Strengthening Monitoring and Evaluation of National AIDS Programs in Asia

Bangkok, Thailand
November 4–7, 2003

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ANC/MCH	Antenatal Care/Maternal and Child Health
ARV	Antiretroviral
BSS	Behavioral Surveillance Survey
CDC	U.S. Centers for Disease Control and Prevention
CRIS	Country Response Information System
DHS	Demographic and Health Survey
DoC	Declaration of Commitment
Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
IDU	Intravenous Drug User
IV	Intravenous
M&E	Monitoring and Evaluation
MAP	Multi-Country HIV/AIDS Program
MDG	Millennium Development Goals
MEASURE	Monitoring and Evaluation to Assess and Use Results
MTCT	Mother-To-Child Transmission
NAC	National AIDS Council/Commission
NGO	Non-Governmental Organization
PMTCT	Prevention of Mother-To-Child Transmission
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Funds
USAID	U.S. Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

1. INTRODUCTION

This report summarizes the main themes discussed and the action plans developed by country teams participating in the "Strengthening Monitoring and Evaluation of National AIDS programs in Asia" workshop held in Bangkok, Thailand, from November 4–7, 2003. The workshop, hosted by the Thailand Ministry of Public Health, was convened by the Joint United Nations Program on HIV/AIDS (UNAIDS); the U.S. Agency for International Development (USAID); the World Health Organization (WHO); the World Bank; the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund); the U.S. Centers for Disease Control and Prevention (CDC); and MEASURE Evaluation. Participants from five countries—Cambodia, China, India, Thailand, and Viet Nam—were invited to the workshop. National and regional AIDS councils and programs personnel, research institution staff, and program implementers were represented, as were headquarters and country staff from UNAIDS; USAID; WHO; the World Bank; the Global Fund; and CDC. (A complete list of participants is in Appendix H.)

MEASURE Evaluation has worked closely with the various donor agencies to promote the M&E of national HIV/AIDS programs since the late 1990s. One of the major activities undertaken has been a series of workshops to bring country participants together with multiple international agencies to target the M&E of HIV/AIDS programs. Three workshops have been held in Africa from 2001 to 2003, and one was held in Kiev, Ukraine for the Commonwealth of Independent States in 2003. The meeting in Thailand was the first of its kind in Asia. Recently the international community acted to support a growing coordinated response to the worsening global AIDS epidemic at national and community levels. National AIDS programs were restructured and multisectoral AIDS bodies were established. M&E is an important function of these National AIDS Councils/Commissions (NACs). Some countries in Asia have established M&E units and are defining their role and scope within national plans, while others are establishing and developing such units.

Bringing Asian country participants together with the international donor community was a first step towards a coordinated response in the Asian region. The workshop had two primary goals. The first was to strengthen M&E capacity by giving participants the opportunity to share and discuss country practices and plans. Until very recently, international M&E of AIDS programs had focused on the dynamics of the epidemic in the African region. Thus, the second aim was to create a forum to discus the global M&E indicators of AIDS programs within the Asian context. The workshop also intended to provide a platform for international donors to share their perspectives, including the type of help extended and specific to each agency.

The workshop started with a short presentation by each donor representative that summarized international initiatives as a starting point for an interactive discussion with country participants. The countries presented the challenges they faced in developing and implementing the M&E of national or regional AIDS programs. Participants and donor representatives then broke into groups, with at least one country representative per session, to discuss the global indicators and their use within the sociocultural context of Asia. The next part of the workshop was devoted to five working groups, one for each country, to develop a detailed action plan for the next 12 months that specifies the activities to be undertaken to strengthen the M&E of national programs within the countries. Countries presented the plans they developed during these work sessions. The workshop concluded with another panel discussion with the donors that addressed the next steps to be taken in the region.

2. INTERNATIONAL INITIATIVES TO BUILD M&E CAPACITY FOR HIV/AIDS

Representatives from each donor agency were asked to give a short presentation on the role of their organization within the environment of the expanded response to the monitoring and evaluation (M&E) of National AIDS programs. The presentations aimed to provide an informational platform to open the discussion between the donor representatives and the country participants.

