epidemic. Geneva, Switzerland: UNAIDS, 2008. Available at: http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp

¹⁶ Competencies are defined as the combination of knowledge and skills needed to execute complex tasks. Also referred to as the knowledge, skills and competencies (KSC) approach.

¹⁷ Those responsible for M&E of the overall HIV response or national/subnational programs therein, and resident M&E advisors from international organizations whose specific role is supporting the national HIV M&E system.

¹⁸ Six-point scale published by Ghery G, King J, Stevahn L, Minnema J. A professional development unit for reflecting on program evaluator competencies. *American Journal of Evaluation* 27(1):108-123. 2006.

for doing so. M&E trainers can use the competency tool to develop learning objectives for training and benchmarks for evaluation of training participants.

The *Curriculum/Training Standards Tool* focuses on good practice in the development, content, delivery and evaluation of M&E curricula or training. The tool includes five standards, and a series of statements determines whether each standard has been met. M&E professionals can use the standards tool to evaluate the relative strengths and weaknesses of different curricula or trainings so that they can select one that matches their needs and maximizes their learning. M&E trainers can likewise use the tool to pinpoint weaknesses in an existing curriculum or training, or to guide development of a new curriculum or training.

Over the next year, UNAIDS will gather and share information on users' experiences with the two tools. This information will be used to enhance the tools and develop new resources. As part of its organizational capacity-building approach, the UNAIDS M&E Division is piloting the competency tool in the recruitment and professional development of UNAIDS M&E advisors in more than 65 countries. Additional self-assessment tools targeting other M&E positions will be developed in the near future. UNAIDS also plans to use the standards tool to develop an annotated list of curricula and training materials as a resource for professionals and trainers searching for high-quality M&E training materials.

Among the important guidelines and standardized tools developed by the MERG, the *Guidance on Capacity-Building for HIV Monitoring and Evaluation* provides strategies and interventions at the individual, organizational and system levels for improving M&E system performance.

Conclusions

UNAIDS and the MERG have played a leadership role in developing a more unified and standards-based approach to HIV M&E capacity-building. As a result, several widely endorsed guidelines and tools are now available to support implementation of an effective HIV M&E system. As stakeholders involved in M&E use these tools to reach a shared understanding and achieve a coordinated approach to M&E capacity-building, their practical experiences will need to be collected and widely shared.

Supporting Materials Online

- Organizing Framework for a Functional National HIV Monitoring and Evaluation System
- Guidance on Capacity-building for HIV Monitoring and Evaluation
- 12 Components Monitoring and Evaluation System Assessment: Guidelines to Support Preparation, Implementation and Follow Up Activities
- 12 Components Monitoring and Evaluation System Strengthening Tool.

For further information, please contact Eva Kiwango
Team Leader, Monitoring, UNAIDS Monitoring, Evaluation and Operations Research Team
Website:

<http://www.globalhivmeinfo.org/AgencySites/Pages/MERG%20UNAIDS%20ME%20Reference%20Group.aspx>
E-mail: kiwangoe@unids.org Telephone: +44 (0) 22 791 32 83

ENHANCING SURVEILLANCE THROUGH FIELD EPIDEMIOLOGY TRAINING

HAF area: Leadership

SI area: Surveillance

Geographic region: Global

Background

In the 1950s, the US Centers for Disease Control and Prevention (CDC) developed the US-focused Epidemic Intelligence Service (EIS), a workforce development program for public health “disease detectives.” The success of the EIS initiative in preventing and containing epidemics led other countries to request assistance in creating Field Epidemiology Training Programs (FETPs) to enhance human capacity for disease surveillance, investigation, control and, in more recent years, laboratory management. Since 1980, the CDC has assisted 29 national and regional FETPs that build capacity in 40 countries. Sixteen additional country programs are in development.

Description

With funding from US government agencies and private donors, CDC headquarters implements FETPs in response to country interest and need. The two-year, full-time training and service program is customized to remedy the epidemiology, surveillance and laboratory management capacity shortfalls of the host country’s national health system. The program also focuses on strengthening the leadership and management capacity of participants, who are typically Ministry of Health (MOH) staff. The curriculum—which includes courses in epidemiology, communications, economics and management—emphasizes the development of knowledge and skills to gather and use information for decision-making. Seventy-five percent of learning takes place in the field, where participants conduct epidemiological and surveillance evaluations and interventions under close supervision. Where possible, local universities award a master’s in public health (MPH) degree after completion of courses and field work.

Prior to launching an FETP, the MOH and other stakeholders engage in a one- to two-year pre-development period of preparatory activities such as a stakeholder workshop, program workplan, curriculum creation and negotiation of a sustainability plan. The sustainability plan requires a commitment from the MOH to continue the FETP and provide funds for outbreak support when most or all CDC support is withdrawn. A short course on outbreak detection and surveillance is a useful pre-development activity, as it gives the MOH a preview of what the FETP can provide, as well as generating a list of potential program participants.

A CDC resident advisor, placed within the MOH, serves as the primary FETP teacher and mentor while the program is being established, and typically remains for around six years. CDC-Atlanta staff also support the program. The country pays the salaries of participants (who remain MOH employees during their training), and also covers salaries for the program director and MOH-based administrative support staff. The program is integrated as much as

possible into the MOH, and becomes part of its organizational chart, budget and career track. Eventually, graduates take on teaching and mentoring responsibilities and may roll the program out to lower levels of the health system. For example, the Central America regional program offers abbreviated epidemiology training workshops and fieldwork to local and district health workers in addition to providing the standard two-year program at the central level.

Results

Worldwide, more than 2,000 people have graduated from FETPs since their inception, and approximately 80% of graduates are still working with their MOH five years later, many in leadership positions. Across all countries with FETPs, evaluations show improved epidemiological and surveillance capacity. Graduates of FETPs have played a key role in a number of investigative and surveillance efforts, often resulting in significant policy or programmatic changes. Selected highlights include:

- **Central America:** An FETP trainee project in El Salvador led to the implementation of a new National Injury Surveillance system. In Nicaragua, FETP investigations on chronic renal failure in sugar cane workers led to changes in national labor policies.
- **Brazil:** The FETP in Brazil has provided the country with a robust outbreak investigation and response mechanism that did not previously exist in-country. FETP trainees are viewed as the leading experts in responding to such events throughout Brazil, and data collected by Brazilian participants has led to regulatory changes related to hospital infection control.
- **Kenya:** FETP participants have examined the effect of post-election violence on HIV/AIDS services. A recent evaluation of the surveillance system for multi-drug-resistant TB alerted national policy-makers to the need to improve surveillance as well as intervention programs. A graduate of the Kenya FETP, Resident Advisor Dr. Patrick Nguku is now assisting Nigeria in establishing its FETP and mentoring trainees in evaluation of HIV/TB surveillance systems.
- **Thailand and Zimbabwe:** Self-sustaining FETPs have implemented HIV/AIDS modules and AIDS-related surveillance activities. Zimbabwe has also, with CDC GAP funding, doubled the number of trainees per year, to provide more capacity to respond to HIV/AIDS.
- **China:** China's program (CFETP) was successful in finding the cause of an outbreak of hepatitis A using methods from the program. Dr. Lijie Zhang, who responded to the outbreak, is quick to note that such an outcome was unlikely "if I weren't trained by CFETP."

Conclusions

The worldwide proliferation of FETPs is an indicator of the growing recognition by countries that public health requires effective surveillance systems backed up by high-caliber field epidemiologists. With an FETP track record that spans four decades, it is apparent that the success of FETPs relies on strong MOH commitment and ownership. FETPs are most likely to succeed when ministries of health can tailor the program and workplan to meet specific country needs. FETPs are also an effective means of MOH workforce development, as indicated

by the substantial proportion of graduates who continue to work within their country's public health system. FETPs can and have become sustained entirely by the host country, due at least in part to the joint creation of a sustainability plan right from the beginning of discussions, well-defined job functions that allow epidemiologists within the MOH to practice skills acquired during training and a career ladder that rewards advanced training in field epidemiology.

Supporting Materials Online

- Program development handbook, core curriculum, and training manuals found at <http://www.cdc.gov/globalhealth/FETP/trainingmaterials.htm>
- Logic model for creating and implementing an FETP
- Article on the Central America Field Epidemiology Training Program.

For further information, please contact:
Patricia Simone, MD, Director; Division of Global Public Health Capacity Development
Coordinating Office for Global Health
Centers for Disease Control and Prevention (CDC)
Website: <http://www.cdc.gov/globalhealth/FETP/trainingmaterials.htm> E-mail: pms6@cdc.gov

IMPROVING UNDERSTANDING AND COMMITMENT TO MONITORING AND EVALUATION AT THE PROVINCIAL LEVEL IN VIETNAM

HAF area: Leadership

SI area: M&E

Geographic region: Asia

Background

In Vietnam, the in-country response to HIV relies heavily on the leadership and commitment of all sectors and administrative levels. Since the National Strategy on HIV was launched in March 2004, the Ministry of Health has made great efforts to develop a productive monitoring and evaluation (M&E) system in keeping with the principles of the “Three Ones.”

The National M&E Framework for HIV Prevention and Control Programs was approved in 2007 to harmonize all existing M&E systems into one consistent national system. The resulting national M&E system covers four levels (central, regional, provincial and district), based on the existing four-level HIV system in Vietnam.

After creation of the National M&E Framework, the Vietnam Administration for HIV/AIDS Control and Prevention (VAAC) asked UNAIDS to support development of the national HIV M&E capacity. Because a wide range of institutions and practitioners working at the provincial and district levels have a role in the local HIV response, the first and necessary step toward this goal was to work with different decision-making entities at the local level to increase their understanding of the HIV epidemic, the concept of HIV M&E and the use of data in crafting an effective response.

Description

In collaboration with the Nha Trang Pasteur Institute (the regional M&E unit for 11 central provinces), UNAIDS organized a series of two-day workshops in six provinces for provincial and district authorities from multiple sectors. Preparation for the workshops began in 2008, and included numerous pre-development discussions with partners to ensure a shared understanding of M&E and the activity’s goals. UNAIDS and the Institute jointly developed all materials, and a team of facilitators and presenters from the Institute, VAAC, the National Assembly and UNAIDS conducted the workshops in December 2008. The workshops focused on strengthening understanding of the HIV epidemic, the concept of HIV M&E and effective use of strategic information in program development and implementation.

Results

Over 70 provincial leaders from six provinces participated in the workshops. Participants represented four government departments (Health; Labor and Social Policy; Education and Training; and Police) as well as provincial AIDS centers, people’s committees, the Women’s Union and district-level preventive medicine centers. In addition to the training provided to workshop participants, the activity created capacity in the Nha Trang Pasteur Institute,

supporting its ability to develop materials and facilitate workshops. The materials created for the workshops will be used as the activity is rolled out to other provinces.

In addition to collaborating on the workshops, UNAIDS has worked with VAAC and other partners to develop training materials on basic M&E, data use and data management. Trainings have also been organized for M&E practitioners from relevant national departments and regional institutes.

Conclusions

According to the *National M&E Framework for HIV Prevention and Control Programs*, “HIV M&E is a new field with a considerable need for capacity building” in Vietnam. The workshops represent a first step toward meeting that need. Informal feedback indicates that the workshops empowered attendees in their role as decision-makers, giving provincial leaders practical information in context, helping them to understand the need for decisions based on strong evidence and increasing their commitment to M&E efforts. This activity is effective as part of a larger continuum of M&E system strengthening and capacity-building efforts. The next step planned on this path is to adapt to Vietnam’s context the regional module for creating strategic costed national AIDS plans as laid out by UNAIDS, the United Nations Development Plan, the World Health Organization and the Asian Development Bank.

Supporting Materials Online

- Vietnam National M&E Framework for HIV Prevention and Control Programs (available in English and Vietnamese):
http://unaids.org.vn/sitee/index.php?option=com_content&task=view&id=31&Itemid=72.

For further information, please contact Vladanka Andreeva, DDS, MPH
Monitoring and Evaluation Adviser
UNAIDS Vietnam
E-mail: andreevav@unaids.org

NONGOVERNMENTAL ORGANIZATIONS AS LEADERS IN MONITORING AND EVALUATION CAPACITY-BUILDING IN UKRAINE

HAF area: Leadership

SI area: M&E

Geographic region: Europe

Background

Before 2004, Ukraine's monitoring and evaluation (M&E) system for HIV/AIDS was fragmented. Although a number of NGOs were implementing programs, each reported according to its own specific donor requirements and pieced together a strategic information (SI) system to serve those requirements. In 2004, Ukraine began receiving funds from the Global Fund, which required the public system and other partners to follow consistent M&E guidelines, putting Ukraine's limited M&E capacity in the spotlight. Spurred into action, Ukraine created a national system with standards and indicators to which programs are beginning to adhere. The International HIV/AIDS Alliance in Ukraine (which is one of the biggest implementers of USAID funded programs in Ukraine and recently became an independent Ukrainian organization) was an integral lead partner in creating the national system. While continuing to provide support at the national level, the Alliance is now also focusing on creating the capacity to operationalize the system at the oblast (province/region) level.

Description

SI capacity-building at the regional level focuses on improving the collection of multisectoral data on regional and national indicators. This is achieved by providing training to SI staff (typically epidemiologists and program managers) at governmental and nongovernmental organizations, including the Ministry of Health and regional State Departments of Health, Ukrainian and regional AIDS Centers, Ministry of Education and regional State Departments of Education, Social Services for Youth, and NGOs providing prevention, care and support services. Training topics include organizing and conducting surveys among vulnerable groups, statistical data entry and analysis, sampling methods, organizing surveillance, M&E of harm reduction projects and operational research.

Participation in the National Conference on Monitoring and Evaluation, sponsored by Alliance Ukraine, acts as an additional element of oblast capacity-building. The biennial conference allows for open professional discussion about current developments in M&E, presentation and analysis of the latest data, and sharing of best practices and approaches. The broad audience at the conference includes epidemiologists, sociologists and programmatic M&E staff from all government agencies, regional AIDS centers, NGOs and research institutions. The conference represents an important opportunity to bring new findings and issues in the national system to the attention of others, including top-level decision-makers. The development of national and oblast M&E units was due in large part to discussion and resolutions at previous M&E conferences.

Results

Since 2004, the Alliance has provided training on national indicators and data collection to 135 regional specialists from 27 oblasts, including epidemiologists and head doctors from regional AIDS centers and specialists from regional Departments of Education, Health, Corrections and Social Services for Youth. In addition, approximately 240 project managers and M&E specialists from 120 projects have participated in training focused on programmatic M&E. Currently, regional M&E units are being created within all oblast AIDS centers, and up to three staff members are being trained within them. (Until now, most AIDS centers had only one fully trained staff person in M&E.) By 2012, all 27 oblasts will have established M&E units with the assistance of the Alliance or another USAID-funded project.

The Fourth National Conference on Monitoring and Evaluation in 2008 brought together almost 200 experts. Particular attention was focused on the monitoring of antiretroviral therapy implementation, which is extremely important for Ukraine at the current stage of its epidemic. In addition, the conference was attended by M&E specialists working in related areas such as STI prevention and treatment.

As a result of these efforts, functional M&E systems now exist where there were previously no systems, and there is greater understanding of the importance of SI. As an external evaluation of the HIV/AIDS response in Ukraine noted in early 2009, “The area of M&E has seen important achievements...in recent years, most notably the acknowledgement at [the] national and regional levels of the importance of M&E for evidence-informed policies and programs.”

Conclusions

Ukraine’s response to AIDS is driven by NGOs who function as key leaders and partners at all levels of the response. A large—and growing—network of Ukrainian NGOs has demonstrated their capacity to develop, implement and monitor successful programs and activities that consistently meet or exceed targets. Activities such as the regional training effort led by the Alliance suggest that Ukraine is ready and willing to continue its progress. Previously, whatever data existed were reported only to the highest levels. Though the new system is not yet perfect, data are now available for decision-making at every level. With large differences in prevalence and need between oblasts, increased data for decision-making at the local level will increase the impact of programs even further.

Supporting Materials Online

- Programme Monitoring and Evaluation Practical Manual developed by Alliance Ukraine

For further information, please contact:

Andrey Klepikov, Executive Director

Olga Varetska, Head of Team: M&E

International HIV/AIDS Alliance in Ukraine

Website: <http://www.aidsalliance.org.ua> E-mail: klepikov@aidalliance.org.ua

PARTNERSHIPS TO STRENGTHEN COMMUNITY-BASED MONITORING AND EVALUATION REPORTING SYSTEM IN KENYA

HAF area: Partnership

SI area: M&E

Geographic region: Africa

Background

In Kenya, the National AIDS Coordination Committee (NACC) developed the Community-Based Program Activity Reporting (COBPAP) system in 2005. The COBPAP was created to address gaps in the existing facility-based reporting system, which did not accurately represent community-level indicators. Adequate community-level reporting is essential for obtaining the funding necessary to support valuable community-based activities.

In July 2006, a range of organizations began to submit reports to the COBPAP system, including civil society organizations (CSOs), faith-based organizations (FBOs), community-based organizations (CBOs) and nongovernmental organizations (NGOs). However, from 2006 through 2008, reporting rates were low and many organizations continued to use parallel reporting systems. Assessing the problem of low reporting, NACC concluded that the reporting forms had failed to consider the user's point of view, resulting in forms that were not user-friendly.

