

Strengthening monitoring and evaluation of national AIDS programmes in East and Southern Africa:

Report of a workshop

Entebbe, Uganda

April 23-26, 2001



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Introduction

This report summarises the main themes of discussion by participants at a workshop on monitoring and evaluation (M&E) of national AIDS programmes, held in Entebbe, Uganda, from April 23-26, 2001. The workshop, convened by UNAIDS, USAID, CDC and MEASURE *Evaluation* and hosted by the Uganda AIDS Commission, brought together participants from Botswana, Kenya, Malawi, Tanzania, Uganda, Zambia and Zimbabwe. National AIDS programmes, research organisations and programme implementers were all represented, as were staff from UNAIDS, USAID and CDC offices, both from headquarters and the countries concerned. A full list of participants can be found in Appendix A.

The full title of the workshop, “Strengthening monitoring and evaluation of national AIDS programmes in the context of an expanded response”, draws attention to recent changes in the landscape of HIV prevention and care. Rising infection and death rates are gradually eroding the denial so commonly associated with HIV epidemics in African nations as elsewhere. The international community has recently swung into action to support a growing willingness to act against the epidemic at a national and a community level. National AIDS programmes are being restructured, often with a view to strengthening the response to HIV at a community or district level. The private sector is starting to respond actively in some countries, and the impact of AIDS is eliciting a response from other sectors of government, the economy and society.

This sudden proliferation of activity, which seeks to make a reality of the “multisectoral response” which has for so long remained no more than rhetoric in most countries, has greatly complicated the task of monitoring and evaluating the national response. But because this increase in HIV prevention and care activity comes backed with more funds and more public interest, both nationally and internationally, it has also increased the pressure to demonstrate that money is being spent responsibly and effectively.

Putting new tools to work

The workshop was far from being a first step. Most of the countries present have been involved in some or all stages of an international process to develop tools for improved monitoring and evaluation of national responses to AIDS. This process, which has been underway for two years, led to the development of a toolkit published recently by UNAIDS and a host of other partners. The toolkit, entitled “National AIDS Programmes – a Guide to Monitoring and Evaluation”, discusses frameworks for evaluation and identifies key standardised indicators for different epidemic states. It brings together a number of existing data collection tools which can be used to gather information from which the indicators in different programme areas are calculated. These tools have been field-tested in several countries, including some of those participating in the current workshop.

Clearly a single guide cannot cover all the information needs of all the actors in the global response to HIV – an issue discussed at greater length below. However a large number of donor organisations co-operated actively with national AIDS programmes to develop the guide, so there is widespread agreement that the specified indicators will

meet most if not all the information needs of donors, as well as programme managers at a national level. The challenge now is to get on and put these new tools to work as part of a routine system to monitor national responses to HIV and track progress towards reducing the spread and impact of the virus. The main focus of the workshop was to develop concrete action plans towards the implementation of more effective M&E systems.

Country experiences: different starting points

As a number of short but informative country presentations on different aspects of monitoring and evaluation demonstrated, the various countries attending the workshop are at very different stages in developing both their national responses to HIV and their M&E systems. The need to do better in fighting HIV, coupled with the recent rush of financial and technical support to the AIDS industry, has occasioned the restructuring of national mechanisms for confronting the epidemic in many countries. Several participants were members of newly formed multisectoral AIDS commissions whose exact operational structure and areas of activity are, as yet, poorly defined. All were, however, clear that monitoring and evaluation of national programme activity was an increasingly important item on the national agenda.

Most participating countries have a national strategic plan for HIV prevention and care. These tend to be couched in rather general terms, rarely addressing specific interventions and more rarely still setting goals for those interventions. Most programmes can therefore use their national strategic plan as only a very general starting point in elaborating specific M&E strategies. This is not, however, a universal rule. One of the countries present – Tanzania – has developed a specific plan for monitoring of the National AIDS Control Programme's current mid-term plan. Other countries such as Malawi are following suit.

Taking stock: what information do M&E systems now provide?

New actors, new programme areas, decentralising health systems, a move away from vertical programmes to integrated programming and surveillance – all of these factors have increased the complexity of monitoring the response to HIV. These changes are taking place just at the time when more donor and taxpayer interest in the epidemic has increased the demand for such monitoring. So it was perhaps a useful time to take stock of existing M&E capacity, and the extent to which it is meeting information needs in various countries.

To summarise comments made in one of the introductory presentations, a national programme needs to know whether it is implementing its programmes correctly and on a sufficient scale, that is, it needs input and output data to monitor programme performance. If it is doing enough of the right things successfully, it can hope to produce changes in the behaviours and conditions that favour the spread of HIV and aggravate its impact. This is measured through outcome data, including parameters such as sexual partnerships, condom use and STI case management. If the behaviours and conditions that determine the spread of HIV have changed, then an impact can be expected. This

impact can most easily be measured by monitoring HIV prevalence. How well are national M&E systems doing at collecting these types of data?

In terms of collecting data at these different levels of the M&E framework, the experience of countries represented at the workshop have been broadly similar. Sentinel surveillance systems for HIV stand at the core of every country's M&E efforts to date. Several countries have well-established HIV sentinel surveillance systems, though few felt that coverage of sentinel sites was adequate to give a complete picture of infection nationally, let alone to meet district level planning needs. It was suggested that population-based surveys of HIV be undertaken periodically in order to validate, calibrate and increase public confidence in data produced by the regular sentinel surveillance system. STI surveillance data are, at present, of poor quality, and the results of regular syphilis screening at antenatal clinics, if indeed it takes place at all, are rarely reported to the national AIDS programme.

Very few participating countries have regular structured surveys designed to track trends over time in HIV-related sexual behaviour. Most participating countries carry out regular DHS surveys, at five-year intervals. A module on AIDS-related behaviour and knowledge has been included in the most recent of these in most countries. However, few countries have analysed all the data available in DHS studies to track trends in sexual behaviour. This may be partly because the responsibility for national surveys such as DHS tends to lie outside the health ministry, for example in the central statistical office, and communication with the AIDS programme during both the planning and the analysis stages of such surveys can be poor.

Only Uganda and Zambia reported large population-based surveys of sexual behaviour in the rather long interval between DHS surveys, and none reported systematic and repeated surveys in groups whose behaviour is the particular target of focused interventions, such as adolescents. Some countries are now planning surveys of this sort, however.

Few systems exist for the regular collection of programme performance monitoring data at the national level. Some countries are working to improve health management information systems that can be used to contribute data in several areas of HIV programme monitoring such as blood safety, TB treatment, STI case management and the prevention of HIV transmission from mother to child. In general, however, very few countries regularly collect, compile and analyse data on inputs and outputs that could be used for even the most basic programme performance monitoring. An exception is condom distribution data, which are regularly collected and compiled from both the private and the public sector in several countries.

Overall, then, data collection is strongest in the area of impact: that is, HIV prevalence. Outcome data are weaker; most countries have not collected behavioural data in a way that could be used to measure trends over time in any systematic way. Input and output data are virtually non-existent for large areas of programming, at least at the national level.

Perhaps the most yawning gap is in the area of financial inputs. A large diversity of funding sources and a larger diversity in the recipients of funding make it difficult to track how much is invested in which activity. Multisectoralism has muddied the waters further, since in many sectors it is not clear what constitutes an HIV-related intervention.

A multisectoral AIDS commission has a clear role in tracking inputs from all the partners in the response, and systems to support this role are badly needed. Some participating countries have begun developing databases of projects, of donor commitments and of disbursement in order to help track resources. UNAIDS Theme Groups have in some countries provided a starting point for development of these resource tracking systems.

Information needs: increasingly complex as the response expands

Clearly, existing M&E systems do not currently collect all the data needed at the national level. But to complicate the picture still further, data are needed not just at the national level but by other partners in the response: by provincial, district and local level groups planning relevant responses, by people in other sectors working to integrate HIV into their planning and programming, by international groups supporting country responses. Not all of the data needed by these different groups will be relevant at the national level, just as national level data will not be able to meet all of the information needs of these different groups.

Some of the complementarities and contradictions in data needs of different groups are discussed in this section. The exchange of information between different groups is discussed in the section on co-ordination, below.

National vs. local information needs

Decentralisation of health systems has become a priority in many countries, partly because it is believed that responses will be more effective if they are designed with local conditions in mind, by people who work closely with members of the community they serve. In practice, decentralisation has been patchy in most countries. But in principle, it means that data for both the design and the evaluation of health interventions must be collected at local levels.