UNAIDS

At the 26th United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001, governments from 189 countries endorsed a Declaration of Commitment (DoC) to fight HIV/AIDS. Besides establishing specific goals and targets to enhance coordination and intensify efforts to reduce HIV infection and minimize disease impact, the DoC also included, on the part of the UNGASS, a pledge to devote time to reviewing the progress achieved annually. To this end, UNAIDS and its partners have developed a set of global and national indicators that allow the monitoring of measurable aspects of the various international and national actions, national program outcomes, and impact objectives outlined in the DoC. The development of the M&E framework aims to build on existing indicators and ensure a multisectoral approach; it also wants to be comprehensive and simple, adaptable to country situations, and consistent with other frameworks such as the Multi-Country HIV/AIDS Program (MAP), Millennium Development Goals (MDG), and the Global Fund. A complete set of indicators is available in the UNGASS report, *United Nations General Assembly Special Session on HIV/AID. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators.*

UNAIDS gave a presentation on the significance of and the challenges facing the expanded international response to build capacity for the M&E of HIV/AIDS programs. It includes a review of worldwide institutional financial commitments to HIV/AIDS programs. The noted challenges to M&E when scaling up national programs includes the increased emphasis on the coverage and quality of services, the use of an increasing number of indicators to reflect the variation in new programs, and the increasing details needed for specific indicators. The discrepancies in indicator demand between the parties of interest—donors, national, and subnational data needs—were also discussed.

WHO

WHO provides significant support to monitor and evaluate the effectiveness of key program interventions through the development of indicators and operational goals. Its work to strengthen M&E systems in the countries is conducted in close collaboration with UNAIDS, the World Bank, the United Nations Children's Funds (UNICEF), CDC, USAID, MEASURE Evaluation and many other partners. A major part of the WHO and UNAIDS global initiative is to provide antiretroviral therapy to 3 million people with HIV/AIDS in developing countries by the end of 2005; this initiative is often referred to as the 3 by 5 Initiative. Another major part of the efforts of WHO and UNAIDS concentrates on the development of guidelines and tools for the M&E of health interventions (see http://www.who.int/hiv/strategic/me/en/). In 2000, WHO and UNAIDS coordinated the development of a guide for national AIDS programs with a set of core indicators for 14 program areas. In subsequent years, work has been ongoing on the development of M&E guides for specific intervention areas such as antiretroviral (ARV) therapy, voluntary counseling and testing (VCT), prevention of mother-to-child transmission (PMTCT) of HIV, care and support, and HIV prevention programs for young people. WHO also facilitates the collection of data on specific indicators of the HIV/AIDS response at the country level. For example, WHO has coordinated assessments of the coverage of key health services in several countries. The results form a baseline against which future progress can be measured.

United States Government: USAID and CDC

USAID and CDC, components of the U.S. Government's joint strategy for HIV/AIDS—in collaboration with UNAIDS, WHO, and others—have worked hard to ensure that monitoring and reporting systems meet the reporting requirements of all agencies. Collaboration with other agencies has allowed USAID to support a part of the M&E system at the country level, with priority on reporting on USAID's program results and effectiveness. Whereas both USAID and CDC have worked hard to improve and expand national sentinel surveillance systems to track the rate of HIV transmission and monitor national impact, CDC has taken the lead in strengthening sentinel systems while USAID focuses on program monitoring for results.

World Bank

The World Bank's approval of the US $500 million MAP I for Africa in 2000 represents the first phase of a 12-to-15-year commitment to support the M&E of country HIV/AIDS programs. The World Bank works closely with other donors, bilateral agencies, and the Global Fund to implement the MAP approach. The World Bank presented the recently developed an M&E manual designed to be a guide for establishing M&E systems for MAP in the countries. The manual emphasizes the monitoring of program performance, linking it to grant disbursements.

The Global Fund

The Global Fund was constituted in 2002 as an independent, public-private partnership to lead the fight against AIDS, tuberculosis (TB), and malaria. Its purpose is to attract resources and manage and disburse funds to fight the three diseases among communities with the greatest need. The Global Fund is committed to a results-driven approach and efficient and transparent mechanisms. The structure and mandate of the Global Fund give responsibilities for implementation to local grantees and international partners.