In 2008, determined to start COBPAP afresh, NACC began to actively seek the involvement of organizations and partners closely involved with monitoring and evaluation (M&E) at the community level. Regional M&E officers and representatives from the President's Emergency Fund for AIDS Relief (PEPFAR)-funded organizations, international NGOs and the US government (USG) played key roles in redesigning the COBPAP reporting forms. During the revision process, partners particularly emphasized the importance of considering the user's perspective.

Description

NACC used the following steps to establish a functional COBPAP system:

1. Bring partners and stakeholders together to assess data gaps
2. Implement a "partner mapping" exercise
3. Reconvene the group of partners to reach consensus about reporting indicators
4. Form a Technical Working Group (TWG) to meet quarterly
5. Pilot the COBPAP tool
6. Reconvene the TWG to gather feedback from the pilot
7. Roll out the COBPAP tool
8. Implement a joint supportive supervision component.

During the initial coming together of partners and stakeholders, partners included: the African Medical and Research Foundation; the AIDS, Population and Health Integrated Assistance II Project (APHIA II); CARE; and the NACC. During the partner mapping exercise, CSOs filled out inventory forms that captured their activities' target groups and funding sources. This allowed NACC to update its database on community-level HIV/AIDS programs and develop an aggregate view of the partners funding the CSOs.

The multiorganization partnership of M&E practitioners who comprise the TWG conducted a technical review of the COBPAN tool and developed a training curriculum for COBPAN rollout. In December 2008, M&E officers from APHIA II, NACC and the larger NGOs participated in the first Master's training. Following the first training, the TWG set the ongoing training and rollout agenda, using a cascade approach to train Constituency AIDS Coordinating Committee (CACC) coordinators and partners from smaller organizations (second level of training) and, finally, the CSOs (third level of training). All training was M&E-specific and based on manuals and training toolkits developed by NACC and the COBPAN TWG with support from APHIA II Evaluation, MEASURE Evaluation and Health Policy Initiative.

As the last stage in the process to ensure high-quality reporting, the NACC trained the CACC coordinators to provide quarterly supportive supervision to the CSOs that use COBPAN. The CACC coordinators, in turn, receive follow-up support and supervision from regional M&E officers. To prepare the CACC coordinators and regional advisors for their supervisory roles, the NACC developed a three-day training of trainers and action planning workshop in collaboration with APHIA II Evaluation and the Population Studies Research Institute at the University of Nairobi. At the workshop, regional M&E advisors and CACC coordinators developed an understanding of their role in training, supervision and support for COBPAN implementation; gained skills in training and supporting users in the application of COBPAN and data quality; and created action plans for training and supporting CSOs.

Results

Before the design of a viable, user-friendly community-based reporting system (i.e., pre-COBPAR), there was little incentive for CSOs to improve their services. With the implementation of COBPAN, CSOs now understand that their ability to secure ongoing funding is contingent upon their success in providing quality services that are reported accurately and on time. Systematic data collection also provides a mechanism by which local organizations can appreciate the results, or outcomes, of their efforts. At present, over 8,000 CSO representatives from all 210 constituencies in Kenya have been trained in the COBPAN system. NACC reports that "the majority of all partners have bought into the training and now we are sharing data in one system with one set of denominators." Ongoing support to the COBPAN system is ensured through quarterly regional meetings funded primarily by the national government with support from various development partners (e.g., USAID) and in close collaboration with CACC coordinators.

Conclusions

Through a collaborative process, NACC was able to garner and maintain buy-in for the revised COBPAN system. Increased reporting has allowed NACC to differentiate active from inactive

CSOs. As one individual commented, “Even if there is no data, the lack of data needs to be reported faithfully every quarter.” Over the longer term, it will be important to consider mechanisms to sustain collective interest in and commitment to the M&E process. NACC is considering giving out quarterly performance awards to the CACC coordinators with the strongest reporting records, and quarterly certificates to CSOs that submit expected reports (with funding contingent on receipt of reports). In the future, NACC also hopes to sponsor data use workshops.

Supporting Materials Online

- Resource Toolkit for Training, Supervising, and Supporting Facilitators on COBPAR
- Resource Toolkit for Training, Supervising, and Supporting Implementers on COBPAR.

For further information, please contact **Ben Mundia, Program Officer**
Research, Monitoring and Evaluation

The National AIDS Coordination Committee (NACC)

Website: <http://www.nacc.or.ke> E-mail: communication@nacc.or.ke Telephone: +254 020 2896000

Other Notable Practice

Joint Supervision of Decentralized M&E Staff in Zambia

In Zambia, HIV M&E is decentralized. Districts collect data and report up to provinces that, in turn, report to the National HIV/AIDS/STI/TB Council (NAC). Beginning in 2008, NAC initiated a joint supervision approach to provide quarterly support to staff in the decentralized M&E system. NAC coordinates the joint supervision effort, which involves collaboration between the Zambian government, UNAIDS and USG-funded partners such as the National Association of State and Territorial AIDS Directors (NASTAD) and the Support to the HIV/AIDS Response in Zambia (SHARe) Project. The various partners provide vehicles and personnel to conduct supportive supervision visits. To date, 50% of the country’s 72 districts have received visits, and NAC reports an increase in understanding of indicators and reporting completeness.

THE POSITIVE IMPACT OF JOINT MISSIONS ON HIV MONITORING AND EVALUATION PARTNERSHIPS

HAF area: Partnership

SI area: M&E

Geographic region: Africa

Background

Monitoring and evaluation (M&E) specialists from HIV partner organizations typically focus their technical assistance (TA) on the M&E teams of the National AIDS Commission (or equivalent) and national M&E technical working groups. Invariably, the same finite pool of in-country professionals is called upon to meet with visiting agency teams, who may request meetings and field visits, hold workshops and planning activities and require deliverables and information in various formats and timelines. Increasingly, specialists from HIV partner organizations have come to recognize that they often provide parallel (and, in many cases, similar) support, while creating confusion and redundancies. Countries face the challenge of managing multiple agency requests in a coordinated manner and trying to make sense of the range of M&E definitions, terminology and strategies used by HIV partners. Despite overall agreement on the need for one national HIV M&E system, external M&E specialists frequently focus on their own specific tools and approaches without looking at the overall process.

Description

In response to these challenges, partners are placing greater emphasis on harmonizing TA to strengthen national HIV M&E systems, reduce duplication and find more efficient and less burdensome ways to report progress to donors. At the beginning of 2006, key partners working in East and Southern Africa, including the US Government, World Bank, UNAIDS and the Global Fund, held a series of meetings. Participants determined that joint missions represented a practical step toward developing a shared M&E workplan in countries that support one national HIV M&E system.

To date, six countries have benefited from joint M&E missions: Lesotho, Namibia, Rwanda, Swaziland, Tanzania and Zanzibar. The missions were planned well in advance and lasted up to five days. In addition to giving relevant officials, stakeholders and partners an opportunity to provide adequate input, the joint missions also allowed participants to tap into the collective technical expertise of the visiting group and to experience the benefits of working together. In most cases, the missions focused on the common objective of operationalizing existing M&E frameworks and working to develop appropriate job descriptions for in-country M&E advisors.

Results

The joint missions have led to positive outcomes at both the partner and country levels. First, the missions have challenged partners to see beyond the boundaries of their own agency and scope of work. As a logical outgrowth of the missions, external and government partners have begun to develop shared workplans that are enabling a transition from partner-led M&E

systems development initiatives to government-led initiatives. Second, as governments become increasingly articulate about their needs and how partners can help, country M&E systems are becoming stronger. For example, in all six African locations where joint missions have taken place, in-country M&E officials are now developing and distributing timely annual M&E reports and quarterly HIV service coverage reports.

The work of the joint missions has been facilitated by the broader trend toward standardization, which is both a key result of and driving force behind the partnership approach. It is likely that a regional M&E training curriculum—nearing completion—will help address differences in terminology and knowledge of how to build M&E systems. In addition, the global endorsement of the 12-component framework for national HIV M&E systems makes it possible for partners to assess and agree upon the necessary components of a given M&E system.

Conclusions

The push for a unified, coordinated effort in support of M&E implementation began somewhat organically at the regional level and continued to build at the country level. As advisors came together from different regional and national bodies (ranging from multilateral agencies, donors, nongovernmental organizations and civil society organizations), it was not difficult to “sell” the benefits of harmonization. On the other hand, successful partnerships take time, energy and a commitment to minimizing bureaucracy. Joint missions also require that participants stay in touch through regular phone calls, e-mails, and conference calls, and serve as advocates for greater coordination among partners. Although joint M&E missions should be encouraged as a key mechanism for effective partnerships, the success of this mechanism depends on the M&E specialists who participate. Specialists’ willingness to get involved in the details of communication, coordination and collaboration is a key determinant of their ability to bring synergy to capacity-building efforts. This and other types of partnerships require a concerted effort from individuals who are able to look beyond the organizational boundaries and issues of their own agency and actively participate in a more broadly-based effort.

Supporting Materials Online

- HIV/AIDS M&E Getting Results Report on Strengthening Partnerships in HIV Monitoring and Evaluation: How joint missions build and strengthen partnerships to support the realization of the third “one” – national M&E systems
- HIV/AIDS M&E Getting Results Report on Using National HIV Monitoring and Evaluation Road Maps to reach the “Third One” more quickly and efficiently

For further information, please contact **Masauso Nzima, Regional UNAIDS M&E Advisor**

Website: <http://www.unaidsrstesa.org> E-mail: nzimam@unaids.org

or

Marelize Gorgens, World Bank Global AIDS Monitoring and Evaluation Team

Website: www.worldbank.org/aid E-mail: mgorgens@worldbank.org or aids@worldbank.org

MUKURU ON THE MOVE: GEOGRAPHIC INFORMATION SYSTEMS MAPPING OF COMMUNITY HIV PREVENTION IN A KENYAN SLUM

HAF area: Partnership

SI area: GIS

Geographic region: Africa

Background

The Partnership for an HIV-Free Generation (HFG), funded by PEPFAR, was launched in December 2008 in Nairobi, Kenya. With an initial focus on a relatively new urban slum settlement, Mukuru, the overall objective of HFG is to reduce the incidence of HIV infection in youth aged ten to 24 by 50% in five years. HFG focuses on two of the largest of Mukuru's 14 villages, home to approximately 200,000 people.

Led by the Rollins School of Public Health at Emory University, the Mukuru on the Move (MOTM) project is a key activity of the HFG partnership. Involving a range of external, government, nongovernmental organization (NGO) and local partners, the MOTM project was developed based on research that highlights the critical role of community members as the nexus of information on availability and quality of services within their communities. The MOTM project has a number of overlapping aims. First, recognizing that community-based information systems (especially in urban slum settings) tend to be weak, the project focuses on strengthening community capacity to organize and use geographic and programmatic information about the local HIV/AIDS service environment. Second, the project seeks to improve community awareness of and access to locally available resources. Third, by expanding the process of information gathering and sharing both within the community and beyond, the project strives to enable decision-makers and donors to evaluate possible gaps in coverage for particular kinds of services. A final MOTM objective is to capture information to inform program planning, monitoring and evaluation.

Description

Working in partnership with the PEPFAR/Kenya office, government and bilateral organizations and large NGOs, the MOTM team first identified 54 potential HIV prevention sites in the two selected Mukuru villages. Next, the MOTM project initiated a participatory mapping exercise that invited community members to draw pen-and-paper maps of health assets in their community. Using what PEPFAR refers to as a "combination prevention" perspective (targeting people everywhere they live), the project team sought to identify and map all possible venues that could be used for prevention work, including faith-based institutions, schools, clinics, voluntary counseling and testing sites, sports programs, theater programs and other youth-focused locations. Working with community-based NGOs, the team identified community leaders and users of services, and facilitated a series of community meetings focusing not only on HIV/AIDS but also on health care delivery more broadly. By engaging community members to draw maps of local sites capable of delivering HIV/AIDS and other health and social services,

the number of identified community prevention sites increased to 200, or almost four times more sites than originally identified.

Results

Using the results of the community mapping exercise, the project is moving into a second phase, characterized by public-private collaboration between PEPFAR partners, NGOs and industry partners. This multisectoral partnership is developing a combination prevention initiative that addresses individual behavior change as well as longstanding structural factors that contribute directly to HIV risk. The impressive roster of collaborators includes:

- Global and regional AIDS partnerships (Africa Media Broadcast Partnerships Against HIV/AIDS [organized under the Global Media AIDS Initiative], Rotarians for Fighting AIDS)
- Service organizations (Girl Scouts of the USA, Junior Achievement, Grassroots Soccer)
- Foundations (Coca-Cola Africa Foundation, Draper Richards Foundation, MTV Staying Alive Foundation, Nike Foundation)
- Businesses (Accenture, APCO Worldwide, Global Business Coalition, Hasbro, Intel, AmericaShare/Micato Safaris, Microsoft, Mitchell Silberberg & Knupp LLP, TechnoServe, Warner Bros. Advanced Media Services Inc.)

The prevention initiative will make use of data gathered during the community mapping process about community members' health-seeking patterns and service delivery priorities. The intent of MOTM is to build on local knowledge to ensure that services are accessible and actually meet needs identified by the community. For example, if a clinic location is proposed on a road that washes out at certain times of year, making the clinic inaccessible, the community data gathered by the MOTM would ensure more appropriate site selection.

Conclusions

The effective use of resources requires knowing what assets are already available in a given community. Through an assets-focused participatory mapping exercise that drew on community leaders' and members' knowledge of local resources, the MOTM project identified 200 potential community prevention sites. An important next step will be for community members to assess the capacity of each prevention site to actually deliver services and, where needed, strengthen and build their capacity to deliver services.

For further information, please contact the Partnership for an HIV-Free Generation (HFG)
Websites: <http://hivfreegeneration.warnerbros.com>
<http://www.pepfar.gov/ppp/hivfree/index.html>

PARTNERSHIPS FOR EFFECTIVE USE OF GEOGRAPHIC INFORMATION SYSTEMS TECHNOLOGY FOR HIV/AIDS INTERVENTIONS IN AFRICA

HAF: Partnership

SI area: GIS

Geographic region: Africa

Background

Many African countries have spatial data infrastructure (SDI) initiatives under way to address the burgeoning interest in spatial tools and data, including geographic information systems (GIS). All too often, however, the health sector is not involved in these efforts. Even when SDI challenges have been conquered by national mapping agencies, ministries of health and National AIDS Commissions typically have difficulty accessing mapping expertise and spatial data. As a result, investments made by countries in developing SDI may fail to benefit those working to protect the health of citizens.

Harmonizing national mapping and health efforts has the potential to strengthen national SDI and allow countries to more effectively combat HIV/AIDS. In April 2009, a group of partners hosted a one-day workshop in Addis Ababa, Ethiopia to encourage dialogue between 188 health leaders and GIS specialists from 30 African nations and six non-African nations. US partners included MEASURE Evaluation, the President's Emergency Plan for AIDS Relief (PEPFAR) and the US Agency for International Development (USAID), while multilateral partners included the Joint United Nations Program on HIV/AIDS (UNAIDS), the World Health Organization (WHO) and the UN Economic Commission for Africa (UNECA). The workshop was the first time government representatives from the health and mapping sectors had ever met on such a large scale anywhere in the world.

Description

The purpose of the one-day workshop was to foster connections between representatives of the health and mapping sectors, and to develop mutual understanding of each sector's value and potential to contribute to the other sector. At a practical level, the workshop also sought to build awareness of existing SDI capacity and health data in each country.

The morning sessions included five formal presentations organized around the themes of National Service Provision and Community-Based Reporting:

- Analyzing geographic coverage of antiretroviral treatment clinics using GIS: an example of collaboration between several institutions in Malawi
- Mapping Task Force Committee: developing a health facility GIS database in Tanzania

- GIS applied to HIV/AIDS interventions monitoring: the case of Rwanda's TRACnet system
- Identifying priorities for improving the quality of routine community HIV and AIDS information in Kenya
- The use of GIS for mapping HIV/AIDS susceptible areas in Addis Ababa, Ethiopia.

The second half of the workshop consisted of group breakout sessions that divided participants into six geographic and linguistic groups. Each group was charged with enumerating data and technical capacity requirements, assessing current capacities, identifying existing and potential linkages between health sectors and national mapping agencies and recognizing challenges to the formation of these linkages.

Results

The workshop confirmed the importance of forging robust networks between the health sector and national mapping agencies to promote the use of geographic information in support of HIV/AIDS programs. As a direct result of the workshop, the United Nations Economic Commission for Africa (UNECA)'s Committee on Development Information, Science and Technology approved resolutions calling for improved cooperation between ministries of health and national mapping agencies. Delegates also urged member states to actively engage the health sector in national SDI efforts, and encouraged donors and other partners to support these efforts. Participants expressed a newfound awareness of the value that each sector brings to the table, and reported optimism that the workshop would lead to increased collaboration between mapping and HIV experts. Workshop participants also recommended that a web-based communication and advocacy strategy be developed to promote the use of geographic information at the continental, regional and national levels. UNECA and MEASURE Evaluation are currently developing a virtual community to facilitate continued collaboration that will soon be announced in MEASURE Evaluation's newsletter, *Monitor*.

Conclusions

Providing opportunities for stakeholders from the mapping and health sectors to come together is an important first step toward building the partnerships needed to bring GIS technology to HIV/AIDS intervention work. Meetings of this type should be user-driven, and the role of sponsors and funders should be limited to providing financial and logistical support. In the case of the Addis Ababa workshop, sponsors and funders took the lead in articulating the benefits of linkages between the two sectors. Representatives from the mapping and health sectors should play a larger role in planning, organizing and implementing future workshops, and should engage in a process that allows them to discover and articulate for themselves the value of linkages and health sector involvement in SDI.