Different countries are at different stages in their decentralisation process. It is not yet clear exactly what information gathered at the local level would contribute actively to a more effective response to HIV. It is, however, clear that material and, more particularly, human resources for data collection, analysis and use are already strained at the central level. It is unlikely that these resources exist in each of the provinces and districts where decision-making is expected to take place in a decentralised health system.

Uganda, one of the countries that has taken decentralisation furthest in practice, has ensured that the collection of impact and outcome data – surveillance of HIV and the behaviours that spread it – remains a national activity, carried out under the auspices of central government. It seems likely, given current constraints on capacity, that this will be the most workable as well as the most cost-effective model for most countries. Countries rethinking their M&E systems for HIV may, however, have to consider how to expand or restructure their surveillance activities to be more responsive to the needs of lower levels of government, for example by increasing geographic coverage or by disaggregating data differently for different users.

For programme performance data – information on inputs and outputs – the picture is slightly different. These data can only really be useful to local decision-makers if they are collected at a local level. Substantial guidance and training may be needed to create the capacity to collect this information reliably at a local level.

Central vs. sectoral information needs

In several countries, AIDS units have been set up in different line ministries as part of the “multisectoral response”. In most of these countries, the responsibility for monitoring and evaluating the responses to AIDS in each sector lies with the M&E staff in the relevant ministry. The information they collect should, in theory, be passed to the national AIDS coordinating body, which can incorporate it into national statistics.

In practice, AIDS councils commissions in the few countries that actually do have any sectoral programmes are not always getting the information they need from other ministries. This is not entirely surprising. It is likely that M&E officers in those other ministries, say for example agriculture, are already overworked, and it is unlikely that they have any special knowledge of the field of AIDS, let alone any familiarity with the standard indicators in this field. In addition, if they take any interest in agriculture’s relationship to AIDS, it is likely that their primary concern is the impact of AIDS on agriculture, not the contribution that the agricultural sector is making to reducing the spread and impact of AIDS. For these reasons, it might be considered somewhat Quixotic to expect that sectoral M&E officers will make a substantial contribution to a national AIDS council’s ability to track progress in checking the epidemic.

One participant also pointed out that some sectors of society are actively obstructive to some forms of data collection. Religious leaders who promote abstinence until marriage and lifelong monogamy within marriage, for example, are unlikely to support or facilitate the collection of data that show that the majority of young adults have sex with more than one partner before marriage. Resistance from important sectors of the community can actively impede national data collection efforts in critical areas such as the sexual behaviour of young people. They may be even more obstructive at a local level – a further danger of devolving responsibility for surveillance of HIV-related behaviours to local levels.

Information for advocacy vs. information for programming

Monitoring and evaluation skills at a project level have typically been weak. This is often because projects are run by people driven by a desire to act urgently against the epidemic, but without any special training or interest in measuring their progress. This barrier to effective monitoring is likely to grow stronger as national programmes actively encourage a greater response at the community level, where M&E skills are in even shorter supply.

In any case, the data necessary at the project and the community level are very different from those needed at the national level. Projects need detailed information – information about who they are reaching with what services, about the quality of their services, about how their services are perceived in the communities they seek to reach – if they are to use the information to improve their programming. At the national level, on the other hand,

programme managers need just enough information to determine whether the national effort is going in the right direction. This information helps them plan for the future and lobby for necessary resources, legislative changes, etc. At this level, one or two core indicators for each programme area, aggregated from a representative sample of sites, will be sufficient to give an idea of whether the national response is making any significant headway against the epidemic.

This is not to say that project managers at the community level are not collecting the data needed at the national level. It may simply not be clear to them which data are needed, or how they should pass that information up the chain.

The idea of common reporting forms was raised several times in response to these concerns. Well-designed, easy-to-use reporting forms (forms that ask only for data that will actually get used) can go a long way towards encouraging collection of standardised data at project level, and ensuring that national data needs are met. These tools can also provide guidance to technical units responsible for M&E in different line ministries and sectors. To encourage the completion of these forms, it is essential that data submitted are compiled and fed back to users at the appropriate level, and that those actually providing the data are kept informed of how these data are used.

International vs. national information needs

Attention has recently been focused on the information needs of international partners by a report by the General Accounting Office of the United States, entitled, “US Agency for International Development Fights AIDS in Africa, but Better Data Needed to Measure Impact”.¹ The United States is by far the largest single funder of the international effort to reduce the spread and impact of HIV in the developing world, budgeting 330 million of public money for that purpose in 2001.

Several participants, including those from international agencies, recognised that international information needs should not impose an additional burden on national data collection structures. By supporting an international effort to develop standardised indicators and data collection instruments for use by national AIDS programmes, and by incorporating these indicators into its own reporting structure, USAID has gone a long way towards ensuring that its own data needs can be met by data that national programmes are (or should be) collecting for their own use. Additional data needs for projects specifically funded by USAID should largely be met by the collection at the project level of input and output data; again these data should be routinely collected by project implementers for their own use in determining how a project is performing. Copying these data through the USAID country office to those overseeing international assistance should not impose too great an additional burden on project staff.

The International Partnership on AIDS in Africa (IPAA) is working at strengthening M&E at two levels. The first focuses on prevention and care activities, the second on concepts such as co-ordination and strategic planning. Presenters of the IPAA initiative stated that separate indicators and reporting guidelines were being developed to monitor

¹ GAO 01-449, Washington DC, March 2001.

the progress of international initiatives. Many of the suggested indicators were of the yes/no variety (does a strategic plan exist, are HIV-related activities included in sectoral budgets, etc.) – and are, as indicators, useful for tracking progress when aggregated internationally.

Better co-ordination: a universal theme

The preceding section has illustrated the different needs of different users of data. However many of these needs can be met by using the same raw data. It is a matter of filtering what is necessary at which level, aggregating or disaggregating data appropriately, and packaging it to meet the needs of the different end users. All of these tasks rely on what was perhaps the most central theme of the workshop: effective coordination.

An M&E co-ordinating unit: is there a best practice?

A special unit charged with the monitoring and evaluation of national efforts to reduce the spread and impact of HIV was universally considered to be necessary. However different countries took different approaches to this unit. In some it remains housed in the ministry of health, where most of the surveillance expertise has so far been built up. It seems desirable that responsibility for maintaining and improving HIV surveillance systems remain in the Ministry of Health, not least because that ministry is responsible for most of the clinics where surveillance takes place and the staff that carry it out.

But monitoring and evaluation of AIDS programmes is much more than just HIV surveillance. Some countries are concerned that a concentration of M&E capacity within the health ministry will lead to the neglect of programme monitoring in other sectors which are trying to develop prevention and mitigation activities. Further, they point out that health ministries have relatively little experience in social surveys necessary to track sexual behaviour. Participants pointed, too, to the potential limitations of embedding an M&E body in a ministry which continues to implement the majority of HIV-related activities in every country. Such bodies may have greater difficulty in collecting, confronting and acting on data which point to programme weakness or failure. It was thought that a rather more detached body bringing together people from a variety of implementing partners might be more successful in confronting “bad news” data and using it to improve programmes in the future.

Some countries have therefore chosen to create an M&E unit within the overarching multisectoral AIDS body. These bodies are generally rather new and their roles, responsibilities and authority in collecting or requesting information from implementing agencies is as yet poorly defined. Not all AIDS councils have been able to hire the expertise they need in the technical area of monitoring and evaluation. If there is a move to make these bodies the implementing bodies for M&E rather than just co-ordinating bodies, there will almost certainly be some interruption to key activities such as surveillance as staff are hired and trained.

Another model is to leave the technical capacities in the line ministries where they now reside, and carve out for the M&E unit of the national AIDS council a co-ordinating role. The experience of Uganda is instructive in this regard. Uganda’s National AIDS

Commission is responsible for co-ordinating the HIV-related M&E activities of various partners in the national response, including those of the M&E units of line ministries. Ugandan workshop participants said that the success of this model has been mixed at best, largely because no clear structure exists to ensure that data collected by sectoral M&E sub-units is systematically forwarded to the M&E unit at the National AIDS Commission. In addition, data collected at the individual project level are frequently passed directly to donors, thus not contributing to the picture being built up by the National AIDS Commission. If M&E units are to have principally a coordinating role, then this must be accompanied by a clear reporting structure and clear mechanisms for ensuring that data are in fact passed on as necessary.

Some countries have identified a technical working group on monitoring and evaluation – involving line ministries, donors and other key partners – as a central co-ordinating forum for M&E activities. These working groups are, however, often largely inactive. Incentives to key programme planners, implementers and funders to participate actively in these groups are needed. The best incentive might be open exchange of data between partners in the group, together with the visible use of those data in improving programme planning and implementation.