The Global Fund presented an overview of its M&E framework that focuses on coordinating and linking performance-based results to grant disbursements. It also emphasizes financial and program monitoring as a basis for crosschecking financial and activity data. The M&E systems are expected to demonstrate how the grant program's intended results complement the broader national plan and objectives. The M&E systems will maintain the use of existing standard indicators as much as possible.

3. COUNTRY PRACTICES AND CAPACITY

All the countries gave a short overview of their current practices and of the challenges that they face in the M&E of their national AIDS programs. Country guidance distributed to participants before the meeting is included in Appendix A. Participants were asked to briefly summarize the background of the AIDS epidemic in their country before providing an overview of an existing national M&E plan or their efforts toward developing one. All activities relating to the M&E of national programs, including surveillance of the incidence and prevalence rate of HIV, programs, and the use of indicators are included in this overview. Finally, countries were asked to identify some challenges posed to either the development or implementation of a national M&E program. Since the health infrastructures in India and China are based on state/provincial systems, countries were asked to address regional M&E programs, if appropriate, within the national context. The presentations are in Appendix B.

Cambodia

Cambodia has the highest HIV prevalence rates recorded in Asia: 2.6% of adults in 2002, down from 3.3% in 1997. Most infections are sexually transmitted. While some M&E of core indicators occurred at the time of the meeting, a comprehensive national plan was being developed. This plan, in addition to the one the Ministry of Health implemented using the national Health Information System, was submitted and approved by the Global Fund. It includes M&E within health facilities, behavioral and health sample surveys, knowledge, attitudes and practices, and a Demographic and Health Survey (a national survey carried out by MEASURE *DHS*+) in 2000 and another one planned for 2005. Cambodia has various sources of data, such as the Human Development Report and a Commune Database, which need to be coordinated with the M&E system. Coordination between data sources and agencies conducting data collection under a comprehensive national plan was identified as the main challenge.

China

The overall prevalence rate of HIV infection in China is lower than in Cambodia: 7% of intravenous drug users (IDUs) and 1.3% of patients with sexually transmitted infections (STIs) are infected with HIV. Prevalence estimates of general adult or antenatal infection were not available. The largest proportion of infections was traced to intravenous (IV) drug use (64%), with sexual transmission accounting for only 8% of the cases. China has proposed a midterm evaluation of two major national AIDS prevention efforts: the China Medium- and Long- Term Plan for AIDS Prevention and Control (1998–2010) and the China Action Plan to Contain, Prevent, and Control HIV/AIDS (2001–2005). The midterm evaluation aims to measure the progress of both these plans and to identify appropriate indicators for them. The evaluation is being conducted on the provincial level, down to each prefecture, and comprises core indicators for each province and additional indicators for areas with a higher number of reported cases. These plans cover the presence of facilities, care and support, and knowledge. China also presented results for some of the UNGASS indicators. Difficulties in reporting the DoC indicators, for cultural and other reasons, the need to refine them accordingly, and support needed from the donors (training and financial backing) are some of the challenges identified.

India

In India the estimated prevalence rate of HIV in adults in 2002 is 0.8%, with heterosexual transmission accounting for 84% of the infections. In the northeast State of Manipur, where the epidemic is primarily driven by IV drug use, the prevalence rate of HIV infection among drug users is 50%. The first national response to HIV/AIDS began in 1992, by raising awareness and building capacity. Since 1999, the re-

sponse has focused on decentralization to the states and behavioral interventions. India has an extensive M&E plan in place, including a national and state-by-state sentinel surveillance of blood banks, sexually transmitted diseases (STDs) clinics, and antenatal care (ANC) clinics. India has also produced a handbook of indicators based on the global indicators developed by UNAIDS, which also includes core indicators for every region and additional and optional regional indicators depending on the nature of the epidemic in each specific state. The challenges presented include the poor quality of data, the lack of participation of the private sector, the lack of ownership by states, and the need for capacity building at the state level.