For further information, please contact MEASURE Evaluation
 Website: <http://www.cpc.unc.edu> E-mail: measure@unc.edu

STRENGTHENING REGIONAL MONITORING AND EVALUATION SYSTEMS THROUGH PARTNERSHIP IN UKRAINE

HAF area: Partnership

SI area: M&E

Geographic region: Europe

Background

In Ukraine, almost 80% of HIV/AIDS programs are implemented at the regional level. Therefore, the effectiveness of regional programs largely determines overall national effectiveness. In 2004, the Cabinet of Ministers of Ukraine issued a decree to central authorities to conduct monitoring and evaluation (M&E) of HIV/AIDS activities, based on a list of national indicators. To adequately respond to this request, regional involvement in M&E efforts was clearly essential. In 2006, the Futures Group—through the USAID-supported Policy II Project, the Health Policy Initiative (HPI) and the current Service Capacity Project (USCP)—began partnering with regional authorities to build capacity in M&E while maintaining the goal of sustainability and a high level of regional ownership.

Description

HPI/USCP provides technical assistance to regional government structures with the goal of making the regions the key implementers of the M&E capacity-building effort. The assistance started in eight regions in 2006, expanding to a total of nine regions in 2009. The project has a memorandum of understanding (MOU) with each region's Administration. Under the MOU, regional Administrations provide space and salaries for staff, and take on some responsibility for project implementation and success. In exchange, the project provides the regions with training opportunities for staff and additional data on regionally-based programs.

Together, the HPI/USCP-regional partnership has developed regional indicators, conducted training and set up M&E units within nine Regional AIDS Centers. Training topics, to date, have included indicator development, data collection and interpretation, use of databases and collection of financial information. Future trainings will focus on using strategic information and determining what data are needed for programmatic decisions. After each training event, HPI/USCP project staff work closely with trainees and authorities at the Regional AIDS Center, giving them immediate practice using their new skills.

Results

Over an 18-month period, the HPI/USCP-regional partnership developed 26 standard regional indicators that can be used across regions. Allocating adequate time to the indicator development process was vital for setting up the regional M&E system and obtaining regional and multisectoral buy-in for the indicators. This buy-in, in turn, made it possible to get needed data and convince programs to use the results.

The project has also spearheaded the development of a regional M&E infrastructure. Staff from each region have been trained as M&E specialists, and a Regional M&E System Development Manual has been created and made available in both Ukrainian and Russian. Six Regional M&E Centers have been established and are fully functional, with an additional three under way. As it happens, these efforts have allowed the nine project regions to play a vanguard role nationally, as the National AIDS Program decided in 2008 to set up an M&E Center in each region. In 2010, the project will begin to step back from its current role in M&E Center operations, allowing the regional governments to take full ownership.

The Regional M&E Centers have been very well received at the national level, as it has become apparent that regions with M&E Centers are better able to provide the data needed for national decision-making. An internal review conducted by UNDP also showed that the development of a national HIV/AIDS operational plan went more smoothly in regions with functional M&E Centers, due to improved multisectoral collaboration between different regional departments, compatibility of the regional process with the types information needed and greater availability of data.

Conclusions

The regional M&E approach is now being adopted by other donors and partners¹⁹, an indication that development of regional M&E capacity has been a very successful intervention for Ukraine. As a further step, USCP is advocating for the regional indicators to be made mandatory for all related ministries and regional Administrations. Mandatory status for the indicators would help ensure that the ministries and regional Administrations adequately prioritize the M&E process, making it easier for the Regional M&E Centers to collect the wide array of data needed for optimal decision-making.

The regional M&E project found that it is important to ensure that findings are used in a neutral or constructive manner to identify areas of needed improvement rather than to justify punishment or other negative reactions. Authorities or programs that lack this understanding of M&E goals or remain uninvolved in data collection may otherwise ignore or cast doubts on less-than-perfect findings.

Supporting Materials Online

- Regional M&E System Development Guides (available in Ukrainian and Russian).

**For further information, please contact Andriy Huk, Country Director
Health Policy Initiative
Futures Group
E-mail: ahuk@futuresgroup.com**

¹⁹ In 2009, the International HIV/AIDS Alliance in Ukraine that provides technical assistance to Regional Administrations applied the same approach to build M&E systems in an additional eight regions. GTZ is planning to use the approach to support M&E system development in four additional regions starting in 2010.

ENHANCING HIV SURVEILLANCE AND DECISION-MAKING ACROSS SECTORS IN MOZAMBIQUE

HAF area: Partnership

SI area: Surveillance

Geographic region: Africa

Background

The data that can be extracted from national surveys and surveillance are critical for programming routine HIV/AIDS public health interventions. However, the ability to interpret and disseminate epidemiological, survey and surveillance data often requires advanced capacity in epidemiology and biostatistics, which are lacking in many PEPFAR countries. In 1999, the Mozambique government responded to these two interrelated issues during preparation of the country's first national strategic plan to combat HIV/AIDS. The government brought together key stakeholders from several sectors (including the ministries of health, planning and finance, statistics, health statistics and the Center for Population Studies) to discuss existing surveillance data and reach consensus on the regional prevalence of HIV. As an outgrowth of these discussions, the government formed a multisectoral technical group (MTG) later in 1999. Over the past ten years, the MTG has continued to meet on a regular basis to share methods and information, analyze data and identify data gaps, and interpret and disseminate findings and recommendations on HIV/AIDS in Mozambique.

Description

The MTG's current membership has expanded to include the ministries of education and agriculture, the newly-formed National AIDS Council, the University of Eduardo Mondlane and the medical school, as well as UNAIDS, DANIDA, USAID and the Centers for Disease Control. The USAID-funded Health Policy Initiative (HPI) provides technical assistance and administrative support.

One of the MTG's primary responsibilities is the calculation of new HIV/AIDS incidence and prevalence rates in Mozambique. The MTG provides the advanced biostatistics and epidemiologic knowledge required to produce the highly technical calculations. As an impartial scientific body that represents various organizations and sectors of society, the MTG also helps mitigate the sensitive and politicized dimensions of HIV incidence and prevalence calculations. Using a consensus model, MTG members reach general agreement on critical data, which are then disseminated (as appropriate) to government decision-makers, the general public and the media.

A second important MTG responsibility—still in the process of being scaled up—involves support to provincial health systems to improve their technical capacity for data collection, processing, analysis and interpretation, and province-level dissemination of results. This activity reflects the realization that provinces may be more likely and able to apply MTG findings to HIV/AIDS programming since they are more directly involved in service provision.

Results

The MTG regularly publishes a number of documents on HIV/AIDS and surveillance activities, including a biannual publication of the *Demographic Impact of HIV/AIDS in Mozambique*. National advocacy groups and policy programs use these and other MTG findings for advocacy, resource mobilization and programmatic purposes such as estimating the number of people to be covered by specific interventions. The MTG also has drawn attention to the need for additional research and/or data triangulation to ascertain the impact on HIV/AIDS-related infection, illness and migration of wider sociocultural variables such as socioeconomic factors, risk perceptions and cultural practices in relation to sexuality.

Over time, the epidemiological and statistical capacity of MTG members and the quality of their data analysis and interpretation have increased through knowledge sharing among members and technical assistance from HPI. For example, MTG members have received training in spectrum analysis for estimation of annual incidence, and are well positioned to train other public health practitioners in this area. In turn, support from the MTG has strengthened provincial monitoring and evaluation capacity and programmatic information. Some provinces and districts have established their own MTGs. In Niassa province, for example, the Mandimba district MTG provides district-specific HIV/AIDS information to local authorities, civil society representatives, local radio and television stations and the public.

Conclusions

The national MTG has improved epidemiological and surveillance capacity at the central level in Mozambique. With a focus on rigorous epidemiologic methods and biostatistics, the MTG model has created a cadre of government and civil-society members who play a critical role in decision making around HIV/AIDS programming and in the general discourse about HIV/AIDS. Over time, the MTG will also increase the capacity of provincial-level government and civil-society staff to occupy a similar role in local decision-making and data dissemination efforts.

For further information, please contact Matthew Rosenthal
USAID/Maputo, HIV Team
E-mail: mrosenthal@usaid.gov

USING DATA TRIANGULATION FOR COMPREHENSIVE ANALYSIS IN VIETNAM

HAF area: Partnership

SI area: Surveillance

Geographic region: Asia

Background

Data triangulation is the process of synthesizing, integrating and using data from many sources to provide a more comprehensive analysis for policy development, trend calculation and program impact estimation. The process of data triangulation uses quantitative and qualitative measures as well as expert opinion, and has several practical advantages. First, it can offer stronger support for interpretations and conclusions, and provides a stable basis for subsequent decision-making. Second, it can be used to corroborate findings across data sets. In addition, it can help reduce the biases that might occur in a single study. With technical assistance from the Global Health Sciences program at the University of California-San Francisco (UCSF), UNAIDS and the Centers for Disease Control (CDC), Vietnam has begun to use data triangulation as a strategy for analyzing HIV/AIDS surveillance and programmatic data and answering key questions for the Vietnam context.

Description

The Government of Vietnam, the National Institutes of Health and Epidemiology (NIHE) and the Vietnam Administration for AIDS Control (VAAC) are receiving guidance from UNAIDS, CDC (both Atlanta and Vietnam offices) and UCSF in the identification of key questions and analysis of data. UNAIDS has played the main administrative role. Data come from a wide range of PEPFAR-supported partners as well as government facilities. Relevant data sets include biological and behavioral surveillance studies, demographic information, programmatic or routine data, research, expert opinion and data on context, geography, economics, history, legal issues or other factors known to be linked to the matter under investigation.

Stakeholders are following a phased process of planning, conducting and communicating. Specific steps include:

- Identifying key questions and data sources (planning)
- Gathering existing data (conducting)
- Noting trends (conducting)
- Identifying additional data sources if necessary (conducting)
- Determining findings and recommendations (conducting)
- Communicating findings and recommendations to the appropriate audiences (communicating).

Results

In January 2009, participants at a National Stakeholder Workshop brainstormed a list of key research, policy and programmatic questions on HIV/AIDS in Vietnam. Participants selected a subset of these questions using six criteria to determine that the focus of the question: (1) accounts for many infections, (2) is actionable, (3) is not duplicative, (4) data are available, (5) can use triangulation as an appropriate analysis method, and (6) is feasible to address in the short term. The list was reduced to two key questions:

1. What are the regional differences in trends in the HIV/AIDS epidemic in Vietnam, and what factors are driving these trends?
2. To what extent does Vietnam's HIV/AIDS programmatic response for prevention and care match regional epidemic trends?

After the workshop, five staff responsible for data analysis and M&E process management for the government and partners traveled to UCSF for a two-week data triangulation course. These individuals identified 11 major data sets for use in the triangulation effort, including more than a decade of sentinel surveillance, population-based surveys of youth, DHS data, modeling data and programmatic data from numerous implementing partners. In addition, 46 published papers and several small local studies were catalogued for inclusion. Following collation and sharing of the data sets, currently under way, triangulation analysis will begin. Early findings have already been shared during a data dissemination meeting with stakeholders, which helped identify data gaps and refine results. After the full analysis is complete, another stakeholder meeting will be held to build consensus on the data and translate findings into policy and programmatic recommendations. Final dissemination is planned for late January 2010.

Conclusions

Data triangulation can strengthen evidence-based decision-making, if done consistently and carefully. In Vietnam, the triangulation process has already ensured greater attention to available data, while highlighting key questions of interest and consolidating most information into a single location. By building the capacity of existing government and other local staff, the data triangulation effort is likely to generate heightened interest in data utilization and will eventually become a routine activity for the government and its partners.

Supporting Materials Online

- Overview of triangulation process and resource guide.
<http://globalhealthsciences.ucsf.edu/PPHG/triangulation/materials.html>

For further information, please contact Linh-Vi Le
Senior Technical Adviser for Surveillance, Monitoring and Evaluation
CTS Global, Inc.
E-mail: levl@vn.cdc.gov

or

Patrick Nadol, Strategic Information Chief
Centers for Disease Control and Prevention (CDC)
Global AIDS Program, Vietnam
Website: <http://globalhealthsciences.ucsf.edu/PPHG/triangulation/index.html>
E-mail: nadolpj@vn.cdc.gov Telephone: +84 4 3850 5100, Ext. 5058

STRENGTHENING HUMAN RESOURCES FINANCING CAPACITY IN PERU

HAF area: Finance

SI area: M&E

Geographic region: Americas

Background

Health managers are often tasked with the responsibility of understanding complex economic principles and applying them at the local and national levels. The Global Health Workforce Alliance (GHWA), a WHO-led partnership created in 2006 that includes “national governments, civil society, international agencies, finance institutions, researchers, educators and professional associations dedicated to identifying, implementing and advocating for solutions” to the global health workforce crisis, created a Financing Task Force to advocate for and support this growing emphasis. The Financing Task Force with its Secretariat at the Results for Development Institute in Washington, DC, developed the *Resource Requirements Tool* (RRT) as a decision tool to assist country-level planners and decision-makers in estimating and projecting the costs of desired health workforce scale-up and development.

In Peru, where a universal health care package was recently approved, Ministry of Health (MOH) officials saw the RRT as a potential tool to help determine the cost and extent of human resources needed to implement the new health care package at national and subnational levels.

Description

The RRT is an Excel-based tool that builds on previous tools such as the World Bank Group Costing Tool (2007) and the WHO Costing Tool (2002). By varying the parameters (e.g., attrition rate, number of annual graduates), users can project costs according to different scenarios and determine which interventions might most effectively improve the HR situation in their country. The tool has three primary components:

- **Employment:** Provides costs for hiring, retaining and deploying the planned human resources for health (HRH) (including new hires’ salaries and benefits, hardship and performance incentives, in-service training costs and costs for operations and management).
- **Pre-service training:** Determines costs for training HRH (taking into account the current number of students trained, costs for additional new students within the capacity of current institutions, costs for additional students above the capacity of current institutions and competition for employing graduates between the public and private sectors).
- **Affordability:** Calculates a country’s ability to fund the first two components (employment and pre-service training) from domestic and external sources.

The RRT can also be used to calculate the number of graduates needed according to the country's plans, expected graduates, HR attrition and entry from abroad and from other sectors.

Peru MOH officials first received training on the use of the RRT and then agreed to pilot test the tool in three regions to begin to determine the costs of implementing the universal health care package. They then worked with partners from the Pan American Health Organization (PAHO), the United States Agency for International Development (USAID), Results for Development and the Capacity Project to develop RRT training materials in Spanish to roll out HRH finance capacity-building at the subnational level.

Results

Peru applied the RRT at the subnational level and is in the process of applying lessons learned to further roll out the use of the RRT. Outside the Latin America region, the GHWA has trained consultants and national personnel in five other countries (Ethiopia, Ghana, Liberia, Mozambique and Uganda in Africa, as well as the Philippines) on the use of the RRT. Although it is too early to know the results of training in Peru, feedback from Ethiopia and Liberia indicates that ministries of health there perceive the RRT to be a useful costing tool.

Conclusions

Although the RRT tool was designed, and has only been used, for HRH projections, we believe the tool could be adapted and used to calculate and project costs for SI/M&E human resources. This would likely involve a fair amount of financial and technical resources and time. However, because SI/M&E human resources systems tend to be smaller and less complex, it is possible that the current tool could be simplified.

Supporting Materials Online

- RRT description, Frequently Asked Questions, and to order a copy of the RRT <http://www.who.int/workforcealliance/knowledge/publications/taskforces/ftfproducts/en/index.html>

**For further information, please contact Marty Makinen
Results for Development Institute**

Website: <http://www.who.int/workforcealliance/en/>

E-mail: ddmitrova@resultsfordevelopment.org or mmakinen@resultsfordevelopment.org

FUNDING OF DISTRICT AIDS COORDINATION ADVISORS FOR MONITORING AND EVALUATION IN ZAMBIA

HAF area: Finance

SI area: M&E

Geographic region: Africa

Background

In the early 2000s, the National AIDS Council of Zambia (NAC) recognized that subnational staffing was insufficient to address the country's HIV/AIDS monitoring and evaluation (M&E) needs. To support routine monitoring efforts, Zambia's decentralized and multisectoral HIV/AIDS response required staffing in each of its 72 districts. However, funding the salaries and supplies for the district-level staff posed a challenge. In 2004, the United Nations Development Programme (UNDP) helped the NAC address this human resources challenge by placing UN volunteers in the role of district AIDS coordination advisors (DACAs). The 72 DACAs work with each District AIDS Task Force to support district-level monitoring and reporting of HIV/AIDS activities, in alignment with Zambia's national HIV/AIDS strategy.

Description

The DACA program supported recruitment, training and placement of the UN volunteers, as well as salaries (1,000 USD per month) and supplies (computer, color printer, Internet service, desk and office supplies and materials). With funding support from the UN and World Bank, each DACA was also provided with a car; the NAC disbursed a quarterly grant to each DACA to maintain and fuel the car. Applicants for DACA positions were expected to have a degree or diploma in social sciences, public administration or public health, and at least three years of relevant work experience.

The DACAs' primary responsibilities include providing support for district-level efforts to:

- Implement HIV/AIDS monitoring plans
- Develop annual HIV/AIDS action plans
- Monitor and document HIV/AIDS interventions
- Integrate HIV/AIDS in strategic plans.