Data use: unexploited opportunities

Using existing data sources

Several countries identified existing data sources which were under-utilised in the context of monitoring HIV-related behaviours. Malawi, for example, identified trend data on sexual behaviour in sequential nationally representative DHS surveys undertaken in 1992, 1996 and 2000. The country also mentioned the existence of data on HIV prevalence in blood donors, which has not been systematically analysed.

Many countries cited a wealth of data derived from academic studies, but few have formal mechanisms to ensure that they are able to incorporate the results of such studies into their national M&E system in a timely way. It was suggested that academic studies often serve the needs of researchers far more than the needs of the populations that are subject to the research. A formal mechanism for screening research and feeding its results back into the national M&E system might ensure that research becomes more relevant and its results more likely to be used to improve programming.

Health information systems ought to provide quite a bit of data relevant to monitoring HIV prevention and, particularly, care. However these systems are often weak, undermined by low staff motivation and by concerns about confidentiality, which contribute to underreporting of HIV and many associated conditions.

Building on existing data collection systems

In some cases, it is easier to expand existing data collection systems to include new types of data collection than to construct a whole new system. Discussions in this area centred on the expansion of household-based surveys such as DHS to include biological markers of risk, including STI testing and anonymous testing for HIV itself. A nationally

representative HIV sero-survey at intervals of around five years would help to interpret the results of sero-surveillance systems operating annually, giving information on the relationship between infection rates in pregnant women and women in the general population, as well as information on men, for whom no easily accessible sentinel population is available.

In addition, since most DHS surveys in participating countries now contain an AIDS module with detailed information on risk behaviour, it would in the long run increase our ability to relate changes in behaviour to changes in infection. On the downside, such an exercise would be costly and may, because of refusal or other biases, compromise the quality of data collected for other important purposes such as monitoring fertility and child welfare.

Using data in programme planning

One of the principal reasons to monitor programme implementation is to determine what is working and where improvement is needed. Very few countries, however, identified formal mechanisms for regular review of data by programme managers and implementers, with a view to determining the implications for programme activities. Those that did, such as Malawi, did so through a technical working group.

Packaging M&E data for different users

Most programmes described some form of annual report in which AIDS cases and the results of sentinel surveillance are publicised. Indeed, AIDS case reporting continues to take up a disproportionate amount of space in most annual reports, despite it being universally recognised that case reports are at best uninformative and at worst misleading. Participants raised concerns that the discrepancies between reported AIDS cases and national estimates based on HIV surveillance were creating confusion in the public arena.

Few of the national reports currently bring together all of the data available from sources outside the Ministry of Health data collection system, such as behavioural surveys, academic research, and programme information from condom social marketers and other implementers. Data collected for regular progress reports to donors on the programme elements they fund almost never appear in national reports.

That said, national surveillance reports are in high demand. Some countries organise briefings for specific user groups such as politicians, religious leaders and community groups, but few have produced written materials geared specifically to the interests of these groups. Nearly all countries identified ways that surveillance and other programme data could be made more “user-friendly”. These include packaging data differently for different users, writing briefs for journalists, and translating materials into a wider variety of languages.

Filling resource gaps

Every country cited limited capacity as a major constraint to stronger M&E activity. In shortest supply was human capacity – people trained to undertake M&E and to use its

results. Certain skills were particularly neglected, while a lack of material and financial resources was also cited.

Staffing levels

Appropriate staffing depends to a certain extent on the structure and mandate of an M&E unit. Obviously, a co-ordinating unit will need fewer staff (and staff with different skills) than a unit charged with actually undertaking surveillance and monitoring of inputs, outputs and outcomes of HIV prevention and care programmes.

That said, those co-ordinating staff have to have data to co-ordinate. Staff are still needed to carry out routine data collection activities, even if they are not placed inside the AIDS programme or a similar body. In practice, most data collection takes place in public health facilities – precisely the facilities where staff are already stretched to the limit and where levels of skill and motivation are typically low. Adding specimen collection and record-keeping to their workload for the purposes of M&E will, unless extra training and support are provided, be unlikely to result in high quality data.

Skills levels

Most countries cited the need for a broader mix of skills for effective M&E. M&E specialists have tended to emerge from the health sector, and epidemiological and data analysis skills are often relatively well represented in M&E units. Communications, planning and management skills tend to be thinner on the ground, although these are just as necessary if the data collected are to be used to maximum effect. It was, however, noted that it is not necessary to have people with all of these skills housed permanently inside an M&E unit or even a national AIDS programme. Human resources can be accessed from other sources, including academic institutions, commercial research companies and PR firms, as necessary, as long as this is budgeted for in designing M&E activities.

The theme of capacity building was raised frequently, but in rather general terms. It was thought necessary to increase training in M&E skills at all levels, and to mainstream the topic into curricula of medical schools and schools of public health. Few countries settled on specific mechanisms through which they intended to build the capacity they need in the timeframe available.

There was some discussion also of the difficulties of retaining trained staff. In some countries, civil servants are somewhat demoralised and high staff turnover is a norm. AIDS-related mortality has added to attrition. And with the demand for M&E skills increasing as more partners join in national responses, it is to be expected that international and private organisations will be chasing the same pool of qualified staff as national programmes, often offering better terms and conditions.

Funding and material resources

As a rule of thumb, it is recommended that national programmes dedicate around 10 percent of their budget to monitor and evaluate their progress. Financial resources for

M&E should, therefore, increase in proportion to programme effort, although this dynamic has not actually been recorded.

Donor dependence remains high in the field of M&E in general and surveillance in particular. Shortages of even relatively small inputs continue to jeopardize much larger data collection efforts. For example, shortages of reagents, pipettes and other basic supplies have threatened the quality of surveillance data in more than one country. Difficulties in paying for software licences and even in having simple reporting forms printed were mentioned. If countries were to budget for surveillance and M&E activities out of central funds, many of these problems could potentially be avoided. It remains to be seen whether the renewed commitment to M&E expressed in many strategic plans will be backed up by budget lines which will reduce donor dependence and ensure continuity in data collection.

Moving forward: ambitious but concrete plans

One of the principal aims of the workshop was to emerge with plans for each country aimed at detailing steps needed to strengthen and improve monitoring and evaluation of the national response. International partners at the workshop sought to identify ways in which they could actively support the implementation of the plans developed.

The diversity of programme structures and stages of development among the countries represented led each to take a different approach to identifying a plan of action. Some began by identifying data needs and then detailing which of those needs were already being met and how gaps might be filled. This included detailing specific indicators, data collection instruments and partners, and sources of funding and technical support. The exercise was carried out either for a single area of programming (e.g. by Botswana, which focused on M&E of voluntary counselling and testing services) or across all major programme areas specified in the national strategic plan (e.g. by Zimbabwe). Tanzania, Uganda and Malawi, which already had taken steps towards the development of M&E plans or frameworks at a national level, focused on steps needed to increase capacity for implementation, as well as expansion of M&E activities to currently neglected areas of programme endeavour. Strategies for improving dissemination and use of data to prompt other partners to action were also developed. Zambia focused on mapping out a pathway and timeframe for the development of an M&E plan, based around the technical working groups which have already been identified in the structure of the national response. Kenya developed quite a detailed work plan for activities in four major areas: developing an M&E plan, strengthening surveillance capacity, implementing surveillance and developing M&E activities for major areas of programming.

The action plans or matrices developed by each of the participating countries are included in Appendix B.

Some common themes emerged from these different approaches. The first was the need to be inclusive in the development of a national M&E plan. Most country participants said the mandate for development of such a plan would have to come from a larger group of people involved in the national response. Many envisaged as a first step a thorough briefing of colleagues on the outcomes of the Entebbe workshop, followed by the

convening of a larger group (sometimes a technical working group) which could collectively develop and commit to an action plan.

Most action plans mentioned the need to define roles and responsibilities and develop a sound mechanism for co-ordination of data collection at different levels. The state of flux in which many national AIDS programmes and councils now find themselves made this a major concern to many participants, but also hampered their ability to commit to clear steps in this area.

Overall, the country action plans were ambitious in their scope. However, most were also focused on clearly-defined activities and many included defined time-lines. It was suggested that a meeting be convened in 12 months' time to review progress in carrying out the activities envisaged in the plans.