THAILAND

Thailand was one of the first countries in Asia to identify HIV as a problem and to implement an effective national response. The HIV/AIDS case-reporting system was implemented in 1984, and a serosurveillance system was instituted 5 years later. In 1995, a behavioral surveillance system was created. In 2002, the prevalence rate of HIV infection among adults in Thailand was estimated to be 1.8%. Incidence and prevalence rate of HIV infection has dropped in Thailand since the early 1990s. Among sex workers, the prevalence rate of HIV infection reached 33.2% in December 1994 and dropped to 12.2% in June 2002. The number of new infections reported nationally dropped from 142,819 in 1991 to 23,676 in 2002. Thailand has implemented a range of interventions since then, including a brothel-based, 100% condom use campaign and antiretroviral therapy during pregnancy and labor. Many M&E systems are in place and are included in the national AIDS plan. They include a Country Response Information System (CRIS) and respond to UNGASS and the Global Fund. Challenges identified by the Thai participants include identifying a focal institution to respond to the different donors and compiling indicators from all sources into a general matrix to identify core and additional indicators for the country and its regions. Help from donor institutions for technical and financial support, as well as capacity building, will help meet these challenges.

VIET NAM

In Viet Nam, the number of AIDS cases reported has risen sharply since 1990, when the first case was detected. The number of new infections reported continues to rise. For example, the annual number of new infections has increased from 11,107 in 2000 to 14,263 in 2001 and to 16,032 in 2002. In 2002, the majority of infection cases (59%) were found among IDUs, with TB patients (4%) and commercial sex workers (4%) accounting for the next largest number of cases; 21% of cases were listed as other or unknown. In 2002, the prevalence rate was estimated at 29.4% among IDUs but was much lower among commercial sex workers at 5.9%. Some M&E systems were in place, such as behavioral surveillance surveys (BSSs) and seroprevalence surveillance among special groups. Viet Nam is just starting to implement national M&E systems and has identified several areas where assistance could be provided. These areas entail improving technical skills, seeking ways to implement an M&E system through the health system, and broadening behavioral and seroprevalence surveillance.

4. WORKING GROUP SESSIONS ON HIV/AIDS M&E PROGRAM AREAS WITHIN THE ASIAN CONTEXT

Participants were asked to join one of six groups to discuss the measurement of the global HIV/AIDS M&E indicators within the Asian context. At least one country participant was to join each group to share perspectives on the composition and practicality of each of the indicators discussed. The groups were facilitated by representatives from the donor organizations and MEASURE Evaluation. Each of the groups was devoted to a set of indicators within separate M&E program areas. Originally, there were to be five different groups: 1) IV drug use, 2) National commitment and action, 3) Sexual behavior and negotiation, 4) HIV surveillance, VCT, and PMTCT, and 5) HIV/AIDS-related knowledge and stigma. Just before the start of the workshop, it was decided to pull the Care and Support indicators from several other groups and form a sixth group to discuss these indicators. Participants were given a list of indicators within each programmatic theme to discuss the challenges involved with using the indicators as presently constructed in their countries, as well as the important issues to consider about their measurement and use. The original guide and indicator list is in Appendix C.

A. INDICATORS OF IV DRUG USE

The problems in collecting these indicators in the Asian context are the same as elsewhere in the world. Because of the stigma and the political/legal environments, it is difficult to identify populations and elicit true answers. IDUs can be identified in clinics or in the community, the latter being far more difficult. It was suggested that peer interviewers with special training could best work with IDU communities. The indicators listed are said to be generally feasible for Asia with the following minor changes and additions:

- An indicator is needed on the access to clean equipment.
- Sharing equipment should be covered in one indicator, with the recall period being 1 week instead of 1 month (suggested wording: Injecting drug users never sharing equipment during the last week. Source: *National AIDS Programmes Guide to M&E*).
- Indicators are needed to measure the interaction of sexual behavior and non-injecting drug use, since it increases the risk of HIV transmission. For example, reduced inhibitions, higher-risk sex after substance use, lower condom use. Thus, non-injecting drug use should be monitored as well.