Results

The DACAs have played a pivotal role in supporting and coordinating the national HIV/AIDS M&E strategy in Zambia. At the outset of the program, UNDP funding was expected to last for four years, at which time the DACA positions were to be absorbed into NAC. A roadmap was developed to outline their transfer from the UN to NAC, modeled after a similar and successful effort for nine provincial AIDS coordination advisors (PACAs). After four years, however, NAC was unable to absorb the expense of the large subnational workforce, and the transfer time period was extended by an additional two years. In 2009, the DACAs were successfully transitioned from the status of UN volunteers to NAC employees with funding

provided by the Global Fund. NAC is responsible for overall coordination while the Global Fund provides salaries and support.

Conclusions

Establishing a district-level cadre to support and streamline M&E efforts can help ensure that HIV/AIDS resources are used wisely. Three other African countries (Ethiopia, Malawi and Zimbabwe) have also adopted the model of placing UN volunteers in M&E positions at the subnational level. In Zimbabwe, the model was expanded to three individuals (rather than one) per subnational level, after it was determined that one person was insufficient to support the full range of HIV activities. District-level HIV/AIDS coordination and monitoring is a demanding position that requires a triple focus on finance, coordination of partners and M&E. To ensure adequate support for all three dimensions, two additional individuals may be needed per district, as in the Zimbabwe model.

Supporting Materials Online

- National UN Volunteer Specialist Job Description
- National UN Volunteer Scheme Report
- Roadmap/Transition Strategy for UN Volunteer Functions from UNDP to the National Multisectoral Response to HIV and AIDS in Zambia

**For further information, please contact Michael Gboun, M&E Advisor
UNAIDS/Zambia**

**Website: <http://www.unaids.org> E-mail: Gbounm@unaids.org
Telephone: +260-211-252645/3501/3496**

or

**Dr. Rosemary Kumwenda, Assistant Resident Representative/Advisor HIV/AIDS and Poverty
UNDP/Zambia, HIV/AIDS and Poverty Unit**

**Website: <http://www.undp.org/zm> E-mail: Rosemary.kumwenda@undp.org
Telephone: +260-1256891**

PERFORMANCE SUPPORT TO IMPROVE HEALTH MANAGEMENT INFORMATION SYSTEMS IN UGANDA

HAF area: HRMS

SI area: HMIS

Geographic region: Africa

Background

The Uganda Protestant Medical Bureau (UPMB), the coordinating body for the country's Protestant health services, is a network of 258 health institutions that provide promotional, preventive, curative and rehabilitative health care. UPMB requested assistance to improve its capacity to make informed strategic decisions by strengthening the functionality of its health management information system (HMIS) and increasing the reliability and timeliness of data collection and reporting. UPMB's HMIS collects the same information as collected by the Ministry of Health (MOH), including data on drugs, staffing, inventory, income and expenditures. Previous attempts to improve UPMB's HMIS performance focused on training registrars on which data to collect, how and when to collect them and preparation of reports.

Description

The USAID-funded Capacity Project responded to the UPMB request with a performance support intervention in all 258 health facilities. The intervention targeted UPMB officers engaged in HMIS management, including HMIS officers at the national unit, health coordinators at the diocese level and health unit "in-charges" at health facilities and at all levels of the system (hospitals and health centers II, III and IV). The intervention was carried out in five steps:

1. Establish agreements and commitments among stakeholders
2. Decide on the expected performance of local teams
3. Assist local teams in carrying out performance improvement
4. Manage change and performance support efforts
5. Celebrate and recognize progress.

During the initial steps, central-level players (including the UPMB executive director) and officers involved in HMIS management gathered for rigorous planning and training in HMIS performance improvement strategies. At a three-day national workshop, the Capacity Project and diocese in-charges completed a detailed task analysis and designed performance standards summarizing the good practices that local teams must put in place to register, compile, analyze, report and use HMIS information for proper health unit management and decision-making.

Next, the Capacity Project and UPMB staff designed performance assessment tools based on the approved standards. Capacity Project staff carried out assessments in 72 health facilities with the involvement of health facility managers, diocesan health coordinators and records assistants. Whereas the UPMB secretariat's baseline perceptions regarding the HMIS's poor performance centered primarily on the belief that local-level registrars lacked resources (e.g., forms, pens, calculators, computers), the performance results revealed that resources were, in

fact, generally available. The assessment pointed, instead, to deficiencies in analyzing and reporting data and making data-informed decisions.

Responding to the assessment results, the Capacity Project and the UPMB secretariat designed a web-based HMIS tool to make data analysis automatic and allow reporting in real time. Because some diocesan health coordinators and records assistants do not have computers and Internet access, UPMB dioceses provided funds to allow them to access the HMIS system from Internet cafes in the townships nearest to the facilities. This approach was seen as more cost-effective than procuring computers and paying for Internet access. Local health teams also designed and implemented action plans to fix identified performance gaps under their control.

Results

A follow-up performance assessment to measure progress found that average compliance with HMIS performance standards improved at all facility levels. Improvement was particularly dramatic in the areas where the baseline assessment identified the largest shortcomings: compliance with data analysis standards increased from 45% to 81%, and equally sizeable increases occurred in the areas of reporting (from 34% to 79%) and decision-making (from 28% to 72%). Performance in hospitals improved the most (from 33% to 94%).

The performance support methodology allowed local health teams to understand that they could easily address and solve many issues affecting HMIS effectiveness, and could also proactively solicit the UPMB secretariat's support for local performance improvement initiatives and action plans. The action plans developed by the local teams mobilized local resources and initiatives to solve a range of deficiencies, such as making forms available, ensuring complete data collection and matching data in the reporting forms to data in the original data collection tools. The local teams also welcomed the new web-based automatic reporting and data analysis tool, which has allowed them to comply with reporting deadlines and prepare and display graphs about key indicators for use in local decision-making.

Conclusions

The five-step methodology used to strengthen HMIS performance in Uganda has been applied elsewhere to support health workers' clinical performance, using national or international clinical guidelines as the starting point. Because there were no available guidelines to direct the HMIS performance improvement effort, stakeholders began with a three-day workshop that drew on the knowledge and experience of facility in-charges to analyze tasks and identify desired performance standards. Although time-consuming, this process provided a useful framework for assessing performance at the health facility level. Implementers emphasized the importance of following all five performance support steps. Somewhat surprisingly, the final step—recognition of progress—is often difficult for organizations to implement successfully and may require outside support.

Supporting Materials Online

- Uganda HMIS Performance Support Assessment Tool, June 2009.

For further information, please contact: The Uganda Protestant Medical Bureau (UPMB)
Website: <http://www.upmb.co.ug> E-mail: lmuhirwe@upmb.co.ug Telephone: +256 (0) 414 271776

JOINT SUPERVISION MISSIONS AND TRAINING FOR DISTRICT MONITORING AND EVALUATION OFFICERS IN INDONESIA

HAF area: HRMS

SI area: M&E

Geographic region: Asia

Background

Capacity-building for HIV monitoring and evaluation (M&E) is a major issue faced by the National AIDS Commission (NAC) in Indonesia. Currently, the NAC works with all 33 provinces in the country and 171 of 400 districts. Although M&E is a key program component, staff and other resources were not readily available at the subnational level, and there were no specific resources dedicated to supervision of HIV/AIDS programs.

Beginning in 2007, NAC made a concerted effort to strengthen district-level AIDS commissions through the use of joint supervision missions with other government ministries such as the Ministry of Health, the Ministry of Home Affairs and the Police Department. With funding provided by the Government of Indonesia, joint missions are now taking place annually in each province that include supervision and mentoring of district M&E officers. In addition, NAC initiated an M&E training program that is also a key component of efforts to strengthen M&E functions in the districts. The training program is the first initiative to focus specifically on M&E training of field staff.

Description

The objective of the comprehensive supervision effort is to strengthen the ability of district AIDS commissions to coordinate and manage three core components of HIV programs: M&E, finance and administration. The three-day joint supervision missions typically include five participants representing NAC, civil society agencies and other government sectors. The well-planned and structured missions use supervision tools provided in advance by NAC to the provinces to allow the provinces to gather the necessary information and set up appointments. By using the same instruments and applying the same procedures across missions, the mission participants are consistent in how they share findings and conduct debriefings in each province.

A key aspect of the HIV/AIDS M&E component of the joint missions involves field visits with community-based organizations and representatives at the provincial and district levels. The district M&E officers participate in these joint visits. During the visits, the joint mission team and M&E officers discuss the HIV/AIDS program with program stakeholders to ascertain if their needs are being met and explore other elements of program impact. Stakeholders may include local prisons and hospitals, NGO field representatives, sex workers, transgendered individuals and others. The meetings are particularly beneficial for the M&E officers, who build confidence and get to know other key people in their districts. During this process, M&E officers also receive mentoring from the joint mission representatives on how to develop broader networks.

The NAC-initiated M&E training program began with a small team of trainers who conducted regional trainings at three locations in the country. Because of the lack of prior M&E training, the program emphasized the general HIV information and basic computer skills that district M&E officers need to use M&E tools and carry out M&E tasks.

Results

The NAC launched the joint supervision effort in 2007 in 100 districts representing all 33 provinces. By 2009, the number of participating districts had increased to 171. A key outcome of the project has been to solidify relationships and strengthen communication between the national, provincial and district levels, resulting in improved M&E reporting compliance, timeliness and data quality. With the improvements in reporting, national staff are better able to monitor programs. Before the supervision program, district staff perceived national-level officials as lacking interest in the provinces and districts; as a result, district staff did not always feel compelled to report on their activities.

The information generated by the supervision missions has also strengthened planning and decision-making between the district and provincial levels. At the conclusion of each mission, the mission team reports its findings and recommendations to the provincial AIDS commission. In addition, NAC posts the findings and recommendations to other provinces and districts to allow for sharing and comparison of results. As a result, districts have become more active in reporting information to the provincial AIDS commissions, and the provincial AIDS commissions, in turn, have begun to more actively supervise the districts.

Conclusions

Scheduling is the biggest challenge associated with joint supervision missions, particularly when the visits span several dozen provinces. It can be difficult for one or two staff members to synchronize the schedules of five busy team members. After the mission visits are scheduled, the provinces should be responsible for arranging the required meetings and site visits in the districts.

The NAC has expanded and improved its M&E training program over time, due to high turnover rates and the continual need for additional and refresher training. Ideally, M&E training programs should begin with a training of trainers to ensure appropriate training design, delivery skills and course content, and to avoid the problem of information overload.

For further information, please contact **Dr. Kemal Siregar**
Deputy NAC Secretary for Program Development
E-mail: kemal.siregar@aidfindonesia.or.id

Other Notable Practices

Supportive Supervision of HIV Monitoring and Evaluation Staff in Haiti

In Haiti, the President's Emergency Fund for AIDS Relief (PEPFAR) implementing partners provide subgrants to community-based organizations (CBOs) to provide HIV/AIDS services. However, partners have faced the challenge of increasing the amount and accuracy of data collection and reporting by the CBOs. After harmonizing and standardizing the information to be collected by implementing partners, MEASURE Evaluation instituted a process for the M&E staff of the implementing partners to provide mentoring and supportive supervision in data collection and reporting during site visits to their CBO subgrantees. To strengthen the M&E staff's ability to act as supervisors, MEASURE Evaluation provided training and developed a

guidebook. Technical advisors from MEASURE Evaluation provide additional on-the-job training by periodically accompanying the implementing partners' M&E staff on their supportive supervision and mentoring visits. Finally, MEASURE Evaluation brings together the M&E staff of all the implementing partners for monthly meetings during which everyone shares experiences from their site visits. This provides a forum for continued learning and process improvement.

Supporting Materials Online

- Supervisor's Guide (in French)
- Supervision Visit Checklist (in French)
- Tool to Verify Completeness of Registers (in French).

Mentoring and Supervision for Community Reporting in Zanzibar

The Zanzibar AIDS Commission oversees the Zanzibar HIV and AIDS Programme Monitoring System (ZHAPMOS). To ensure comprehensive reporting, the AIDS commission provided M&E and ZHAPMOS training to M&E point persons from more than 350 HIV/AIDS stakeholder groups, including NGOs, CBOs, faith-based organizations (FBOs), districts, *sheria* (smallest local administrative unit) and ministry departments and agencies. Commission staff, ZHAPMOS trainers and district HIV/AIDS focal persons then mentored the trainees at their place of work to reinforce the knowledge and skills they had gained. As part of the mentorship process, trainees received assistance in developing the M&E systems, monitoring tools, data collection plans and management processes that they need to effectively monitor and evaluate their work and use M&E data. Supportive supervision and data auditing support are provided to all HIV/AIDS stakeholders. The AIDS commission also has a system in place to orient new HIV/AIDS stakeholders in M&E and the HIV reporting system.

DEVELOPING A NEW CADRE OF MONITORING AND EVALUATION OFFICERS IN BOTSWANA

HAF area: HRMS

SI area: M&E

Geographic region: Africa

Background

An acute shortage of skilled monitoring and evaluation (M&E) personnel has been a major challenge to Botswana's response to HIV/AIDS, particularly at district levels. Data are often handled by health care and administrative workers who have other primary responsibilities and lack experience and ownership over the data monitoring process. In 2007, the Ministry of Local Government (MLG), with funding from the President's Emergency Plan for AIDS Relief (PEPFAR), hired 44 new M&E information management officers. This represents an important step in building nationwide capacity to provide strategic information and quality M&E data.

Description

The M&E district officers were recent university graduates hired on three-year contracts. Previously, the MLG had hired seven other officers (also recent graduates) through funding from the African Comprehensive HIV/AIDS Partnership, a nonprofit corporation established by Merck Company Foundation and the Bill and Melinda Gates Foundation. PEPFAR funding covers the M&E officers' training and salaries for the three years, after which time the positions will be absorbed by the government.

The combined cadre of 51 officers comes from wide-ranging backgrounds. With no prior M&E experience, the new officers require considerable training and mentorship. The International Training and Education Center on HIV (I-TECH), based in the University of Washington's Department of Global Health, is the lead implementation agency for training and mentoring. Other key partners include the MLG, the National AIDS Coordinating Agency, the Ministry of Health (MOH), the United Nations Joint Program on HIV and AIDS (UNAIDS), Centers for Disease Control (CDC)/Botswana and the PEPFAR program.

I-TECH and other partners strove to build the new officers' capacity to perform M&E functions by:

1. Conducting a baseline assessment of each officer's work experience and computer skills
2. Developing a long-term training and mentoring plan for each officer that is reassessed periodically for evolving needs
3. Ensuring that new officers attend a series of week-long courses on M&E and health information systems, prior to field placement
4. Conducting a five-day follow-up training on health systems and data flow for workers after their first three months at post
5. Offering additional courses on data management, national computer data collection programs, data analysis and data use.

The officers are closely monitored to ensure that they are absorbing the knowledge and skills they need to perform their jobs. I-TECH specialists provide mentoring support in the form of district visits, and the ministries conduct technical and administrative site visits. As part of its scope of work, I-TECH also provides mentoring to senior ministry M&E officers who supervise others in the districts.

Results

At present, every district in Botswana has at least one M&E officer. In 85% of districts, there are two officers, one of whom works with the district health team and the other with the district AIDS coordinator. Two years into the program, the career path for the M&E officers is still evolving. The MLG has taken responsibility for the officers during the PEPFAR funding phase, while the MOH and other partners are working on longer-term plans to absorb the new cadre into the government payroll system. Although there has been some turnover, partner organizations have worked to bring new officers on board with the same level of training and support.

Recent focus groups involving half of the M&E officers generated positive feedback about their work to date. Focus group participants reported a strong sense of cohort identity as M&E officers, and pride in developing a new career path. Partners have provided the officers with opportunities to share best practices so that everyone can learn and grow professionally; this has fostered positive attitudes among the officers and a willingness to reach out to one another.

Improved data flow and data quality represent the ultimate indicators of success for a training and mentorship program of this type. After two years, incremental progress is seen, with more facilities reporting data in a timely fashion and more officers getting involved at the facility level.

Conclusions

A foundational premise of this training and mentoring program was that unemployed university graduates would be full of potential, hungry for work and ready to take on the challenge of M&E as a career path. This has proven to be the case in Botswana, and is a promising model for other countries as well. We recommend several steps to ensure program success. First, to avoid miscommunication and manage expectations, it is important to orient existing district staff regarding the M&E officers' anticipated role and skills *before* the officers' arrival in the districts. Second, on-site mentoring is critical for newly hired M&E officers—to reinforce the skills acquired during training, allow for individualized problem-solving and target support where there is the greatest need. Finally, strategies should be considered that allow governments to absorb the M&E positions so that the officers become institutionalized. As long as M&E officers remain employed on a contractual basis, attrition will be an issue due to concerns about job security. Placing two officers in each district may serve to limit the impact of attrition.

Botswana's M&E officers are a promising step toward instilling an organizational culture that recognizes the utility of data for local decision-making, and understands the importance of high-quality and timely data. Future efforts should focus on improving the quality of data generated at the community level.

For further information, please contact the Director of Department of Primary Health Care Services for the Ministry of Local Government
Website: <http://www.gov.bw> Telephone: +267 3658400

Other Notable Practices

Hiring Nationwide Monitoring and Evaluation (M&E) Staff in Rwanda

Rwanda's Ministry of Health (MOH) recently created an integrated M&E system for public health at the national level. Data generated by the system will provide a key resource for M&E and program planning. However, the MOH has recognized the critical need for staffing to ensure the system's success. The Global Fund and CDC are providing initial funding for approximately 400 newly hired data managers at health facilities. After five years, the government of Rwanda will take over responsibility for the salaries.