Donor support

The issue of constrained resources, and most particularly of the dearth of appropriately placed staff qualified to implement and co-ordinate M&E activities, was a recurrent theme throughout the workshop. After hearing the country action plans, representatives of bilateral and international organisations detailed the support that they could provide countries with in working to implement those plans. UNAIDS is in the process of developing a "Technical Resource Network" of people and institutions who can provide support in the field of M&E. Countries should be able to draw on this pool of people with expertise in monitoring and evaluation as they develop and implement their own M&E plans. UNAIDS might, for example, be able to fund the participation of members of the Technical Resource Network in country-based technical working groups. Training will also be provided.

USAID has contracted a number of groups – including MEASURE *Evaluation*, MEASURE DHS+ and Synergy – to provide support for countries in implementing the priority areas of the action plans developed at the workshop. Synergy will also be working with individual USAID country offices to help develop plans to monitor the particular projects they fund. The aim is to develop plans that will meet reporting requirements of the U.S. government and taxpayer, while remaining as much as possible within the M&E framework defined by each nation's AIDS programme. Help with the monitoring and evaluation of regional and cross-border projects will also be provided.

CDC is already actively engaged in improving M&E capacity in a number of countries where it works, most obviously by supporting the strengthening of surveillance for HIV and risk behaviour. CDC is expecting to identify regional focal points whose function would be to support M&E activities across a number of countries, and headquarters in Atlanta will also be able to provide short-term technical assistance at the request of partner countries.

Perhaps the final word on the way forward should be left to Dr. David Kihumuro Apuuli, the Director General of the Uganda AIDS Commission which hosted the workshop:

“CDC, UNAIDS and USAID can help us, but we have to do the work ourselves”.

Appendix A: List of Participants

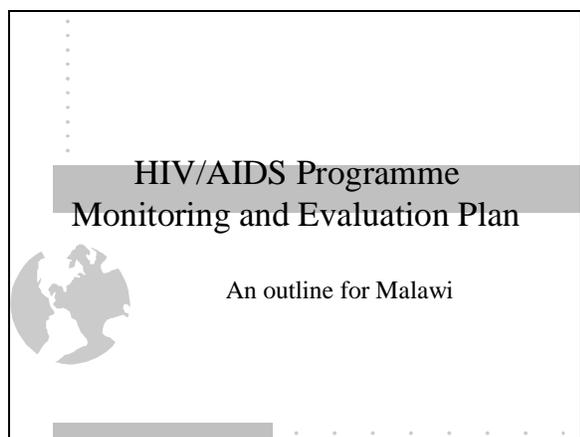
Name	Institution	Country
Alwano, Mary Grace	Centers for Disease Control and Prevention	Botswana
Tselayakgosi, Monica	National AIDS Coordinating Agency	Botswana
Chak, Chantha	USAID/Cambodia	Cambodia
Roels, Thierry	CDC/Côte d'Ivoire	Côte d'Ivoire
Naamara, Warren	UNDP	Kenya
Njoroge, Francis	Ministry of Health	Kenya
Sonnichsen, Cheryl	USAID/Kenya	Kenya
Marum, Elizabeth	CDC/Kenya	Kenya
Magiri, Gilbert	Pathfinder International	Kenya
Mwalali, Phillip N.	National AIDS Control Council	Kenya
Cheluget, Boaz	National AIDS/STD Control Program	Kenya
Patel, Mahesh	UNICEF Regional Office	Kenya
Damisoni, Henri Jerome	National AIDS Secretariat	Malawi
Hauya, Roy	National AIDS Control Programme	Malawi
Kachiza, Chifundo	Save the Children	Malawi
Chirwa, Alfred	USAID/Malawi	Malawi
Habiyambere, Vincent	WHO	Switzerland
Massoud, Nicole	UNAIDS	Switzerland
Williams, Brian	UNAIDS	Switzerland
Malangalila, Emmanuel	World Bank	Tanzania
Scott, Cheryl	CDC/Tanzania	Tanzania
Maboko, Leonard L.	Mbeya Regional AIDS Control Programme	Tanzania
Hemed, Yusuf	Adult Morbidity Mortality Project (AMMP – 2)	Tanzania
Somi, Geoffrey R	National AIDS Control Programme (NACP)	Tanzania
Swai, Rowland	National AIDS Control Programme (NACP)	Tanzania
Kagoro, Passy M.	USAID	Uganda
Kirungi, Wilford Lordson	Ministry of Health - STD/AIDS Control	Uganda
Kyambadde, Andrew Paul	USAID/Uganda	Uganda
Mukyala, Rebecca	Makerere University	Uganda

Okwero, Peter	World Bank	Uganda
Polaine-Brown, Laura	Uganda AIDS Commission	Uganda
Rwomushana, John	Uganda AIDS Commission	Uganda
Apuuli, David Kihumuro	Uganda AIDS Commission	Uganda
Baingana, Emmanuel K.	Uganda AIDS Commission	Uganda
Kalule, Josephine Katende	AIDS Information Center	Uganda
Konde-Lule, Joseph	Makerere University	Uganda
Mwesigwa, Kindyomunda Rosemary	Uganda AIDS Commission	Uganda
Ntozi, James	Makerere University	Uganda
Ochai, Robert	The AIDS Supporting Organisation (TASO)	Uganda
Sekatawa, Emmanuel	Makerere University	Uganda
Jacobi, Jantine	UNAIDS/Uganda	Uganda
Ayers, Elise	USAID/Uganda	Uganda
Bunnell, Rebecca	CDC/Uganda	United States
Davis, Margaret	CDC/Malawi	United States
MacGowan, Robin J.	Centers for Disease Control and Prevention	United States
Mermin, Jonathan	CDC/Uganda	United States
Peersman, Greet	Centers for Disease Control and Prevention	United States
Rugg, Deborah L	Centers for Disease Control and Prevention	United States
Ottoson, Judith	Georgia State University	United States
Marconi, Katherine M.	HRSA	United States
Bessinger, Ruth	Macro International, Inc.	United States
Bishop, Kaci	Carolina Population Center	United States
Boerma, J. Ties	Carolina Population Center	United States
Eckert, Erin	JSI Research & Training Inst., Inc.	United States
Bicego, George	Macro International, Inc.	United States
Destler, Harriett	USAID	United States
Novak, John	USAID	United States
Rogers, Roxana	USAID Bureau of Africa	United States
Nelson, David	CDC/Zambia	Zambia
Mukuka-Chilaika, Chilandu Vivian	Zambia Integrated Health Program (ZIHP)	Zambia
Simwanza, Alex Harrie	Zambia Integrated Health Program (ZIHP)	Zambia

Shelley, Karen	USAID/Zambia	Zambia
Dube, Noleen	Project Support, Zimbabwe	Zimbabwe
St Louis, Mike	CDC/Zimbabwe	Zimbabwe
Taruberekera, Noah	Population Services International	Zimbabwe
Matanhire, David	Zimbabwe National AIDS Commission	Zimbabwe
Henn, Carl	USAID/Zimbabwe	Zimbabwe

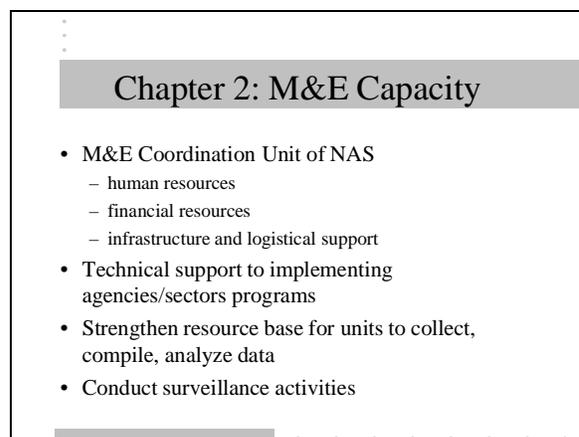
APPENDIX B: COUNTRY PLANS

MALAWI



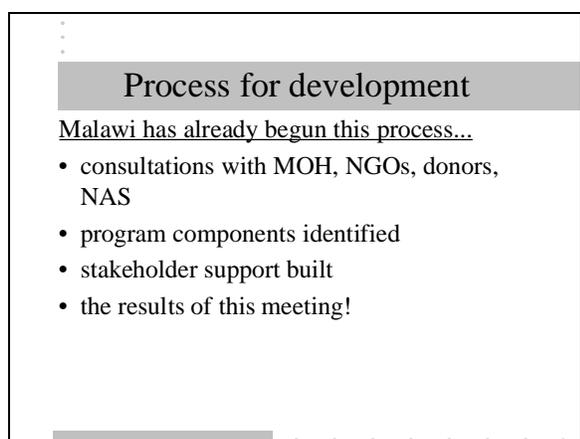
**HIV/AIDS Programme
Monitoring and Evaluation Plan**

An outline for Malawi



Chapter 2: M&E Capacity

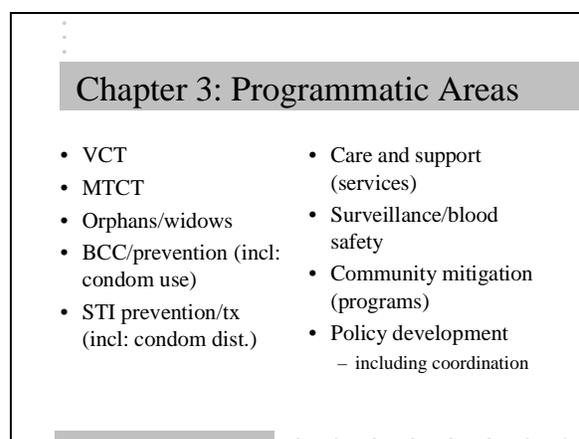
- M&E Coordination Unit of NAS
 - human resources
 - financial resources
 - infrastructure and logistical support
- Technical support to implementing agencies/sectors programs
- Strengthen resource base for units to collect, compile, analyze data
- Conduct surveillance activities



Process for development

Malawi has already begun this process...