B. INDICATORS OF NATIONAL COMMITMENT AND ACTION

For some country participants, subnational indicators in this area are vital, since AIDS programs are often implemented on a smaller level, such as by province or state. Thus, the M&E of these programs would need to take place on these subnational levels as well. Since the incidence of the epidemic varies in larger countries such as India and China, some indicators may be more appropriate for some regions than others. The commitment of the private sector is also mentioned as an important input to this group of indicators. With these caveats in mind, it was concluded that the existing indicators are appropriate for Asia. The following changes were suggested to better tailor the indicators:

- An indicator is needed to measure stigma in the public sector, according to the number of human rights-related complaints.
- In the existing indicators, the country-specific context should be recognized with regard to life-skills-based education and ARV treatment.

C. Indicators of Sexual Behavior

Sexual behavior is very difficult to study and measure in many Asian countries, because of strong cultural norms that deem discussion of such issues inappropriate. This is especially true for non-marital sexual activity, particularly for women. In many countries the social stigma associated with risky sexual activity is such that survey responses are likely unreliable. The group concluded that many of the indicators, as currently written, would not work in the countries represented, particularly those aimed at young people. The group made the following comments:

- Among young people, issues such as knowledge and misconceptions of sexuality and the ensuing health consequences need to be assessed, as well as the intent to practice healthy behaviors.
- Partner histories should only be collected on married men over 18, and in Viet Nam and China the appropriateness of this schedule in general population surveys was questioned. The representatives from Viet Nam and China suggested that such surveys should only be administered to special populations.
- There is a pressing need for more in-depth information on sexual behavior in Asia, and qualitative methods would be the best approach to collecting such data.
- Rather than focusing on 'sexual negotiation,' questions should focus on spousal relationships and the extent and quality of spousal communication, which would be a proxy for how well women can negotiate for safer sex.
- The questions on sex workers were fine, but "unorganized." For example, non-brothel-based sex workers would be missed unless special efforts were made include the 'unorganized' workers, who account for much of the paid sex activity in Asia.

D. Indicators of HIV Surveillance, VCT, and PMTCT

Challenges were identified in the coverage, scope, and quality of HIV surveillance. Some countries have more advanced systems than others do, which justify the need for surveillance performance indicators to monitor the system. Suggested indicators are as follows:

- Proportion of sites with adequate number of trained staff, with "adequate" defined by the country at hand.
- Proportion of sites reporting data in a timely (again defined by the country) basis.
- Proportion of sites operating according to protocols.
- Determination of whether behavioral surveillance occurred in the past 2 years.

Specific comments made on the following VCT indicators are as follows:

- The proportion of individuals requesting an HIV test and knowing the results: Smaller countries could include this on population-based surveys, and larger countries may need an alternative indicator that measures VCT site coverage. This indicator is deemed more important in high-risk populations.
- Districts may not include data from private VCT services, an important service source in many countries. The data from public sites should be available through the routine reporting systems already in place.
- Seropositivity by risk group: Since risk groups vary from country to country, the specific groups should be deleted from the indicator definition and appropriate groups should be named by the countries. Some countries may require special studies for hard-to-reach populations because of stigma, such as men who have sex with men.

Overall, the PMTCT indicators would work well for the region.

E. Indicators of HIV/AIDS-Related Knowledge and Stigma

Most of the knowledge indicators are appropriate and useful for the Asian region. It is still very important to measure knowledge, because it is low in many of the countries; information, education, and communication campaigns are still greatly needed. As noted in the handbook, questions or misconceptions should apply to the country context. Some conflict related to breastfeeding between the PMTCT indicator and the policies of the national maternal and child health was noted as well.

The group, which discussed the knowledge and stigma indicators, concurred that some of the stigma indicators are not appropriate at the national level for countries with a low prevalence rate of HIV. These indicators may be implemented regionally within some countries or they may target certain populations, such as health care workers, on a national level.

F. Indicators of Care and Support

Several challenges were identified with the indicators of care and support and the following recommendations were made:

- Stigmatization and discrimination of affected individuals will require additional exploration within the care and support provision.
- The development of national, comprehensive care and support programs, guidelines, and training of all types of practitioners (including private and traditional) will help standardize the reporting of the care and support indicators.
- To harmonize the information demands of donor and national agencies, a health sector-based M&E coordinating committee that includes representatives from ministries of health, United Nations agencies, donor agencies, and non-governmental organizations (NGOs) at the national level is needed.
- There is a need to adapt sampling methods to decrease additional effort and resources over the long term. Methods may differ according to context; for example, using a rotation method to eventually cover the whole country, but not at once, or by using targeted sampling.