Recruiting Monitoring and Evaluation Staff at Multiple Levels in Ethiopia

The rollout of antiretroviral therapy (ART) in Ethiopia in 2005 raised complex reporting issues, but also presented the country with an opportunity to streamline and standardize HIV reporting. As part of the ART initiative, the Federal HIV/AIDS Prevention and Control Office, in collaboration with Ethiopia's MOH, US Agency for International Development (USAID), partner universities and the World Health Organization (WHO), adapted the WHO generic patient monitoring tools and began conducting training courses for health care providers on their use. It became clear that full-time facility-level data clerks were needed to manage growing M&E needs, and in 2007 Global Fund support was provided to recruit, hire, train and deploy about 300 data clerks. After the data clerks' training and deployment, program planners recognized that regional data managers also were needed to synthesize and follow up on facility-level reporting, and improve the flow of information between the regional and national levels. Regional M&E focal persons therefore were recruited, and the data clerks and regional managers underwent training on use of the WHO patient monitoring tools. This multilayered M&E staffing initiative has helped ensure that facility-level clinical staff members are not burdened with M&E responsibilities, while the improved reporting has increased policy-makers' ability to make evidence-based decisions. Ethiopia is considering using HIV M&E staff to help collect key information for other components of the health sector.

Development of Monitoring and Evaluation (M&E) Job Descriptions in Vietnam

A national M&E framework is being implemented in Vietnam. The M&E Working Group chaired by the Vietnam Administration of AIDS Control received PEPFAR funding and technical assistance from the United Nations, UNAIDS and other local and international partners to develop job descriptions and minimum competencies and standards for M&E staff at different levels of the health system. As a first step, the M&E Working Group has developed a list of the minimum criteria needed to fill various M&E positions at the central and provincial levels and the skills necessary to carry out those positions effectively. The next step will be to assess M&E staff members' skills to ensure that necessary M&E trainings are made available.

UNIVERSITY OF PRETORIA SHORT COURSE ON MONITORING AND EVALUATION FOR HIV PROGRAMS

HAF area: Education

SI area: M&E

Geographic region: Africa

Background

As a part of the Masters of Public Health curriculum, the University of Pretoria (U of P) conducted a monitoring and evaluation (M&E) course for health, nutrition and population programs. Post-course feedback suggested that the majority of participants were working in, or had interest in, HIV programs and wanted HIV-specific M&E training. In 2004, a MEASURE Evaluation M&E workshop led to a proposal for regional trainings in HIV M&E. Since this proposal was in line with U of P's already-existing goals, the idea took hold and planning began for the first course held in March 2006. The university currently offers two courses per year with approximately 30 participants in each course.

Description

The School of Health Systems and Public Health at the U of P oversees a two-week non-degree course in M&E for HIV programs. It aims to build the capacity of professionals (primarily from Anglophone African countries) to design, implement and use HIV-related M&E systems. Participants are selected on the basis of country of residence, degree of involvement in the HIV response, employment/professional position, gender balance and likelihood to promote and apply M&E knowledge. Most participants work in M&E posts but have never had formal M&E training; significant proportions work for nongovernmental organizations or are employed within national or local government.

In week one of the course, U of P staff and visiting lecturers from MEASURE Evaluation lead classroom exercises and lessons. Course content focuses on the role of strategic information in decision-making, M&E frameworks and indicators, evaluation design, M&E plan development and data quality. Classroom learning is supplemented by practical group exercises. Participants present group work and respond to questions and comments from others, including the technical experts leading the program. Week two concentrates on application of the principles to various HIV intervention programs, practical experiences and a field trip.

Each course attendee pays tuition of roughly 15,000 South African rand and must cover the cost of his or her accommodations, airfare and meals. Almost all participants are sponsored by their employers. MEASURE Evaluation also awards three to five scholarships per course to support individuals who do not otherwise have the means to attend. Technical experts from the U of P and MEASURE Evaluation jointly develop, manage and adapt the course content, while the university's Continuing Education department (which has the infrastructure to manage training programs) handles all facilities and logistics.

Results

The objective of the course is not only to strengthen the M&E knowledge and skills of professionals working within HIV/AIDS programs, but also to create a cadre of leaders willing

to champion the role of M&E in program design, implementation and assessment. Informal feedback from course evaluations suggests positive outcomes. The course has led to the creation of an ongoing online network of M&E practitioners, and MEASURE Evaluation creates listservs for each group at the end of each course, so that the conversation begun at U of P can continue virtually. Program sustainability for the courses is ensured through effective partnerships with local educational institutions, PEPFAR-supported organizations and through the financial support provided by participant fees.

Conclusions

The U of P School of Health Systems and Public Health has extensive experience offering M&E training courses, including one for managers and practitioners supported by Japan International Cooperation Agency (JICA), and a three-day workshop for M&E managers highlighting strategic planning and use of data for decision-making. This experience has ensured the success of the two-week M&E for HIV Programs course. To avoid information overload, course planners have paid particular attention to the careful selection of course content. Participants have requested that the course confer a certificate of competence.

For further information, please contact the University of Pretoria

School of Health Systems and Public Health

Website: <http://www.up.ac.za> E-mail: csc@up.ac.za Telephone: +27 (0) 12 420-3111

Other Notable Practices

Development of Regional Monitoring and Evaluation (M&E) Training Capacity

MEASURE Evaluation partners with selected universities and training/research centers in developing countries to offer training programs in M&E and to strengthen the institutions' capacity for conducting regional M&E activities. Currently, MEASURE Evaluation has partnerships with the Public Health Foundation of India; the University of Pretoria, South Africa; the Centre Africain d'Etudes Supérieures en Gestion, Senegal; the Instituto Nacional de Salud Pública, Mexico; and Addis Ababa University, Ethiopia. Outcomes of these activities include: strengthening the capacity of the regional training partners to offer permanent short- and long-term M&E training programs in a technically and financially sustainable way; strengthening the capacity of the partners to become centers of reference for M&E in their regions; and building a cadre of developing country professionals who are highly trained in M&E.

Nationally Accredited Monitoring and Evaluation (M&E) Course in Botswana

In 2006, the National AIDS Coordinating Agency in Botswana conducted a one-week basic M&E module (later expanded to two weeks in length) that aimed to develop and strengthen participants' capacity to monitor and evaluate HIV/AIDS programs. MEASURE Evaluation mentored and provided technical support for the course, which drew on expertise from accredited courses from nearby universities. A local organization, the Institute of Development Management, now organizes and conducts the trainings. To date, 288 participants from national and district-level government, civil society and nongovernmental organizations have completed the course, which has strengthened Botswana's capacity to develop quality data analyses and broadened HIV workers' appreciation for M&E as a practice, particularly at the district level, by providing M&E basics to diverse audiences throughout the country.

THREE-WEEK EVENING CERTIFICATE COURSE ON MONITORING AND EVALUATION AT THE UNIVERSITY OF ZAMBIA

HAF area: Education

SI area: M&E

Geographic region: Africa

Background

Recognizing that monitoring and evaluation (M&E) staff in Zambia often do not have formal academic training in M&E, the University of Zambia (UNZA) Demography Program identified the need for M&E training for working professionals. The UNZA Demography Program was founded by the United Nations Population Fund (UNFPA), which early on advocated for the program to be field-oriented. Program administrators realized that offering short courses, including a short course in M&E, could ensure practical relevance for participants. Therefore, with conceptual support from UNFPA and financial and technical support from the Centers for Disease Control and Prevention (CDC)/Zambia, the UNZA Demography Program developed a three-week M&E certificate course.

Description

The M&E short course has the dual objectives of bridging the gap in M&E training for current M&E professionals and capturing the local M&E training market. The course, offered at the UNZA campus in Lusaka, is geared toward current professionals; thus coursework takes place in the evening from 4:30 to 8:00 pm and focuses on applied principles. The UNZA system confers official status on the course, and UNZA's dean of the School of Humanities and Social Sciences signs certificates for all who successfully complete the training.

The majority of instructors are from the UNZA Demography Program, though instructors from other schools, including the School of Education, provide supplemental lessons. The training program also benefits from guest instructors who are practicing M&E professionals, including staff from CDC, UNFPA, the Joint United Nations Program on HIV/AIDS (UNAIDS) and the United Nations Children's Fund (UNICEF). The Demography Program manages the certificate course and coordinates the guest lectures, scheduling a different line-up each time the course is offered.

CDC/Zambia provided initial start-up funding. The course costs cover tuition and materials, but not accommodations. The Demography Program uses the tuition funds to run the course. Although the majority of guest lecturers do not receive payment, some receive honoraria. Because it is a formal certificate course housed in the Demography Program, salaries for UNZA faculty are covered in-kind by the university.

Results

The Demography Program offers the M&E certificate course twice a year. To date, the three-week course has been offered seven times, reaching approximately 400 attendees. Initially, the

majority of students were from Lusaka. At present, students come from across the country, with 15%-20% of participants coming from outside Lusaka.

At the completion of each three-week session, both instructors and participants complete a course evaluation, eliciting information about what they enjoyed and suggestions for improvements. Some modifications have been made to the course content and structure based on this feedback, particularly regarding the guest lecturers. UNZA is interested in eventually completing a follow-up study with course graduates to ascertain whether the certificate course was helpful to their careers.

Conclusions

The three-week M&E certificate course has been popular, drawing over 50 working professionals each time it has been offered. This level of attendance suggests that the course is meeting a clearly perceived need. Because the course relies, in part, on a revolving series of different guest lecturers, a consultant for the UNZA Demography Program is developing a manual to help standardize the curriculum.

In the long term, UNZA intends to house an M&E Center of Excellence that would serve as an umbrella organization for both short-term (three-week) and long-term (semester) M&E courses.

Supporting Materials Online

- Planning, Monitoring and Evaluation Short Course Outline.

For further information, please contact the University of Zambia, Demography Program
Website: <http://www.unza.zm>

WORLD HEALTH ORGANIZATION COLLABORATING CENTRE FOR CAPACITY-BUILDING IN HIV/AIDS SURVEILLANCE IN CROATIA

HAF area: Education

SI area: Surveillance

Geographic region: Europe

Background

In the Eastern Europe/Central Asia/Middle East region, there is a need to train professionals in HIV surveillance and monitoring and evaluation (M&E) and to contribute to the development of context-specific HIV/AIDS surveillance systems. The mission of the Zagreb, Croatia-based World Health Organization (WHO) Collaborating Centre for Capacity Building in HIV/AIDS Surveillance is to increase capacity to implement effective, sustainable and context-specific surveillance systems for HIV/AIDS, which in turn can enable evidence-based development of HIV prevention, care and treatment.

Description

Established in 2003, the WHO Collaborating Centre for Capacity Building in HIV/AIDS Surveillance is a unique institution that brings together an interdisciplinary group of scientists and policy-makers from across the University of Zagreb and from institutions of excellence in HIV surveillance all over the world. The center is based at the Andrija Štampar School of Public Health, which is part of the Medical School at the University of Zagreb in Croatia. The School of Public Health is recognized as a prestigious and unique public health institution in Eastern Europe. The Collaborating Centre was established as a Knowledge Hub in 2003 under the framework of the project “Capability Strengthening for Improved Utilization of Financial Resources to Fight HIV/AIDS,” funded by the German Agency for Technical Cooperation (GTZ) and WHO/EURO. The Collaborating Centre provides training and technical assistance (TA) in a number of areas relevant to HIV/AIDS surveillance, and also works to develop partnerships and collaborative networks that bring together a wide range of expertise in the field.

Results

Since the Centre’s establishment in 2003, over 800 M&E and surveillance professionals from 60 countries have received training in Zagreb. Although the Collaborating Centre’s original focus was on surveillance, it has since expanded its scope to include M&E. The Centre currently offers 19 training courses and conducts five to six workshops each year on an array of innovative topics. Courses include:

- Introduction to second generation HIV/AIDS surveillance
- Biological HIV/AIDS surveillance
- Behavioral surveillance

- HIV/AIDS surveillance in hard-to-reach populations
- HIV surveillance among TB patients
- Designing protocols for population-based and clinic-based HIV surveillance surveys
- Monitoring and evaluation of national AIDS programs.

In addition to providing basic training in HIV surveillance and M&E, the Centre is committed to helping countries develop strategic information systems to guide a more effective HIV/AIDS response. To this end, staff provide TA to other countries, assessing their national HIV/AIDS systems and HIV M&E plans. A central concern is to ensure that surveillance systems are based on the best biological and behavioral methods and that the information obtained from surveillance supports the development of HIV prevention and control strategies. The Centre's TA efforts in other countries have focused on:

- Assessment of the quality of existing HIV surveillance systems, including STI and behavioral surveillance
- Identification of priority groups and areas where HIV surveillance needs to be established
- Assistance in identifying and implementing operational research and pre-surveillance assessment
- Assistance in implementation of surveillance surveys, including clinic- and facility-based surveillance, and population-based surveys among most-at-risk groups
- Development of surveillance protocols and operation manuals
- Selection of HIV and STI tests and testing algorithms
- Training of surveillance professionals and field staff who work on survey implementation
- Analysis and interpretation of data, and report writing
- Development of HIV surveillance strategies, workplans and budgets.

Conclusions

The Collaborating Centre is a well functioning example of an interdisciplinary resource that offers comprehensive, capacity-building services. Currently, there are plans to replicate the Collaborating Centre model to develop regional training centers in Iran and Vietnam.

Supporting Materials Online

- WHO Collaborating Centre for Capacity Building in HIV Surveillance. Report for the period 2004-2009. Zagreb, Croatia: Andrija Štampar School of Public Health, 2009.
http://www.surveillanczagreb.org/userfiles/file/Report_WHO_CC_Zagreb_2004-2009.pdf

For further information, please contact the WHO Collaborating Centre for Capacity Building in HIV/AIDS Surveillance, Andrija Štampar School of Public Health, Zagreb, Croatia
Website: <http://www.nacoonline.org> E-mail: training@snz.hr Telephone: +385(0) 1 45 90 142

SURVEILLANCE AND EPIDEMIOLOGICAL PROFILE TRAINING IN HAITI

HAF area: Education

SI area: Surveillance

Geographic region: Americas

Background

Haiti is one of the few developing countries that have emphasized HIV/AIDS surveillance. In countries with a bigger HIV/AIDS impact, it could seem overwhelming to put in place a case surveillance system. In Haiti, the scale of the epidemic offers an ideal setting to pilot and test such a system, both to better target programs to meet documented needs in Haiti and to establish a model that can be replicated elsewhere.

The National Alliance of State and Territorial AIDS Directors (NASTAD) has worked in Haiti since 2002, when it was invited to collaborate with the Haitian Ministry of Health (MOH) to assess the existing HIV surveillance system. NASTAD found that a good system had been in use through the 1990s. Due to political unrest and leadership changes, however, the public health infrastructure relating to disease reporting had subsequently received little support, leading to minimal disease reporting and little enforcement of policies or procedures. In 2004, the MOH, in partnership with NASTAD, began to develop a new surveillance system that included training as an important component. After two pilot sessions, Haiti launched a nationwide HIV case notification system in December 2008. Paper-based case notification forms are fed from the site level into an electronic central surveillance system called MESI (the Monitoring and Evaluation System Interface).

Description

With Centers for Disease Control (CDC) funding and guidance, NASTAD and the MOH developed and implemented surveillance and epidemiologic profile training programs as part of the national HIV/AIDS surveillance system. Two local organizations provided significant parts of the training: the Monitoring and Evaluation Team of Haiti and SOLUTIONS, creators of the MESI online surveillance system.

The three-day Surveillance Training course covered five basic topics:

1. Basic surveillance and epidemiology (overview and purpose)
2. Case notification (overview and purpose)
3. Haitian policies, procedures and forms for case notification
4. How to use the data generated through case notification
5. Privacy and confidentiality issues.

NASTAD and the MOH developed the Epidemiological Profile Training program after first creating an HIV/AIDS epidemiological profile for the Grand Sud, a region consisting of four

departments in Haiti. Recognizing the decision-making value of seeing diverse information gathered in one place, displayed with simple graphs and charts and accompanied by data-driven recommendations for future activities, the MOH decided to make the epidemiological profile approach available at the department level.

The three-day Epi-Profile Training also included five components:

1. Value of epidemiological profiles (including a sample eight-page profile to demonstrate that a profile can be simple and does not have to be huge or glossy)
2. Data sources available and used in Haiti
3. Participants' knowledge of, access to and experience using available data sources
4. Simple data summary and presentation techniques (including a focus on tailoring data to the intended audience and anticipating likely questions)
5. Use of data for decision-making.

Results

Over a one-and-a-half-year period, 500 people completed the three-day Surveillance Training programs. Representing most organizations and facilities that provide HIV/AIDS services in Haiti's ten departments, participants included voluntary testing counselors, disease reporting officers, data clerks, site supervisors and departmental (provincial/state) HIV/AIDS program coordinators. The training was necessarily tailored to the literacy, language and arithmetic abilities of participants, whose educational backgrounds were diverse; only some participants had prior medical training or experience, and many were community-based workers with, at most, a secondary education. To obtain participant buy-in for systematic data collection, trainers led conversations about the benefits of surveillance data for the individual, family, community and country. Trainers also added the discussion of confidentiality and privacy to the curriculum following participant questions and concerns in these areas, emphasizing the importance of fully understanding the consequences of disclosing HIV-related information in Haiti's typically close-knit communities.