- consultations with MOH, NGOs, donors, NAS
- program components identified
- stakeholder support built
- the results of this meeting!



Chapter 3: Programmatic Areas

- VCT
- MTCT
- Orphans/widows
- BCC/prevention (incl: condom use)
- STI prevention/tx (incl: condom dist.)
- Care and support (services)
- Surveillance/blood safety
- Community mitigation (programs)
- Policy development
 - including coordination

Chapter 1: Introduction and Background

- Epidemiological profile
- Rationale behind the development of the plan
- Goals of the plan

Chapter 3: Programmatic Areas cont....

For each programmatic area, the plan will address:

- Current status of programme
- Goals and objectives
- Main activities
- Core indicators
- Time frame
- Data collection and analysis

Chapter 4: Evaluation & special studies

- Evaluate the implementation of the strategic plan
- Conduct special studies on cross-cutting themes and areas of special interest
- Conduct operations research to inform program design

The way forward...

1. Develop budget for planning process
2. Engage consultants to develop concept papers
3. Formation of technical committee
4. Convene consensus meeting to review papers
5. Draft M&E plan including implementation budget
6. Feedback from stakeholders
7. Final plan written and published
8. Dissemination of the plan
9. Implementation/M&E of plan



Chapter 5: Dissemination and Use

- Levels of dissemination (district, region, national, Africa region, international)
- Target audiences
- Modes of dissemination and products produced (reports, newsletters, etc.)
- Timing of dissemination activities
- Use of data for programming (how will NAS assist others to use data for decision-making)

Timeline

Activity	May	June	July	Aug	Sept	Oct	Nov	Dec	2002
Form Tech. Committee	■								
Dev. SOW for consultants		■							
Engage consultants			■						
Draft papers ready				■					
Convene consensus workshop					■				
Draft M&E plan						■			
Feedback on plan							■		
Finalize plan and budget								■	
Dissemination of plan									■
Implementation of plan									■
M&E implementation of plan									■

Chapter 6: Implementation

- Discussion of role of NAS as coordination unit
- Discussion of implementing agencies and relationship with NAS

This is not the end...

It is the
BEGINNING!



TANZANIA

COUNTRY GROUPWORK

TANZANIA

STRENGTHENING M&E TECHNICAL CAPACITY (2)

Composition of M&E Technical workgroup

- Programme Manager
- M&E Principal Coordinator
- 2 Behavioral Scientists
- An Epidemiologist
- One Member from each of the four programmes
- Supportive Donors/Agencies are UNAIDS, CDC USAID, WHO, UNDP, World Bank, DFID, RNE

INTRODUCTION

- M&E Plan has been developed
- Contains six key areas:
 - HIV/STD surveillance
 - Monitoring of sexual Behavior
 - STD care and prevention
 - Voluntary counseling and testing
 - Blood safety
 - Condom Availability and Accessibility

STRENGTHENING OF HIV SURVEILLANCE (1)

- Expansion of ANC surveillance sites to cover most geographical areas in the country
- Link with population based AMMP/NSS
- Identify sources of sustainable funding
- Regular collection of data from all sites in one quarter of the year
- Technical workgroup to supervise all surveillance activities
- Collect behaviour survey data from catchment areas of ANC sentinel sites

STRENGTHENING OF M&E TECHNICAL CAPACITY (1)

- Additional requirements are 1 epidemiologist, 1 behavioral scientists and 1 biostatistician
 - Opportunities to obtain technical services from other institutions/organizations e.g. NIMR, University etc. exist
 - Employment
 - Training
- A technical workgroup has been identified but not launched.

STRENGTHENING OF HIV SURVEILLANCE (2)

- Complement results with research findings
- Solicit for inclusion of AIDS module in DHS,
- Explore potential of National Census (2001)
- Link/Relate biological data with Behavioural data

M&E PRIORITY PROGRAMS

- Programs included in current M&E plan
 - STD care and prevention
 - VCT Services
 - Blood safety
 - Condom availability and accessibility
- Program areas under development to be included in the future
 - Care and support
 - PMTCT
 - Policy

NEXT STEPS

- To secure funds for implementation of HIV and Behavioural surveys
- Share the outcome of the workshop with National Co-ordination body (TACAIDS)
- Launch the technical working group
- Update partners on the Status of M&E activities
- Implement improved dissemination and use of M&E findings

M&E RESULTS AND DISSEMINATION

(1)

- Modes of reporting and dissemination
 - Annual reports in different formats
 - A detailed report - the traditional version
 - An English and Kiswahili version consisting of graphics and tables
 - A media version
 - Electronic version
 - Semi-annual update
 - Selected data presented in public health and medical journals

M&E RESULTS AND DISSEMINATION

(2)

- Press conferences with selected information
- Oral presentations to national/regional/district forums including churches and mosques
- Target info for different sectors and partners
- Community meetings

UGANDA

UGANDA Group Presentation

M&E Workshop
Entebbe, Uganda
April 26, 2001

Monitoring the Scale-up (Draft Database Tool)

- Activities
- Implementors
- Geographic Coverage
- Thematic coverage (from NSF)
- Timeframe
- Funding amount
- Funder (Government/development partner)
- Technical Assistance

Areas Accomplished

- Draft M&E Plan developed
- Draft database tool for tracking resource inputs developed
- Outline of next steps developed

Outline of next steps for M&E Strategy

- 1) Establish M&E TRN
 - Date: 30th April 2001
 - Who? UAC
 - Resources: Not available yet
- 2) Harmonize M&E Indicators with National Strategic Framework
 - Date: 15 May 2001
 - Who? UAC
 - Resources: Partially available

Draft M&E Plan Components

- Programme Area and Indicators
- Measurement Tools
- Who is responsible
- Resources available or needed
- Frequency of reporting

Outline of next steps for M&E Strategy

- 3) Identify existing M&E data/information
 - Date: 1st May 2001
 - Who? UAC
 - Resources: available
- 4) Circulate draft M&E Plan to key stakeholders
 - Date: 31 May 2001
 - Who? UAC
 - Resources: available

Outline of next steps for M&E Strategy

- 5) Identify M&E capacity gaps in the implementing entities (needs assessment)
 - Date: 31st July 2001
 - Who? UAC
 - Resources: partially available
- 6) Report of the needs assessment including resources circulated
 - Date: 31 July 2001
 - Who? UAC
 - Resources: available

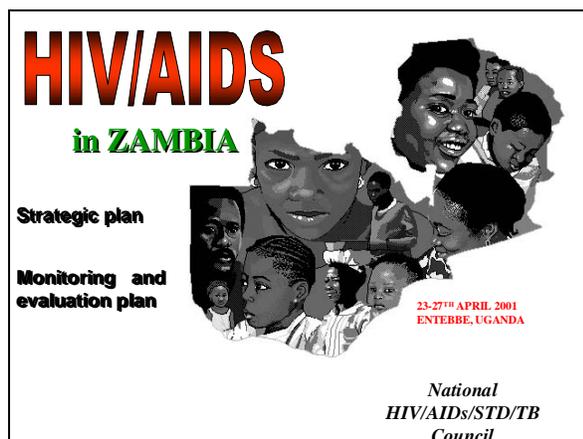
Outline of next steps for M&E Strategy

- 7) Consensus Workshop
 - Date: end August 2001
 - Who? UAC
 - Resources: Not available
- 8) M&E Plan Finalized
 - Date: mid-Sept. 2001
 - Who? UAC
 - Resources: partially available

Outline of next steps for M&E Strategy

- 9) Resource Mobilization for M&E Plan and implementation
 - Date: on-going
 - Who? UAC
 - Resources: partially available
- 10) Launch of M&E Plan
 - Date: 15 October 2001
 - Who? UAC/Minister of Finance
 - Resources: partially available

ZAMBIA



SHORT-TERM ACTION PLAN		
ACTIVITY	TIME FRAME	OUTPUT
BRIEF DIRECTOR ON WHY M&E? ♦EMPOWERS COUNCIL & SECRETARIAT ♦IMPROVES PROGRAM QUALITY ♦SYSTEMATIC APPROACH FOR VIEWING ENTIRE PROGRAM	MAY 2001	INFLUENCE THE PACE ON THE WORK ON M&E BY THE COUNCIL/ SECRETARIAT ♦Time line on naming working group ♦TWG Meetings ♦Making an M&E plan

PLANNING TOWARDS THE DEVELOPMENT OF A NATIONAL M&E PLAN

ZAMBIA National AIDS Program - Strategic Objectives						
I. RESOURCE MOBILISATION WORKING GROUP						
PREVENTION			CARE AND SUPPORT			
2. Knowledge of HIV and Sexual Behaviour <i>IEC, Condom promotion, Life skills, Workplace, Peer education, IEC Working Group</i>	3. STD Services <i>Priority, Early Dx, Rx, Prevention & control, Youth friendly, Drug supply, STI Working Group, 3.</i>	4. VCT <i>Priority, Increased services, VCT Working Group</i>	5. HIV Vaccine & Treatment <i>Working Group</i>	6. TB Working Group	7. Home & Community Care <i>Priority, Orphan, V Children, widows (or), PLWHA, OVC, Families, OVC Working Group</i>	8. MTCT <i>Priority, Reduced transmission, MTCT Working Group</i>
INTERVENTIONS						
10. MONITORING AND EVALUATION WORKING GRP						

INTRODUCTION

- ♦ MANDATE TO MAKE M&E PLAN
- ♦ PROPOSAL BASED ON NSP
 - TWG (ADVISORY)
 - DRAFT MEMBERSHIP
- ♦ SHORT TERM ACTION PLAN

AGENDA -DIRECTOR MEETING

- ♦ OBJECTIVE OF MEETING-CONSENSUS ON HOW TO MOVE M&E AGENDA FORWARD
- ♦ BACKGROUND
 - UGANDA MEETING
 - STRATEGIC PLAN
- ♦ ADVANTAGES OF M&E PLAN
- ♦ THOUGHTS OF THE DIRECTOR
- ♦ NEXT STEPS

IMPLEMENTATION STRATEGY

- ◆ BEGIN WITH CURRENT M&E ACTIVITIES (SEE M&E FRAMEWORK)
- ◆ CREATE M&E PLAN WITH A LIMITED NUMBER OF THE MOST IMPORTANT INDICATORS

CREATION OF M&E PLAN-TIMELINE

ACTIVITY	TIME FRAME	OUTPUT
APPOINT MEMBERSHIP	EARLY JULY 2001	
MEETING OF TWG	MID JULY 2001	
MAKE DRAFT M&E PLAN	DECEMBER 2001	

Monitoring and Evaluation of HIV/AIDS				
HIV/AIDS Activities at National, District and Site Levels				
Major Components	National Surveillance	National Behavioral Survey	Health Management Information System	Programmatic/ Research Initiatives
				Cross-border program District/community-level activities Condom Distribution Risk Reduction among Youth MITCT FACEAIDS VCT expansion SCOPE-OVC
Data Source	22-site antenatal-based anonymous testing	MEASURE Zambia sexual behavior survey	District-level reporting	UAB HIV/AIDS Projects
Reportable Key Indicators	Prevalence 15-24 year olds, reported annually	Condom use with non-regular partners in last sex act # of partners	# STIs treated # TB cases # HIV Cases	various program-specific indicators
Dissemination	AIDS IMPACT Model, followed by training of key groups	Publication followed by workshop	Annual bulletin, quarterly self-assessments	Program-specific reports and research publications National Health Research Conference National Annual Workshop on OVC Periodic Stakeholder HIV/AIDS Meetings on Treatment Issues Case Studies, Best Practices & Success Stories

A look at the current M&E activities

- ◆ Surveillance activities not going on according to schedule
- ◆ Data collected at program level but not reported centrally
- ◆ Quality of routine data (HMIS)
- ◆ No central coordinating mechanism

KENYA

Monitoring and Evaluation Strategic Plan

There is no comprehensive framework for M&E in the National Strategic Plan. There is a M&E plan in the Ministry of Health AIDS Control Unit (NAS COP) but there are no such plans in the other ministries charged with developing ACUs, nor is there a plan for M&E at the National AIDS Control Council. There should be a national workshop to develop consensus on the M&E plan, but this workshop should occur after a draft M&E plan has been developed. The workshop should include key stakeholders from NACC, the ACUs, donors and implementing partners, NGOs, and selected representatives from PACCs, DACCs, and CACCs.

Activities	Rationale	Implementation modality	Responsible Agency	Timing	Source of Funds	Indicator
Prepare Draft M&E Plan	No national plan exists	Joint team from NACC and ACUs, Measure Project	NACC	May- Aug 2001	TA Measure, CDC Funds USAID, UNAIDS	Draft plan prepared
Hold Workshop to review Plan	Involve stakeholders in planning M&E	Workshop	NACC	Sept 2001	TA Measure, CDC Funds USAID, UNAIDS	Workshop held
Finalize and print Plan	Revise plan after workshop	Working team	NACC	Oct-Nov, 2001	USAID, UNAIDS	Final M&E plan available
Disseminate Plan	Involve stakeholders in implementing M&E	Provincial and district level workshops	NACC, PACC, DACC	2002	UNAIDS, DFID	M&E plan distributed and used
Review, update plan	Assess how well M&E plan is working	Desk review, workshop	NACC	End of 2002	stakeholders	Revised M&E plan

M&E Capacity and Infrastructure

There is some capacity for M&E at MOH NASCOP, but very little capacity at the provincial and district level. Equipment is also needed at all levels. Attrition, transfers of staff affect capacity.

Activities	Rationale	Implementation modality	Responsible Agency	Timing	Source of Funds	Indicator
Assessment of current capacity	Current capacity is unknown	Situation analysis	NACC	May-June, 2001	DFID, WB	Report prepared on M&E capacity
Recruit M&E staff	Inadequate staff levels at present	Recruitment/ Deployment	NACC	July-Sept, 2001	GOK	Staff in place
Develop training plan	Personnel need to be strengthened	Consultancy	NACC	July-Sept, 2001	GOK, DFID	Training plan completed
Identify and procure needed equipment, software	Computers, software are lacking currently		NACC	Aug, 2001	TA: CDC Funds: UNAIDS co-sponsors, CDC	Computers in use
Establish national, provincial, and district M&E units	Need to decentralize M&E, increase use of data at local level	Deployment of staff, equipment provided at local levels	NACC and its network	Aug- Dec, 2001	All stakeholders	M&E units operational
Develop standardized record keeping systems	Standardized data are needed	Technical working groups	NACC	On-going	TA: CDC, Measure Funds: CDC, USAID, UN	Forms in use
Involve researchers and NCST on a more systematic basis	Research data not used for policy, programmes at present	Bi-annual meetings, involve researchers in developing plans, update research inventory	NACC, NASCOP, NCST	Aug-Oct, 2001	GOK/WB	Meetings held, researchers involved in M&E design
Involve KANCO and NGOs	NGOs are involved in implementation at local levels	TWG participation, assistance w/ training, M&E	NACC, KANCO	On-going	USAID, DFID, GOK/WB	Documented participation of NGOs/CBOs

Surveillance

Activities	Rationale	Implementation modality	Responsible Agency	Timing	Source of Funds	Indicator
Train facility based data collectors	Capacity needed improvement	Facility based and central training	NASCOP	March & April, 2001	Provided by CDC/POLICY, UNAIDS, WHO	# trained
Plan for data and sample collection	Current forms inadequate	Forms reviewed, new sites evaluated	NASCOP	Feb-March, 2001	CDC, GOK	Revised forms, new sites
Procure equipment, test kits and supplies	Current equipment, supplies inadequate		NASCOP, CDC	March, April 2001	CDC, GOK	All supplies needed in place
Collect data			NASCOP	April-July, 2001	GOK	
Conduct on-going training			NASCOP, CDC			
Introduce BSS	At present, only biomedical data included in HIV surveillance	BSS designed, planned	NASCOP, NACC, FHI, CDC	2001	USAID, CDC, FHI	Surveys prepared
Conduct BSS in selected areas					FHI, USAID	Surveys conducted
Compare HIV and BSS surveillance data			NASCOP, FHI, CDC, NACC			
Expand BSS to new sites						
Conduct DHS	Include AIDS module		MACRO, Institute of Statistics	?2002/3	USAID	