Thirty-five individuals attended the first Epidemiological Profile Training program, including ten central staff from the MOH and teams of five MOH personnel from five departments. Each department sent a senior and junior epidemiologist, the HIV program manager, the HIV assistant program manager and the regional information officer.

Conclusions

In the future, NASTAD plans to integrate its surveillance and data use trainings into other existing training sessions. NASTAD is working with the Haitian National Institute of Community Health (INHSAC), the group that trains and certifies all HIV counselors, and the International Training and Education Centers on HIV (I-TECH), the group that trains medical doctors and nurses on the HIV/AIDS care protocol. Collaboration and partnership with the MOH and other organizations doing similar or related training are critical to ensure that similar language, approaches and techniques are used.

Future trainings will emphasize smaller groups (with 20 to 30 being the ideal number to enable participation from everyone), rely on role plays and hands-on activities as much as possible and solicit early feedback from participants to ensure that the training is meeting their needs.

Supporting Materials Online

- Epi-Profile Curriculum Outline
- Surveillance Curriculum Outline
- Pre-Epi-Profile Training Survey Form
- Post-Epi-Profile Training Survey Form
- Post-Surveillance Training Evaluation Form.

For more information, please contact the National Alliance of State and Territorial AIDS Directors
Website: <http://www.nastad.org> E-mail: nastad@nastad.org Telephone: 202-434-8090

BUILDING SKILLS IN HIV/AIDS MANAGEMENT AND MONITORING AND EVALUATION OF PROGRAM MANAGERS IN CHINA

HAF area: Education

SI area: M&E

Geographic region: Asia

Background

In China, the number of HIV infections and reported AIDS deaths has increased significantly in recent years. The most affected people live in rural areas, are poor and lack education. A core challenge for the health system is to strengthen human resources and program management capacity for HIV/AIDS control at the provincial and lower levels. A 2001 training assessment by the National Center for STD and Leprosy Control found that only 1% of China's six million health workers had any training in HIV/AIDS, and few personnel at the national and provincial levels had been trained in HIV/AIDS program management. Strengthening provincial leadership in the fight against the disease has become a national priority.

Description

In 2004, the China-US Cooperation Global AIDS Program (GAP) and the National Center for AIDS/STD Control and Prevention (NCAIDS) at the China Center for Disease Control and Prevention (China CDC) collaborated to develop and launch the Provincial Program Management Training Program (PPMTP). The program trains provincial, city and county HIV/AIDS program managers from across China, and especially in high HIV-prevalence areas. Participants work in program management in China's extensive network of provincial, city or county-level CDCs. (The network comprises a total of 2,860 CDC offices at the three lower levels and the national level.) The primary aim of the PPMTP is to improve program managers' capacity to engage in HIV/AIDS planning, implementation, supervision and monitoring and evaluation (M&E), as well as to strengthen communication on HIV/AIDS control and prevention activities between the provincial CDCs and NCAIDS. Candidates complete a telephone interview and must have at least three years of working experience with HIV/AIDS control and prevention to be eligible to apply to the program.

The six-month PPMTP includes four weeks of theoretical courses and 20 weeks of on-the-job training. The theoretical courses are taught by domestic and international experts, including HIV/AIDS experts from major Chinese universities and institutions, and from the World Health Organization (WHO), UNAIDS and UNICEF. Areas of focus include: the history of HIV in China; strategies for HIV prevention; HIV counseling, testing and intervention measures; AIDS clinical treatment and care; HIV/AIDS virus research; program planning and management; and M&E.

After the completion of coursework, participants spend the remaining five months rotating through divisions of the NCAIDS. These include epidemiology, health education and behavioral intervention, care and treatment, strategy, policy and information, comprehensive case

management and evaluation, international cooperation, program management and the National Reference Laboratory. As part of this training, participants take part in field work, including supervision of national and Global Fund HIV/AIDS programs, and surveys and prevention efforts among China's most at-risk populations (female sex workers, intravenous drug users and men who have sex with men). After completing a rotation, participants take a qualification exam for that division and receive a personal evaluation report from the division's director. Following graduation from the course, NCAIDS provides ongoing support and refresher training, and encourages continued communication with graduates as they return to their provincial work.

Results

Since the PPMTP's inception, NCAIDS has conducted eight six-month training programs producing a total of 63 graduates from 30 provinces. A December 2008 evaluation that sampled 26 program graduates showed that 96% are directly involved in planning and managing provincial, national or international HIV/AIDS programs; 84% also supervise city or county-level HIV/AIDS planning and implementation; 98% are participating in HIV/AIDS training programs as trainers; and 68% are conducting M&E for national programs, Global Fund or GAP programs (under PEPFAR) in their local areas. The 2008 evaluation also recorded very high levels of satisfaction with the training program.

After several years of hosting participants' rotations through its divisions, NCAIDS has also benefited from the heightened focus on HIV/AIDS program management. The organization recently established a Division of Integration that has the primary responsibility for integrating different HIV/AIDS databases and identifying target groups and individuals who might benefit from HIV testing. Modeled after syphilis programs in the US that use contact investigation, a pilot program using this innovative methodology has already identified 400 new HIV infections.

Conclusions

The Ministry of Health and NCAIDS have commended the PPMTP as "number one" in China and have championed its continuation. The cost-effective PPMTP approach addresses the needs of countries that lack local-level personnel to manage national public health programs. Because implementation is shared by national and provincial institutions who invest in participants, the organizations have a sense of ownership that makes them more likely to provide ongoing support for the program and its graduates.

For further information, please contact **Wendy Wei** or **Christine Korhonen**
US CDC-GAP China Program

Website: <http://www.uscdc.cn/en> E-mail: xyw@cn.cdc.gov or ckorhonen@cn.cdc.gov

GEOGRAPHIC INFORMATION SYSTEMS TRAINING FOR HIV/AIDS HEALTH PROFESSIONALS IN ETHIOPIA

HAF area: Education

SI area: GIS

Geographic region: Africa

Background

Existing training in geographic information systems (GIS) and global positioning systems (GPS) in Ethiopia is both expensive and resource-intensive. As a result, the country uses GIS sparingly within the health sector. To support the use of GIS in health-related activities such as disease analysis and policy planning, USAID/Ethiopia provided funding for training in GIS and GPS.

Description

Beginning in 2008, USAID funded the International Rescue Committee (IRC) to provide short-term professional training and capacity-building of selected USAID/Ethiopia implementing partners to conduct activities related to GIS, including GPS data collection. Through this initiative, IRC offers a five-day training course on GIS for the health sector, and a one-day course on GPS. Both training courses are conducted in Addis Ababa, Ethiopia.

The five-day course—fully sponsored by USAID—includes an introduction to GPS, guidance on the use of GPS utility software and an introduction to GIS and health applications, and is currently the only one of its kind in Addis Ababa that is affordable for USAID cooperating agencies, particularly as it is offered free of charge for PEPFAR-funded partners. Each PEPFAR-funded cooperating agency is invited to send one participant to the course. Course participants generally include monitoring and evaluation (M&E) staff. Participants are provided with GIS software, along with reference materials for the course. Both courses are highly applied, with participants spending significant time using GPS devices and using ESRI ArcGIS software or Open Source GIS software.

Results

As of June 2009, IRC had conducted one GPS course and two five-day courses on GIS for the health sector (involving 18 and 26 participants, respectively). IRC expects to continue providing the five-day course four times per year for roughly 25 participants per course through 2012.

Conclusions

During the first five-day training in 2008, some attendees had little interest in GIS and were not engaged with the training. As a result, the GIS trainers recommended more careful participant selection for future courses. For subsequent courses, trainers made a point of requesting that cooperating agencies send the participants who would most benefit from GIS/GPS training. The majority of participants at later courses were M&E staff.

Supporting Materials Online

- Five-Day Training Schedule for the GIS Health Course.

**For further information, please contact Behar Hussein, GIS Coordinator
International Rescue Committee (IRC) Ethiopia Program
Website: <http://www.theIRC.org> E-mail: beharb@ethiopia.theirc.org**

REGIONAL TRAINING TO IMPROVE ROUTINE HEALTH INFORMATION SYSTEMS PERFORMANCE IN FRANCOPHONE AFRICA

HAF area: Education

SI area: HMIS

Geographic region: Africa

Background

Routine health information systems (RHIS) are the backbone for managing and strengthening health systems all over the world. However, there is an increased realization that RHIS in developing countries are not producing their intended effect. To understand the underlying reasons for poorly performing RHIS, MEASURE Evaluation has developed a framework called the Performance of Routine Information System Management (PRISM). The framework highlights the importance of defining and measuring RHIS performance, and exploring the technical, behavioral and organizational determinants and gaps in RHIS processes.

MEASURE Evaluation has developed an RHIS course to develop skills in strengthening and reforming existing information systems based on the PRISM framework. With assistance from MEASURE Evaluation, the University of Pretoria in South Africa conducted the first course in August 2004 for 34 participants from 15 Anglophone African countries, as well as Iran, Bangladesh and Pakistan. A second RHIS course was offered in Mexico by the Institute of Public Health in Cuernavaca and the Mexican Ministry of Health in 2006 with assistance from MEASURE Evaluation. A total of 23 participants from eight Latin American countries participated in the second course.

Description

After many West African and Francophone countries expressed a need for the RHIS course, the Centre Africain d'Etudes Supérieures en Gestion (CESAG) and MEASURE Evaluation conducted a course in Dakar, Senegal in August 2008 with assistance from the Senegalese Ministry of Health and Prevention. The CESAG course involved 23 participants from 14 Francophone countries, with most attendees representing national ministries of health (MOH) and nongovernmental organizations. Participants also represented multiple organizational levels, ranging from national RHIS director to data managers.

MEASURE Evaluation is providing CESAG with three years of technical assistance to institutionalize the course. MEASURE Evaluation trained the CESAG faculty who are now course trainers, and continues to provide coaching. Because CESAG already provides courses on capacity-building in monitoring and evaluation (M&E) for HIV and Population, Health and Nutrition programs, it is an ideal partner in this activity.

The PRISM framework broadens analysis of RHIS to include the behavior of the collectors and users of data, and the context in which these professionals work. The course objectives are for participants to be able to:

- Understand the roles of RHIS in health service management
- Understand the three areas that determine RHIS performance

- Acquire skills to improve RHIS
- Diagnose performance, including assessment, analysis and problem-solving

During the course, participants use four PRISM tools to complete field work: the Performance Diagnostic Tool, Facility/Office Checklist, Management Assessment Tool and Organizational and Behavior Assessment Tool. At the conclusion of the program, participants create action plans to apply what they learned to their own organizations.

Results

Pre- and posttests were administered to the 2008 Dakar course participants using a case study and open-ended questions. Analysis showed a statistically significant difference between the pre- and posttests, indicating that the course was successful in improving participants' knowledge and skills regarding RHIS. In May 2009, CESAG offered the RHIS course in Dakar again, expanding the course length from two to three weeks to allow for more field work. CESAG plans to continue to offer the regional course on an annual basis every May.

The success of the regional RHIS course is leading to its adaptation elsewhere at the country level. A course cofunded by the US Agency for International Development (USAID) and Canadian International Development Agency (CIDA) was held in Haiti in 2009 with teams of three persons from each of the country's ten departments (counties). The chief of Haiti's HIS served as a cotrainer, adapting the course to the Haitian context. MEASURE Evaluation is also working in Côte d'Ivoire to provide national pre- and in-service training tailored to the country's RHIS. The course is being integrated into existing educational programs at Côte d'Ivoire's nursing school, and Ivorian faculty members are being trained to deliver the courses. MEASURE Evaluation plans to document this experience to allow for replication in other Francophone countries.

Conclusions

The principal challenge to providing regional RHIS training to all who are interested and could benefit is financial. Attending regional trainings is expensive, and there is very little funding within ministries of health or RHIS. Most attendees have therefore obtained funding from sponsoring organizations.

Valuable as the regional courses are, they will not meet all of Francophone Africa's needs. The ultimate goal is to have a core team of three to five trainers in each Francophone African country available to provide training to everyone involved in RHIS in their countries. This would lower the cost and increase the availability of training, allowing the effort to reach the scale needed to have a significant and comprehensive impact. MEASURE Evaluation and CESAG could play an important role by providing technical assistance and training of trainers.

Supporting Materials Online

- May 2009 Three-Week Course Agenda (in French).

For further information, please contact the MEASURE Evaluation
 Website: <http://www.cpc.unc.edu/measure/> E-mail: measure@unc.edu Telephone: 919-966-7482

ADAPTATION OF A REGIONAL MONITORING AND EVALUATION TRAINING COURSE TO THE KENYAN CONTEXT

HAF area: Education

SI area: M&E

Geographic region: Africa

Background

Since 2001, the Population Studies and Research Institute (PSRI) at the University of Nairobi in Kenya has developed a reputation for training expertise in monitoring and evaluation (M&E). MEASURE Evaluation identified the PSRI as its partner for building M&E capacity within PEPFAR-supported organizations in Kenya. The PSRI subsequently developed five-day training courses in basic M&E, as well as M&E training for HIV/AIDS-specific programs, including sessions on cross-cutting issues such as data analysis and information use.

After attending a four-week regional M&E training offered by MEASURE Evaluation in Ethiopia in 2005, the PSRI faculty decided that the course should be adapted and offered in Kenya, focusing on Kenya-specific M&E issues. With support from MEASURE Evaluation, which shared its training materials and provided a training-of-trainers, PSRI faculty condensed the four-week regional MEASURE Evaluation course to two weeks and renamed the course “Monitoring and Evaluation of Population and Health Programs.”

Description

PSRI launched the Kenyan M&E course as an annual offering in 2006. The course is open to M&E professionals from diverse backgrounds, including government and nongovernmental employees, with at least a university degree or diploma from a recognized university plus at least three years of relevant work experience. PSRI offers the course on the university campus in Nairobi when normal university classes are not in session. Because participants pay a 50,000 Kenyan shilling tuition fee, no external funding is required. Together, the PSRI faculty decide how to spend course-generated funds.

The course is primarily classroom-based but also includes a one-day field work component. Participants visit local nongovernmental or governmental agencies to observe applied M&E practices in real-life settings. Afterward, students provide feedback about the M&E systems they observed. The course contains ten modules:

- Overview of M&E
- M&E concepts
- M&E plan
- Frameworks
- Indicators
- Data sources and quality

- Data analysis and interpretation
- Planning and evaluation
- M&E information in decision-making
- Stakeholder engagement for M&E.

Results

The first M&E course, offered in 2006, brought together 35 M&E professionals. Subsequent courses have brought the total of trained M&E professionals to almost 100. To date, no formal assessments of the PSRI training have been conducted. MEASURE Evaluation continues to provide technical assistance as requested to ensure that course content is up-to-date.

Conclusions

To date, the Kenyan M&E course has been fully sustainable. However, PSRI course planners face the challenge of receiving some applications from individuals who cannot afford the course. In the future, PSRI hopes to be able to offer scholarships. Because the course is supported by participant tuition only, a strong advertising plan is likely to play an important role in the course's long-term success and sustainability. At a minimum, the course should be publicized in national newspapers, on university websites and through notifications sent via student networks. Eventually, the PSRI faculty would like to have the course accredited.

For further information, please contact the University of Nairobi Population Studies and Research Institute

Website: http://www.uonbi.ac.ke/faculties/?fac_code=4

E-mail: (Academic Registrar) reg-academic@uonbi.ac.ke Telephone: +254 20 318 262

MSc IN HEALTH MONITORING AND EVALUATION IN ETHIOPIA

HAF area: Education

SI area: M&E

Geographic region: Africa

Background

In 2006, Jimma University—the second largest University in Ethiopia—established a postgraduate MSc program in Health Monitoring and Evaluation (M&E). The first of its kind in Africa and second in the world, it was developed after a needs assessment determined a lack of qualified M&E professionals and a lack of master’s level training in M&E in Ethiopia. Prior to the program’s creation, the only option for graduate training in M&E meant traveling abroad, primarily to developed countries, for MPH training, or participating in nongraduate-level distance-learning. The program was started in collaboration with national and international partners, including the Ethiopian Federal Ministry of Health (MOH), President’s Emergency Plan for AIDS Relief (PEPFAR)/Centers for Disease Control (CDC), Tulane University School of Public Health and Tropical Medicine–Center for Global Health Equity and the National School of Public Health Oswaldo Cruz Foundation of Brazil.

Description

The program’s objective is to develop a new corps of professionals in M&E who, after completing the prescribed academic courses, will work in the public health sector or in other government and nongovernmental organizations in Ethiopia, Africa and elsewhere. The 13-month MSc program awards 28 credits in health M&E. Minimum requirements for include a bachelor’s degree in a health field (or social science field with current work experience in a health program), proficiency in written and spoken English and basic computer skills.

The course is designed to provide professional evaluators with skills in the theory and practice of M&E, as well as technical and analytic areas of evaluation, information technology, report writing, presentation and management skills. The innovative teaching methodology is based on adult learning principles, focusing on defining problems, self learning, field work and group activities combined with lectures. Other major features of the course include integrated skills training throughout the year; exposure to international M&E systems; Internet and computer-based training; and a learning resource center.

The MSc program offers four discrete learning tracks:

- Track one: Sociopolitical context of health
- Track two: Logical models of health programs and national/international responses
- Track three: Logical models of evaluation
- Track four: Communication, networking and information technology.

Currently, employees with the Ethiopian MOH apply to the program through a regional process. Successful candidates then apply to the graduate program. Accepted applicants who are supported by the MOH receive their full salary while in school and agree to return to their MOH position upon graduation for a period of at least two years. The program also offers admission to professionals working for associations representing people living with HIV/AIDS and for some national nongovernmental organizations, but does not enroll private applicants outside of the public health care system.

Results

With Tulane support, the MSc program in M&E has successfully graduated two cohorts (total of 57 students). A third cohort of 36 students is engaged in final thesis work and is expected to graduate in July 2010. Jimma University is now enrolling the fourth cohort (40 to 45 students) in fall 2009. To boost the teaching staff for the MSc program, the university recruited three assistant lecturers from among the top academic performers in the first cohort of graduates.

To date, follow-up has been conducted with 28 graduates from the first cohort. All 28 were public sector employees who returned to public sector employment with the MOH at either the regional or federal level following graduation. More than 50% of the graduates were promoted upon returning to their posts. Current roles include head of health management information systems, head of M&E and head of HIV at their respective regional health bureaus.

Beginning with the third cohort, the program accepted five international students from Tanzania, and will continue to accept students from other African countries depending on the number of placements available after accommodating the Ethiopian health sector. The five students from Tanzania are sponsored by CDC/Tanzania. The Tanzanian MOH, with support from PEPFAR/CDC in Tanzania, offered Tanzanian public sector employees the same arrangement as their Ethiopian counterparts, covering their tuition in return for a two-year signed service agreement with the Tanzanian government after graduation. The tuition fee for international students in 2009 was USD 7,500, excluding thesis costs, book allowances, cost of living and international travel.

Conclusions

The early success of the Jimma University MSc program for M&E demonstrates that the process of developing an in-country educational program is more affordable over time than training individual students abroad. However, development of indigenous graduate training capacity requires long-term planning and early attention to sustainability. Involving the Ethiopian MOH and avoiding a donor-driven approach were key steps to ensure ownership, buy-in and commitment. Tulane had transition conversations with the MOH and Ministry of Education as early as the start of the program.

Jimma University has additional plans to develop a distance-learning program in collaboration with Tulane's Center for Global Health Equity and the National School of Public Health Oswaldo Cruz Foundation in Brazil. Credits from the distance-learning program would lead to a diploma and, eventually, a master's degree.

Supporting Materials Online

- MSc Brochure.

For further information, please visit the Jimma University Institute of Evaluation.
Website: <http://www.jueval.org>

FORUMS FOR STRENGTHENING ROUTINE HEALTH INFORMATION SYSTEMS AND DATA USE

HAF area: Education

SI area: HMIS

Geographic region: Global

Background

The Routine Health Information Network (RHINO) is a unique nongovernmental organization that addresses routine health information systems (RHIS) issues in a practical and sustainable way. With collaboration from developing country governments, donor agencies, technical groups and private voluntary organizations, RHINO seeks to strengthen the role of evidence-based decision-making by engaging organizations and professionals to promote effective collection and use of routine health information, especially at the district level and below.

RHINO targets health care decision-makers, planners, policy-makers and information producers in low- and middle-resource countries at all levels of the health system, from central to district levels. This is accomplished through a number of innovative methods, including a listserv, blog, periodic international workshops and bibliography. In addition, RHINO holds online forums to allow for wide participation of public health professionals from different parts of the world.

Description

RHINO's online forums are held on a quarterly basis. The RHINO online forum on data quality assessment (DQA), held in July 2009, reached 175 participants worldwide, providing them an opportunity to:

1. Review state-of-the-art methods in data quality assessment for RHIS and monitoring and evaluation (M&E) systems
2. Discuss experiences using the various tools
3. Learn about strategies being developed for other DQA aspects (i.e. double counting, computerized data systems and the creation of country- or project-level DQA plans).

The online forums focus on improving RHIS and data use at the service delivery and district levels, where the capacity to produce good quality data is often the weakest. After each forum, the organizers prepare a written document that summarizes the forum content. RHINO disseminates the document to members and makes it available through the RHINO bibliography on a webpage. On the final day of the forum, RHINO sends an evaluation form to all participants asking for feedback on course development and suggestions for other topics they would like to see covered in the future.

Results

In the past several years, countries have placed increasing emphasis on the need to strengthen the quality of RHIS in resource-poor settings. RHINO has helped to address this issue by

providing technical assistance through its online forums, listserv, bibliography and international workshops. The positive response to RHINO's online forum on DQA suggests that there is considerable interest worldwide in increasing the quality of RHIS data.

Conclusions

With the RHINO approach, the strength lies in the fact that people contributing to and using RHINO work directly in the field and understand the connections between data quality, health care decision-making and effective and efficient health service delivery. Over time, it will be important for RHINO (and any other organization providing this type of technical assistance) to be aware of needs in the field and offer information that is both relevant and useful to RHIS and M&E professionals. Such a strong and responsive organizational infrastructure—maintained with the aid of a website and listservs—will help to ensure that the organization maintains a practical connection to its members.

Supporting Materials Online

- RHINO Brochure.

For further information, please contact **Matthew Parker**
Program Coordinator, Routine Health Information Network
Website: <http://www.rhinonet.org> E-mail: mparker@rhinonet.org Telephone: (703) 310-5258

Other Notable Practices

Listserv for US Government-Funded Monitoring and Evaluation Officers in Kenya

Monitoring and evaluation (M&E) programs often face obstacles pertaining to program duplication and a lack of consistent communication about M&E issues. The US Government (USG)/Kenya strategic information (SI) technical working group sought to create a common forum in which M&E officers serving PEPFAR-supported projects could share tools, challenges and information. A moderated e-mail listserv allows all registered participants to engage in conversations about M&E concerns such as indicator definitions and reporting procedures without leaving their workplace. The listserv, launched in January 2009, also provides notification about training courses, capacity-building opportunities and newly released reports. The listserv is managed by the AIDS, Population and Health Integrated Assistance II (APHIA II) Evaluation and moderated by an APHIA II Evaluation staff member who also serves as the SI technical advisor for PEPFAR. At present, 170 M&E officers from the National AIDS Coordinating Committee, the Ministry of Health, USG agencies and USG-funded projects in Kenya are registered and participate on the listserv.

Online Monitoring and Evaluation Training Resources

Through the Monitoring and Evaluation Network of Training Online Resources (MENTOR), MEASURE Evaluation makes available free training materials and tools on monitoring and evaluation (M&E) topics for use by researchers, program managers, trainers, policy-makers, students and other public health professionals. The materials were developed by global experts to provide state-of-the-art information on M&E topics. MENTOR includes three types of resources: a self-instructional interactive mini-course on M&E fundamentals; downloadable training materials on a variety of M&E topics (including routine health information systems and

M&E for population, health and nutrition programs; HIV/AIDS programs; and tuberculosis programs); and web modules that provide information and tools for students and professionals on population-related topics.

Supporting Materials Online

- Interactive M&E mini-course: http://www.cpc.unc.edu/measure/training/mentor/me_fundamentals
- Downloadable training materials: <http://www.cpc.unc.edu/measure/training/mentor/materials>

**For further information, please contact MENTOR
MEASURE Evaluation**

Website: <http://www.cpc.unc.edu/measure/training/mentor> **E-mail:** measure_mentor@unc.edu

COMMUNITY-OWNED MONITORING THROUGH THE USE OF LOW-LITERACY TOOLS IN INDIA

HAF area: Education

SI area: M&E

Geographic region: Asia

Background

As part of the US Agency for International Development (USAID)-funded Samastha Project, a monitoring system was developed for low-literacy peer educators in India. The system helps peer educators keep track of their day-to-day outreach activities and minimize double counting, and also fosters evidence-based planning through the generation of site-specific aggregate data. This approach, called community-owned monitoring, is one component of targeted peer outreach interventions with female commercial sex workers in primarily rural districts of Karnataka.

Description

The objective of the community-owned monitoring activity was to create a more user-friendly monitoring tool for low-literate peer educators. The tool, which was developed through a participatory process, helps peer educators keep track of each of their individual communications with women in sex work. The peer educators (who are often former or current sex workers themselves) fill out pictorial cards to record their outreach activities, with different pictures representing different activities. For example, a picture of a clinic represents whether the sex worker has visited a clinic, a picture of pills indicates whether the sex worker has taken pills and another picture indicates whether the sex worker has seen educational messages presented through folk theater. At the end of the day, the peer educators review their cards with their supervisors, and the data are entered into a computerized monitoring information system.

Peer educators also fill out a calendar of meetings held with a group of four to five sex workers. The identity of the woman is listed vertically on the calendar and the days are listed horizontally. Coded symbols are used to capture the data. The calendars track a range of information, including: when the woman was last visited by the community educator, if she received condoms, if she is enrolled in an antiretroviral program or if she has been referred for voluntary counseling and testing. The cards are color-coded and use different stickers to represent each of the peer educator's contacts, as well as the type of service and outreach provided.

Results

Approximately 1,200 peer educators, including about 200 from across rural Karnataka, have been trained in and are using the community-owned monitoring tools. Approximately 600 "link workers" (higher-level trained village volunteers who link women with services) have also been trained to use the tools, and there are plans to use them throughout the country.

The pictorial monitoring system allows peer educators to identify how people have used the services they offer. Because the tools build peer educators' capacity to analyze their own data, the system also helps educators plan and prioritize their outreach activities and contacts. At the level of supervision, the peer cards can help supervisors determine which peer educators are doing better at outreach and service provision. Project-level indicators (such as the scale of project operations, or the number of times peer educators meet with sex workers) can also be supplied by the tools.

Conclusions

Community input is vital to the development of community-owned monitoring tools. Peer educators need to identify the best pictures to use to symbolize the information recorded on the tool. In addition, tool layout should be simple and easy to understand, and the process for summing up data should be straightforward. Simplifying monitoring systems and tools, and providing an opportunity for peer educators to participate in data collection, can increase educators' sense of program ownership and provide direction for improvements.

Supporting Materials Online

- Peer Education Card and Calendar.

For further information, please contact the Karnataka Health Promotion Trust
Website: <http://www.khpt.org/Samastha.htm>

PROGRESSIVE COURSES TO ADVANCE STRATEGIC INFORMATION CAPACITY IN SOUTH AFRICA

HAF area: Education

SI area: M&E

Geographic region: Africa

Background

In South Africa, nearly one in five adults (a total of more than five million) are living with HIV. The extent and severity of the epidemic require a massive response at every level of the health system. However, insufficient monitoring and evaluation (M&E) capacity—often restricted by a lack of training resources or opportunities beyond M&E basics—tends to hamper evidence-based decision-making. The South Africa Department of Health (DOH) provides one month of intensive training in data capturing (see corresponding practice under the *Policy* section) to M&E staff with a high school education before assigning them to a district, but further training is haphazard. The five-year Enhancing Strategic Information (ESI) project, funded by USAID and implemented by John Snow Inc., was established in 2009 to address the need for improved M&E capacity in three Southern African countries, including the development and institutionalization of a linked progression of training courses for M&E staff from the facility through national levels in South Africa.

Description

ESI is creating courses to provide the skills needed at each professional level—a standardized, linked series of progressively more advanced courses. Currently, staff advance through the professional levels, but may not receive the knowledge and skills needed to do their jobs well. The ESI project provides expert trainers and materials, while the DOH and PEPFAR partners support participant costs to attend trainings and provide the training venues. When all the courses are finalized, ESI plans to have them accredited and taught at government regional training centers.

The basic course, *Evidence-Based Health Program Management*, teaches use of the elements and indicators of the national routine health information system, named the District Health Information System (DHIS). Pivot tables containing real data for the specific area (preferably by health district) are used to assist participants in identifying best practices and critical areas for results (impact and outcome indicators), and then to use input, process and output indicators to identify real shortcomings down to the facility level. M&E staff and program managers at the district levels and higher are placed in a five-day course, while facility-level managers who require less data theory background are placed in a three-day course.

The progressive courses continue at the facility level, with training for data collectors (usually nurses) in element and indicator definitions, data collection, collation and quality and data capturing validation. Data capturers then receive training in data capturing into the DHIS, validation, identification and follow-up, feedback to reporting units and data export to higher levels.

For information officers, training focuses on data import, import validation, analysis of data quality and program progress, export to higher levels, data mart, pivot tables and feedback. Finally, trainers, supervisors and mentors receive instruction in adult learning, mentoring and support principles as well as the contents of the above courses, in order to establish a network of trainers using a standardized approach to optimize functioning of existing systems.

Additional courses—including an intermediate monitoring advisor program geared toward PEPFAR partners that will focus on routine data quality assessment, basic statistics and advanced data management—will be available, though they are not specifically part of the progression. A health auditor training curriculum is also being developed, as no standardized instructional module exists for the health audit process. ESI is also developing an advanced one-year part-time M&E course with a private university that would provide advanced training in preparation for complex tasks, possibly in national-level positions.

Results

Since February 2009, almost 400 staff from all provinces of South Africa have participated in the evidence-based management training. Around 60% of trainees in South Africa have opted to complete a practice-related assignment after their course to identify data quality problems and solutions; the assignment is followed up by a workshop at which participants present their findings and discuss the outcomes of the solutions they have implemented. These workshops have generated numerous requests for the next level of ESI trainings, for which the curricula are still being finalized. The ESI project is currently negotiating the accreditation of this first course so that it can be offered at regional training centers for government-recognized certification, and will do the same for additional courses as they are finalized. Upon finalization, the courses will be adapted for the Lesotho arm of the ESI project, supporting monitoring efforts of HIV programs in two districts.

Conclusions

Curricula for all the courses will be completed by March 2010, and they will be incorporated into the government regional training centers will be completed by June 2011. In the meantime, the courses are being offered by ESI directly to districts. Initial response has been enthusiastic, and many facilities, districts and provinces have requested further assistance. Moreover, since ESI brings together all those working on HIV/AIDS within a given health district, this reduces duplicative efforts and fosters cooperation and shared awareness of activities. By creating a clear step-by-step means for M&E staff to improve skills, and by institutionalizing it in the government's training system by getting courses accredited, ESI is strengthening both the process and the quality of M&E workforce development and subsequent data collection and use.

**For further information, please contact Hitesh Hurkchand
John Snow Inc., Enhancing Strategic Information (ESI) Project
E-mail: hitesh@enhancesi.co.za Telephone: +27 12 346 7490**

BUILDING PRACTICAL PROGRAM EVALUATION CAPACITY FROM A DISTANCE

HAF area: Education

SI area: M&E

Geographic region: Global

Background

There is a new international focus on monitoring and evaluation (M&E) as part of strategic information (SI), in large part due to efforts to turn back the tide of the HIV/AIDS epidemic. In practice, however, the emphasis most often falls on the “M,” while the “E” is seen as something done by external experts with mysterious insights into how to judge programs. In response to an expressed need by US Government (USG) field staff for assistance and capacity-building on program evaluation, the Centers for Disease Control–Atlanta (CDC)—with assistance from ICF Macro—developed the CDC Program Evaluation Capacity Building project to put the “E” back into M&E.

Description

With the goal of demystifying program evaluation (PE), the CDC Program Evaluation Capacity Building project provides technical assistance and mentoring to USG SI officers, program activity managers and partners in PEPFAR countries. The project uses multiple methods for improving evaluation capacity, including the provision of long-distance technical assistance through conference calls and e-mails, as well as in-person country visits that offer the opportunity for focused work at key points in the evaluation process.

Based on a similar and successful US-focused CDC project, the PE project provides structured guidance and support to take participants step-by-step through an actual evaluation of one of their own programs. A workbook provides basic instructions for each PE component, along with relevant tools and instruments. The PE process should take less than one year to follow and consists of the following four major phases and 16 steps:

1. **Readiness Assessment:** Identify stakeholders; write program description; define evaluation focus (three steps).
2. **Protocol Development:** Determine evaluation questions; develop indicators; identify data sources and collection methods; develop data collection instruments and procedures; develop data analysis and reporting plans; allocate resources; submit protocol for clearance (seven steps).
3. **Evaluation Implementation:** Collect, analyze and interpret data; report progress to stakeholders (four steps).
4. **Result Dissemination and Utilization:** Report findings; monitor and ensure implementation of recommendations (two steps).

A pilot course under way in South Africa is using a distance learning approach to share the skills needed to evaluate the supervision component of the country's Home-Based Care (HBC) program. The five-person South African team (one USG staff person and four Medical School faculty members at the University of Limpopo, the local implementing partner) elected to evaluate the HBC program to improve its quality and inform the development of supervision guidelines. Up to four staff from CDC–Atlanta and ICF Macro take part in weekly conference calls and are available by e-mail to answer questions. In addition, the Atlanta team spent two weeks in-country assisting the South African team in developing its evaluation protocol for CDC approval (Phase Two). The Atlanta team will return to provide technical assistance and coaching to the country team during the data interpretation process (Phase Three).

Results

In the pilot program in South Africa, ten of the planned 16 steps have been covered so far, and the PE protocol developed by trainees is in the review and clearance process (end of Phase Two). Evaluation of the project thus far shows that trainees find the step-by-step method quite effective. Moreover, although conference calls may seem like a difficult teaching medium, South African participants report that the combination of calls and project materials are mutually reinforcing. When the PE capacity-building process is complete, the University of Limpopo trainees will become the national resources on PE, with the Atlanta team available for further mentoring. One South African participant states, “We in the field should be doing more program evaluation, especially when it comes to quality of care. This should be an integral part of what we do and not an afterthought.”

The training will likely next be expanded to India, where the CDC will provide technical assistance to evaluate its HIV/AIDS care and support program. Honduras has also expressed interest in evaluating its confidential testing program.