M&E of Priority Programs

Activities	Rationale	Implementation modality	Responsible Agency	Timing	Source of Funds, Technical assistance	Indicator
VCT	VCT not widely available in Kenya, expansion planned	VCT site record Review	NASCOP, NGOs	On-going	GOK/WB, CDC	Plan developed, # of districts where VCT is available # of persons tested, quality of services assessed
Blood safety	Transfusion services now expanded		NPHL, NASCOP	On-going	USAID, CDC, GOK	UNAIDS indicators
PMCT	Pilot programmes about to expand	Clinic record review, surveys, research	NASCOP	On-going	Multiple donors	# of mothers serviced, UNAIDS indicators, research project data
STD control	Data collected but not yet analyzed	Clinic records, facility surveys, assessment of IEC activities	NASCOP, NACC, private sector	On-going	GOK/WB, DARE, WHO	UNAIDS indicators and clinic records. STI IEC in non-health ACUs, STI services in private sector
Care and Support	Multiple programs but not yet monitored or evaluated	Program records and reports, surveys	NASCOP, NGOs, NACC	On-going	Multiple donors	1. # of persons receiving AIDS care 2. modified UNAIDS indicators 3. Community groups trained in HBC 4. # of pilot programmes in ARVs treatment
Condom availability	Current M&E exists	Program records, surveys	NACC, NASCOP, NPHL, KBS	On-going, annual	DARE project, PSI, private sector	Stock reports, availability at other ACUs, UNAIDS indicators

Activities	Rationale	Implementation modality	Responsible Agency	Timing	Source of Funds, Technical assistance	Indicator
School based & youth HIV/AIDS interventions	Program has not been monitored to date	Program records, surveys	NACC/MOE ACU	Late 2001, 2002	GOK/WB, UNICEF, DFID	1. use of curriculum 2. # of teachers trained 3. modified UNAIDS youth indicators
Sex worker		Surveys	NACC	TBD	Univ of Nairobi, FHI	UNAIDS sexual behavior indicators 3, 4, 5
Orphans & vulnerable children	Only limited evaluations to date	Program records, reports, surveys	NACC/ Home Affairs and SS	TBD	UNICEF, KANCO	1. # of street children 2. schooling of orphans 3. prev. of OVCs

M&E Dissemination

Activities	Rationale	Implementation modality	Responsible Agency	Timing	Source of Funds and TA	Indicator
AIDS in Kenya annual report	Needed for advocacy, information dissemination	Distribution of 15,000 reports	NACC, NASCOP, POLICY	Annual	Provided by POLICY project	Report printed # distributed
Short version prepared	Reader-friendly version needed	Editing, printing, distribution	NACC, NASCOP	Annual	POLICY	Version prepared, # distributed
Dissemination to district and CACC level	Knowledge of AIDS in CACCs unknown		NACC	2002	POLICY, NASCOP	# of CACCs with AIDS in Kenya, # of CACCs receiving data from CBOs
Use of data for program development, modification	Limited use of data at present for programme management	Training on use of data	NACC, NHRDC, NASCOP	TBD	MEASURE, DFID, UNAIDS	# of persons trained data analysis & use at programme level

ZIMBABWE

Monitoring the HIV/AIDS Epidemic and the Response in Zimbabwe

The Zimbabwe National Strategic Framework outlines the key domains for strengthening the response to HIV/AIDS in the country. The National AIDS Council (NAC) has responsibility for coordinating this multisectoral response. The National Strategic Framework, which has identified the following key domains for strengthening the national response (see Executive Summary, page v-x):

1. Accurate monitoring and tracking of the HIV/AIDS epidemic
2. Prevention of HIV transmission
3. Management (Care) and Mitigation of the impact of HIV/AIDS
4. Effective coordination of the National Response to HIV/AIDS
5. Improving resource availability, provision, and accountability
6. Strengthening and supporting local/grassroots response to HIV/AIDS

Strategic area	Programme activity	Data needs	Indicators	Data sources	Who does it? (potential resource)
Monitoring and tracking epidemic		Prevalence of HIV, impact	HIV prevalence in 15-24 year-old ANC women Mortality	Sentinel surveillance system, population based sero-surveys	MoH/(CDC) CSO/(Measure DHS)
Prevention of HIV	IEC	Knowledge, attitudes	% correct knowledge % misconceptions stigma indicators	General population survey, Target group surveys	CSO/(Measure DHS) UoZ
	BCC	Sexual behaviour	Median age at first sex Number of sex partners Commercial partner Age mixing	General population surveys Youth surveys Target group surveys	CSO/ (Measure DHS) ZNFPC/ (CDC) UoZ
	Condom promotion	Condom distribution, use	Distribution (by category) Condoms in retail stock Quality control Use at last risky sex	MIS Retail surveys General population surveys Youth surveys Target group surveys	MoH PSI ZNFPC CSO/ (Measure DHS) ZNFPC/ (CDC) UoZ

Strategic area	Programme activity	Data needs	Indicators	Data sources	Who does it? (potential resource)
	VCT	Coverage Capacity and resources Quality	Clients tested and receiving results Trained counsellors Quality post-test counselling	MIS Facility survey Population based survey	MoH, ZAPSO, private/ (PSI) MoH/ (Measure) CSO/ (Measure DHS)
	MTCT	Knowledge, coverage, quality	% who know PMTCT % counselled, tested and know status % +ve women receiving services	MIS Population surveys	MoH/ (UNICEF, CDC) CSO/ (Measure DHS)
	STI treatment	Coverage, quality	% diagnosed and treated % with prevention drug supply treatment seeking	Facility surveys Population survey	MoH (WHO) CSO (Measure DHS)
	Blood safety	Coverage	% transfused blood screened	MIS	NBTS
Care and support	Health care	Coverage, quality	TB management Trained personnel Clinics with capacity to care Drug stocks Referral between facility and community based clinical care Quality home based care	MIS Health facility survey Population based survey	MoH TB programme MoH (WHO, Measure) ZNFPC/ (CDC) CSO/(Measure DHS)
	Social support	Coverage, quality	% households receiving quality non-clinical support	Population based survey	
	Orphan support	Coverage, quality	% households with orphans receiving support % communities with orphan support programmes Orphan welfare measure	MIS Population based survey Community mapping and survey	D Social Welfare (NGOs CFU) CSO/(Measure DHS) Special surveys

Strategic area	Programme activity	Data needs	Indicators	Data sources	Who does it? (potential resource)
Coordination	Intra-government (National, provincial, district)	Coordinated response at different levels of govt	Meetings attended by partners in response API Timely disbursement of funds to CBOs	Meeting reports Key informant surveys Financial statements	NAC/(Safaids) NAC (Big 5/DfiD?)
	Intersectoral	Coordinated response between sectors	Meetings attended by partners in response API	Meeting reports Key informant surveys	NAC/(Safaids)
	International	Coordinated response between international partners	Meetings attended by partners in response	Meeting reports Key informant surveys UNAIDS database	NAC/(Safaids, UN Theme group)
Resource availability and accountability	Lobbying, Legislation	Tracking funds in and funds out, appropriate use	Funds in national budget Line items in sectoral budgets Donor allocations to AIDS Timely disbursement of funds to CBOs	National budgets Sectoral budgets UN Theme group database External audit of NAC and implementing agencies Financial statements	NAC UN Theme group (CDC) NAC (Big 5/DfiD?)
Support grassroots response	Develop capacity at local levels	Coverage of local initiatives, support for local initiatives	% of population actively engaged in response (non-family) Number of proposals from CBOs for support for initiatives Number of CBOs trained in project management	Population based survey MIS	NAC /(ZAN, Safaids) CSO/(Measure DHS)

M&E in Zimbabwe: Next steps

Activity	Time Frame	Responsible institution (individual)
Introduce plan to M&E seminar	Next week	NAC/David
Establish M&E working group	1 month	NAC/David
Develop and disseminate “Guidelines and Standards for M&E in Zimbabwe” for reporting to national level, including indicators and reporting forms	2 months	NAC/CDC/UNAIDS
Identify key M&E elements not accounted for and match with technical capacity	4 months	M&E working group
Publish national M&E reports (one technical, one a policy glossy)	12 months	NAC/UoZ/CDC
Identify capacity needs for better M&E at sectoral, district, project and community level and develop plan to build capacity	12 months	NAC, M&E group

Botswana

Botswana VCT M&E Plan

Strategies for Objective 1

To establish 15 free-standing VCT centers by 12/2001

To provide mobile VCT services from VCT centers.