Conclusions

Many public health professionals have an incomplete understanding of program evaluation, although they may have done monitoring or research studies. Providing step-by-step instructions and assistance in the complete process of evaluating an actual program seems to be an effective way to develop PE capacity, particularly when the evaluation results are perceived to be useful for program improvement purposes. Future activities should include helping participants extend the capacity building process to additional colleagues, to create a larger pool of skilled PE practitioners.

Supporting Materials Online

- Program Evaluation Capacity-Building Program Description
- South Africa Program Evaluation Technical Assistance Plan
- Program Evaluation Capacity-Building Assessment Questionnaire.

**For further information, please contact Yamir Salabarría-Pena
Evaluation Specialist**

**Center for Disease Control and Prevention (CDC)
E-mail: ycs8@cdc.gov Telephone: +1 404 639 8175**

CAPACITY-BUILDING IN DATA QUALITY ASSESSMENTS IN AFRICA

HAF area: Education

SI area: M&E

Geographic region: Africa

Data Quality Assessment for PEPFAR-Funded Programs in South Africa

PEPFAR/South Africa shoulders roughly 25% of the total reporting requirements for PEPFAR worldwide. Given this volume of programmatic reporting, attention to data accuracy and data reliability is critical. In 2005, PEPFAR contracted Khulisa Management Services, a research, monitoring and evaluation firm based in Johannesburg, to conduct data quality assessments (DQAs) with South African organizations receiving PEPFAR funding.

In addition to identifying strengths and gaps in program data reporting, the DQA process strengthens organizational capacity to manage data. Khulisa's DQA approach involves three phases. Phase 1 (self-assessment) allows program management staff to view how data are collected and identify gaps in the data quality control process. During Phase 2 (review), assessors review results of the self-assessment with program staff, review data flow and implement Khulisa's DQA tool. After Phase 2, data quality improvement plans are created. Phase 3 (assess progress), if necessary, is carried out about three months after Phase 2, and provides an opportunity for Khulisa assessors and organizational staff to assess progress toward improving data quality since the implementation of the DQA tool. After Phase 3, outside technical assistance may be requested. As of 2009, Khulisa has worked with over 80 PEPFAR partners and conducted over 200 assessments (with one assessment representing one phase).

For further information, please contact **Mary Pat Selvaggio**
Director of Health, Khulisa Management Services

Website: <http://www.khulisa.com> E-mail: mpselvaggio@khulisa.com Telephone: +27 (11) 447-6464

Training in Routine Data Quality Assessments in Kenya

The purpose of the routine data quality audit (RDQA) process is to employ standardized tools to assess gaps in data quality at the facility or program level and, ultimately, to improve the consistency and quality of data reported. After initial assessments, quality improvement plans (QIPs) are created, and followed with supportive supervisory visits to assist with the implementation of the QIPs. Ideally, with repeated cycles of the RDQA, improved data reporting and quality can be tracked over time.

In Kenya, implementing partner EngenderHealth, among approximately 100 US Government (USG)-funded partners, has worked with district health records and information officers (DHRIOs) to use the RDQA process to address challenges in reporting against specific HIV/AIDS indicators in the areas of prevention of mother-to-child transmission (PMTCT) and antiretroviral therapy (ART).

In 2007, MEASURE Evaluation provided RDQA tools and a one-day training course for all in-country government and cooperating staff from PEPFAR implementing partners. Thereafter, joint EngenderHealth and Ministry of Health (MOH) teams identified locations and indicators with suspected “data risks.” In 2008, implementing partners rolled out RDQA at health facility and community-level sites through four training courses. Eight DHRIOs and six district AIDS and sexually transmitted infection (STI) coordinators were trained first on ART and then on PMTCT RDQAs. Respective MOH and AIDS, Population and Health Integrated Assistance (APHIA II) Nyanza field staff teams involved in behavior change communication programs and orphans and vulnerable children programs participated in two additional training courses. Initial results indicate improvements in data quality.

**For further information, please contact Michael Ochieng, M&E Advisor
APHIA II Nyanza Project/EngenderHealth**

Website: <http://www.engenderhealth.org/our-work/major-projects/aphia-nyanza.php>

E-mail: mochieng@aphianyanza.org Telephone: +254-57-2025941-4

Strengthening Monitoring and Evaluation Capacity through Data Quality Assessment in Tanzania

Data quality assessment (DQA) can be an entry point for monitoring and evaluation (M&E) system strengthening. In addition to generating important feedback about data quality, the DQA process can identify M&E weaknesses and opportunities for capacity-building. MEASURE Evaluation uses a multistep process involving DQA to strengthen the M&E capacity of President’s Emergency Plan for AIDS Relief (PEPFAR) implementing partners. The process begins with workshops and training that prepare M&E staff for the DQA endeavor, as well as “M&E 101” training and a field guide that answers questions about the routine data quality audit (RDQA) tool. After the in-depth DQA process is completed, MEASURE Evaluation and the partner use the results to develop a capacity-building plan that includes a mix of targeted workshops for regional and district staff, one-on-one mentoring and organizational changes to address problems revealed by the DQA. If the DQA identifies a partner as a weak performer, MEASURE Evaluation conducts a follow-up “mini-DQA” one year later to assess progress.

In 2008, MEASURE Evaluation launched DQAs with ten PEPFAR implementing partners in Tanzania. The Salvation Army (which provides care to orphans and vulnerable children) and TMARC (an HIV prevention organization) were two of the first partners that took part in the DQAs. After preparing for and completing their DQAs, the two organizations participated in M&E workshops and one-on-one mentoring. Responding to gaps identified through the DQA process, the workshops and mentoring focused on developing new data collection tools and M&E operational plans. One year after the first DQA, MEASURE Evaluation conducted mini-DQAs to evaluate changes in M&E capacity. The mini-DQAs showed that both organizations not only had M&E plans in place but had developed new reporting tools and had trained their staff and subgrantees to use the new tools. The two organizations also displayed striking gains on the Global Verification Factor (GVF), an indicator that compares numbers recounted during the DQA with numbers reported to USAID. This experience suggests that DQA can play an important role in helping partners learn what is expected in an M&E system and how to strengthen their systems. For partners that score higher on the DQA, follow-up can focus on evidence-based decision-making, use of geographic information systems to improve data quality and decision making and skill-building to enable partners to conduct DQAs on their own.

**For further information, please contact Dawne Walker, Resident Technical Advisor
MEASURE Evaluation
Website: <https://www.cpc.unc.edu/measure> E-mail: dwalker@futuresgroup.com
Telephone: +255 (0) 76540 9795**

REFERENCES

Advance Africa Best Practices Compendium [website]. Advance Africa, 2009.

<http://www.advanceafrica.org/Compendium>

Implementing Best Practices Initiative [website]. 2009.

<http://www.ibpinitiative.org>

Joint United Nations Programme on HIV/AIDS, and Monitoring and Evaluation Reference Group. Guidance on HIV M&E capacity-building. Geneva, Switzerland: UNAIDS, 2008. Available at:

<http://www.globalhivmeinfo.org/AgencySites/MERG%20Resources/Guidance%20on%20Capacity%20Building%20for%20HIV%20Monitoring%20and%20Evaluation.pdf>

Joint United Nations Programme on HIV/AIDS, and Monitoring and Evaluation Reference Group. Organizing framework for a functional national HIV monitoring and evaluation system. Geneva, Switzerland: UNAIDS, 2008. Available at:

<http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1132695455908/GROrganizingFrameworkforHIVMESystem.pdf>

Joint United Nations Program on HIV/AIDS, and Monitoring and Evaluation Reference Group. 12 components monitoring and evaluation system strengthening tool and 12 components monitoring and evaluation system assessment. Guidelines to support preparation, implementation and follow-up activities. Geneva, Switzerland: UNAIDS, 2009.

Joint United Nations Programme on HIV/AIDS/Monitoring and Evaluation Reference Group. Standards for a competency-based approach to monitoring and evaluation curricula & training. Geneva, Switzerland: UNAIDS, forthcoming.

Peersman G, Rugg D, Erkkola T, Kiwango E, Yang J. Are the investments in national HIV monitoring and evaluation systems paying off? *Journal of Acquired Immune Deficiency Syndromes* 52(Supplement 2):S87-S96. 2009.

United States Government Office of the Global AIDS Coordinator (OGAC). Building national HIV/AIDS monitoring and evaluation capacity: a practical guide for planning, implementing, and assessing capacity building of HIV/AIDS monitoring and evaluation systems. Washington DC: United States Government/Office of the Global AIDS Coordinator, 2007. Available at: http://gametlibrary.worldbank.org/FILES/1170_USG%20M&E%20system%20capacity%20building%20guide1.pdf

Annex A: Self-Administered Nomination Survey

Call for Nominations of Promising Practices to Build Human Resource Capacity in HIV Strategic Information and Monitoring and Evaluation

The PEPFAR M&E Technical Working Group has asked The Capacity Project to identify and document promising practices to "plan, develop, and support" national human resources in HIV-related strategic information (SI) and monitoring and evaluation (M&E). By creating a compendium of case examples from a wide range of countries, we hope to provide successful models for those creating country plans to strengthen SI/M&E human resources.

A promising practice is an intervention that has been instrumental in building capacity. We are taking a broad view of capacity-building to include such systems as policy, finance, leadership, partnership, and HR management in addition to education. The practices could include such examples as development of job descriptions, a clear career path or a supervision system for M&E officers; financial planning/policy to ensure adequate numbers and type of country-level M&E staff, HR information system to track M&E trainings or M&E staff deployment; as well as training workshops and other skills development for M&E practitioners. We welcome best practice examples from the wide range of M&E/Strategic Information program areas, including Surveys and Surveillance, HMIS/GIS, Monitoring, reporting and evaluation activities.

Do you know of any promising practice(s) implemented since 2003 for building capacity in national human resources in the area of monitoring and evaluating HIV programs?

If you have a promising practice to recommend, please click on the following link to complete a **very brief** nomination survey. If you are nominating more than one practice, please complete questions I through II for each practice. The survey should take no more than 5-10 minutes of your time:

http://www.surveymonkey.com/s.aspx?sm=DNMIJEYC5hfrRwM7Fij3uw_3d_3d

If you have trouble accessing the on-line survey or have any questions, please contact agalvin@jhpiego.net.

Thank you in advance for your assistance.

The Capacity Project

Annex B: Questions Found on Survey Monkey

Promising Practice #1:

1. Please provide a name/title or brief description of the promising practice in M&E, HMIS/GIS and/or Surveys/Surveillance?
2. In which country(ies) has the promising practice been implemented?
3. Who is the funder for the practice? If there is more than one funder, please check each donor.
 - USG (USAID, CDC, Peace Corps, Other USG)
 - Global Fund
 - UNAIDS
 - World Bank
 - Other, please list _____
4. Who is the primary implementing agency for the promising practice? If there is more than one primary agency, please list the names of all partners.
 - Government Partner, please list _____
 - Cooperating Agency, please list _____
 - Local NGO, please list _____
 - Local FBO, please list _____
 - Other, please list _____
5. Please list the approximate start date of the practice.
Start Date (MM/YYYY): _____
6. Is the practice still underway?
 - Yes
 - No
- 6b. If no, please list the approximate end date:
End Date (MM/YYYY): _____
7. What is the primary objective(s) of this promising practice?
8. Who is the primary target population for this promising practice?
9. Why do you consider the practice especially promising?
10. Is there a project website? If yes, please list the project url.
 - Yes _____
 - No
 - Don't Know

11. Who else do you recommend that we speak to for more information on this practice? Please include an email address and phone number, or any contact information available.

12. If we need more information, may we contact you? If yes, please provide your phone number and/or email address.

Yes

No

Contact Information: _____

13. Do you have another promising practice to recommend?

Yes If **Yes** → **Promising Practice #2 questions 1-11**

No

If No → Thank you very much for your time.

If you have any questions, please contact agalvin@jhpiego.net.

- *The Capacity Project*

Annex C: In-Depth Interview Guide

Name of Intervention/program:

Location(s):

HAF Area:

SI Area:

Primary contact (name/title/organization):

Contact information (email/phone):

Date of interview and Name of interviewer:

PROGRAM DESCRIPTION

This should provide the context and justification for the practice and address the following issues:

1. What is the problem being addressed?
2. Who is the target for your intervention?
3. Who were the key implementers and collaborators?
4. What is the program background/history?
5. Duration of activity (start date/end date/on-going)

FUNDING SUPPORT

6. Who is the donor(s)?
7. Duration of funding (if more than one source, list out separately)

PROGRAM OBJECTIVES ACHIEVED:

8. What are the objectives of the practice?
9. Objectives achieved to date? If yes, can you share any supporting documentation?

Implementation of the Practice

10. What are the main activities?
11. When and where were the activities carried out?

Results of the Practice – Outputs and Outcomes

12. What were the concrete results achieved? e.g. How many people trained, are staff better now than they were before?, do systems function better?

13. Was an assessment of the practice conducted? If yes, what were the results?

AFFORDABILITY

14. What resources are needed for start up (personnel, funding, infrastructure, and technical assistance)?

15. What resources are needed for continuation of activity (personnel, funding, infrastructure, and technical assistance)?

LOCAL OWNERSHIP

16. Describe the role of any in-country partners and their involvement.

17. Is there a long term plan to integrate/transfer this activity to host country government/institution? If yes, please describe the process, timeline, and status to date.

REPLICABLE (WITHIN COUNTRY)

18. Has this activity been replicated in other parts of the country?
- Are there plans to replicate this activity?
 - Do you think it could be replicated?

TRANSFERABLE

19. Has this activity been replicated in other **countries**?
- Are there plans to replicate this activity?
 - Do you think it could be replicated?

SUSTAINABLE

Is the continuation of this practice sustainable? If yes, please describe what has been done to ensure the practice's sustainability?

For others who might be interested in implementing this activity...

Overall, what makes this a promising practice?

20. Do you have any advice or recommendations for others to successfully implement this activity?
- Key steps to implement
 - Lessons learned/take home messages/tips
 - Challenges and solutions

21. Did you use or produce any tools (e.g. frameworks, flow charts etc.) to assist with implementation? If yes, can you share these with us?

Interviewer:

22. List any materials (titles), documents and/or websites that were made available to you.

Annex D: Promising Practice Scoring Table*

Criterion	Level 1	Level 2	Level 3	Score Justification
Program objectives achieved	Initial results are promising; activity is too young to determine whether program objectives met	Activity has demonstrated positive results based on implementer/donor feedback appears to be meeting objectives without formal assessment	Activity met or exceeded stated objectives as evidenced by documentation	
	1	2	3	Score =
Funding support	Less than one year of funding	1–3 years of funding	More than 3 years of guaranteed funding	
	1	2	3	Score =
Affordability	Relies on outside technical assistance, ongoing significant financial/expert human resources	Significant financial/HR start-up costs limited to onset of activity	Relies primarily on existing government infrastructure and financial and human resources	
	1	2	3	Score =
Local ownership	Donor or implementing agency pushes for activity; little buy-in from government/local institutions; intervention/activity would likely fail without external donor/implementer (e.g. no local demand for activity, no involvement of local institutions in activity implementation)	Partial government/local institution ownership of activity; without external donor/implementer aspects of intervention/activity would not continue (e.g., local demand is moderate to high; some evidence of local operational involvement in activity implementation)	Fully integrated into government/local institutions' programming; does not require outside assistance for continuation (e.g., local demand is sustained at a high level; activity implemented entirely by local human and financial resources)	
	1	2	3	Score =
Replicable (within country)	No replication attempted/considered at this stage	Activity considered for replication or small scale replication attempted	Activity successfully replicated over time and/or geography (e.g., beyond pilot/local phase; implemented more than once; replicated in additional provinces, sites or locations)	
	1	2	3	Score =
Transferable (to other countries)	No known example of possible or actual activity replication in another country	Activity considered for expansion or replication in another country	Activity successfully expanded/replicated in another country	
	1	2	3	Score =
TOTAL SCORE =				

*Table adapted from the AIDSTAR One G3P

Descriptive Characteristics (check appropriate box under each category)

Region	SI Area	HAF Area
<input type="checkbox"/> Africa <input type="checkbox"/> Asia <input type="checkbox"/> Americas <input type="checkbox"/> Eastern Europe	<input type="checkbox"/> M&E <input type="checkbox"/> HMIS/GIS <input type="checkbox"/> Surveys and surveillance	<input type="checkbox"/> Leadership <input type="checkbox"/> Policy <input type="checkbox"/> Finance <input type="checkbox"/> Education <input type="checkbox"/> Partnership <input type="checkbox"/> HRMS

The Capacity Project is an innovative global initiative funded by the United States Agency for International Development (USAID). The Capacity Project applies proven and promising approaches to improve the quality and use of priority health care services in developing countries by:

- Improving workforce planning and leadership
- Developing better education and training programs for the workforce
- Strengthening systems to support workforce performance.

The Capacity Project Partnership

INTRAEALTH
INTERNATIONAL

innovating to save lives
Jhpiego
an affiliate of Johns Hopkins University

PATH
A catalyst for global health

IMA
WORLDHEALTH
ADVANCING HEALTH & HEALING
THE WORLD OVER

LATH
LIVERPOOL ASSOCIATES
IN TROPICAL HEALTH

msh
Management Sciences for Health

TRG

The Capacity Project

IntraHealth International, Inc.
6340 Quadrangle Drive
Suite 200
Chapel Hill, NC 27517
Tel. (919) 313-9100
Fax (919) 313-9108
info@capacityproject.org
www.capacityproject.org