Goals of VCT

- To contribute to the prevention of HIV infection in Botswana.
- To contribute to the reduction of the impact of HIV/AIDS among individuals, couples, families and communities.
- To contribute to the reduction of stigma associated with HIV and AIDS in Botswana.

Activities

Determine costs of establishing VCT centers

Determine costs of providing VCT services

Sensitization and District approval

Securing Temporary venue/porto camper and permanent venue.

Objective 1 of 4

To provide sustainable , quality, confidential and accurate voluntary and anonymous HIV counseling and testing to those who wish to know their status.

Activities (continued)

Providing VCT services

Quality assurance and Quality control

Personnel recruitment and training

Procurement of equipment and HIV test kits

Indicators

Cost per center established.

Cost per client served.

No. of Districts with a venue secured and plot allocated.

No. of persons recruited and trained.

Possible National Indicators

Districts with VCT available

Seroprevalence at VCT centers

Quality of counseling

VCT centers meeting minimum standards

Indicators (continued)

% of counseling sessions meeting standards.

% of tests conducted following protocol.

No. of persons receiving VCT.

No. of Positive test results.

No. of training sessions.

No. of months/yr with adequate supplies of test kits in stock.

Data Sources

Letter of allocation of plot from District Officer Lands.

Personnel Contracts signed, training report.

Stock cards & inventories.

Supervisor reports on counseling sessions.

Supervisory reports on testing procedures.

MIS VCT database.

M&E of Voluntary Counselling and Testing Programme, Botswana

Indicators	Nat. Indicators	Data sources	Agency/Organization	Who	When	Method	Resources	Who needs Info	Timeline
Cost per center established.	Districts with VCT. Seroprevalence at VCT centers. Quality of counseling. VCT centers meeting minimum standards.	Letter of allocation of plot from District Officer Land. Personnel contracts signed, training reports. Stock cards & inventory. Supervisory counseling reports. Supervisory reports on testing procedures. MIS VCT database.	BOTUSA & District Counsel, BOTUSA/CDC, DMSAC/ASU, IDM, Tebelopele VCT,	Administrator, District Officer Lands. BOTUSA (Admin, VCT Coord) DMSAC (chairperson) ASU (Head of counseling unit) IDM (training coord) Tebel (Director)	Within 60 days of meeting with District,	Filing system at BOTUSA & District Counsel	Human Resources	BOTUSA, District Counsel	

Cost per client served.

Securing Temporary venue/porto camper and permanent venue

Within 14 days of district mtg.

Within 2 wks of employment.

No. of Districts with a venue secured and plot allocated.

No. of persons recruited and trained.

Appendix C: Summary of Evaluation Forms

Strengthening Monitoring and Evaluation of National AIDS Programs in the Context of the Expanded Response

Entebbe, Uganda

April 23-26, 2001

Evaluation of sessions

I. A national from one of the seven countries

	1 Not Useful	2 Somewhat Useful	3 Useful	4 Very Useful
I – Overview of Intl Programs		x	xxxxxxx xxx	xxxxxxxxxxx
II – Country Panel: Capacity		x	xxxxxxx xxxx	xxxxxxxx
III – Country Panel: M&E Practice		x	xxxxxxx xxxx	xxxxxxxx
IV – Country Panel: Dissemination		xx	xxxxxxx xxx	xxxxxxxx
V – Country Group Work			xx	xxxxxxxxxxxxxxxxxxxx xx
VI – Country Action Plan Plenary			xxxxxxx	xxxxxxxxxxxxxxxx

II. A representative of an international organization (i.e. CDC or USAID) from one of the seven countries

	1	2	3	4
I – Overview of International Programs		XXXX	XXXXX	XXXXX
II – Country Panel: Capacity	XX	XXXXX	XXXXXX	XX
III – Country Panel: M&E Practices	XX	XXXXX	XXXXXX	XX
IV – Country Panel: Dissemination	XX	XXXX	XXXXX	XXX
V – Country Group Work		XX	XXX	XXXXXXXXXX
VI – Country Action Plan Plenary		XX	XXXXXXX	XXXXX

III. Other

	1	2	3	4
I – Overview of International Programs		X	XXX	XXX
II – Country Panel: Capacity		XXXX	XX	XX
III – Country Panel: M&E Practices	X	XX	XX	XXX
IV – Country Panel: Dissemination		XXX	XXXX	X
V – Country Group Work		X	XX	XXXXX
VI – Country Action Plan Plenary			XXXXXX	XX

Recommend another workshop like this one be organized for 7 other countries in Africa?

Yes: 39

No: 1

No Comment: 1

Left it Blank: 2

If yes, what suggestions do you have for improving this workshop? (key themes and comments)

- Several nationals from the seven countries commented that they would have liked more time for the country presentations. A couple of country nationals would have liked a longer workshop.
- Some in the International Organization and Other categories remarked that we should cut down on the time for country presentations. Several would have preferred a shorter workshop.

- Many people (across the board) indicated that more time was needed for group work and discussions.

Other comments and common themes:

- Countries should be better informed prior to the workshop. Clearer more specific guidelines for presentations. Avoid late changes to the agenda.
- Too much repetitiveness in country presentations. Perhaps have each country address some unique aspect of their program or a particular M&E issue/problem they would like to address.
- More focused guidance for group work and specification (at least in outline) of the final product is desired.
- Provide a template (or even 2-3 templates) for a national plan and an associated set of indicators – allow countries to choose from those templates or blaze their own trail (but don't require everyone to blaze their own trail).
- Several suggested providing a facilitator for each country group who could assist the group in achieving objectives.
- Brief explanation of UNAIDS manual and indicators was suggested. Present overview of UNAIDS handbook: find out if it has been used; areas to be improved in the document; difficulties in applying the guide; if not used, why?
- Several participants recommended a smaller meeting, or at least breaking into smaller groups for discussion sessions.
- A couple of country nationals suggested diversifying representation so that both government and NGOs are represented – to start the process of consensus building.
- One participant requested that we use presentation materials besides PowerPoint (which is not available to most countries or individuals).
- Providing copies of country presentations and country NSFs to entire group would be helpful.
- A couple in international organization category suggested the workshop start with the countries (rather than the donors) on all panels, allowing the bulk of the time for country experiences and a bit less for international experts.
- A country national recommended holding similar strategy sessions in each country to build ownership of the activity and to avoid making it too donor driven.

Useful to organize a follow-up workshop in one year to discuss each country's progress on implementing the action plan developed at this workshop as well as to share new experiences?

Yes: 38

No: 2

Need to Assess: 1

Left it Blank: 3

What should be included in follow-up workshop? (key themes and comments)

- Review and share progress; products available; implementation status; findings and lessons learned; challenges/obstacles to implementation; further TA needs; unique components of country plans; and common indicators for regional M&E.
- Provide an update on global M&E activities.
- Perhaps focus on specific areas: advocating for particular needs or gaps; what to include in a technical report; what to include in reports that are audience specific etc.
- Assemble country progress into a document - Experience from the 7 countries: The Way Forward.
- Develop a case study from one country to demonstrate M&E success stories.
- Discuss training and capacity issues.
- Include representation from other sectors.
- Provide more background and explanation of future reporting guidelines.
- Include a field visit.
- Hold the meeting sooner than one year from now.
- Increase TA to countries already engaged in the process of developing and/or implementing M&E plans.
- Have TA on hand to address pre-defined country needs.
- Make workshop shorter and have standard guidelines for presentations etc.

Comments from those who didn't think we should have a follow-up meeting:

- Instead of follow-up meeting have regional (all of Africa) meeting to present and display strengthened M&E systems across the region.
- Not sure of usefulness because key players may have moved on by the time of the follow-up meeting.

Other Comments

- Overall participants thought that the meeting was a success.
- Presence of the international partners was very useful.
- Choice of venue was appropriate.
- Many would have liked more advance notice of the field visits.
- Follow-up with individual countries will be important.
- Mechanism for regional M&E coordination should be put in place.
- There is a need for practical TA support to take this from theory to implementation.
- What are the M&E plans in the USA and UK? What does UNAIDS M&E plan look like?
- Request that MEASURE send information on new initiatives in HIV/AIDS M&E to country participants.