5. COUNTRY ACTION PLANS

Participants from the five countries worked on the development of detailed action plans for the next 12 months to strengthen M&E activities at the national (and/or subnational) levels. Each country was asked to outline the specific activities to be undertaken and to include contact information for the primary persons responsible for implementing M&E activities at the national (or state/provincial) level. The guidance presented to the country teams for this work section is in Appendix D and all final country plans are in Appendix E. The following section summarizes the content of each of the plans.

CAMBODIA

The current M&E system in Cambodia is based mainly on the health sector and includes a number of surveys, such as behavioral surveillance and facility assessment surveys. However, the current system was not tailored to provide adequate M&E of the National HIV/AIDS Strategic Plan. The strengths identified include the current review and revision of the national health information system, the existence of a comprehensive National HIV/AIDS plan and surveillance system, and commitment at high government levels. Areas where strengthening is needed are coordination and leadership, the sharing of data, capacity for data management, and funding allocated for M&E. The proposed action plan includes setting up a multisectorial M&E coordination committee, developing a national M&E framework and data management system, and establishing protocols for data analysis and dissemination as well as a research agenda.

CHINA

China's current M&E system was designed to meet the needs of both national M&E priorities and reporting on global indicators, such as the UNGASS indicators. The system includes surveillance, routine M&E activities, a special nationwide survey, and M&E for specific programs. The proposed plan to strengthen the current M&E system includes activities related to the establishment and development of M&E review teams, a multisectorial M&E resource group at the national and provincial levels, and an M&E management information system. Other activities proposed are the strengthening of AIDS case-reporting, BSSs for special populations (e.g., IDUs, commercial sex workers, and attendees at STI and ANC clinics), and training and capacity building for current project staff.

INDIA

India also has a fairly well established M&E system. The current challenges identified include incomplete information at the central and state levels, suboptimal use of existing data, multiple donors with diverse M&E needs at both the national and state levels, a low priority for M&E, and the lack of involvement of the private sector. The proposed plan includes activities related to these issues, such as training and capacity development, an advocacy workshop to boost the commitment to M&E, and the involvement of professional organizations and laboratories in the private sector.

THAILAND

The current system is comprehensive, including the involvement of the health and private sectors, NGOs, and international agencies. The coordination of all these agencies is identified as one of the current most pressing needs. The objectives of the proposed plan are to identify the ministry of public health as the focal point for national M&E planning and development, compile all existing indicators into one source, develop M&E tools and systems, and strengthen national capacity to implement the M&E system. Vari-

ous activities aimed at attaining these objectives were presented, including endorsing an M&E work plan for the national AIDS committee, reviewing lists of indicators and available data sources and database systems, and developing M&E tools.

Viet Nam

Viet Nam's current M&E system was less established than that of the other countries at the time of the workshop. The challenges identified are to align the system to meet the requirements of the national strategic plan, establish a framework for M&E that coordinates the existing independent systems, and coordinate the governmental and non-governmental agencies involved with M&E. The proposed plan includes many activities to strengthen and develop the system, including coordinating at the central and provincial levels, developing an M&E framework, building M&E capacity, and incorporating technical assistance and training.

6. EVALUATIONS

Workshop evaluations were filled out by 19 of the country participants; the sample form is in Appendix F. Each session and workshop objective was rated quantitatively on a scale ranging from 1 to 5, with 1 being "Needs Improvement" and 5 being "Excellent." Comments were elicited on these questions and through a set of open-ended questions that followed; they pertained to the usefulness of the workshop and suggestions for change.

The evaluations show that most participants found the workshop very useful and of high quality. The mean scores for all the sessions range from 3.8 to 4.3, with all but one falling between 4 and 5. How well the workshop met its objectives was rated only slightly lower, with the mean range between 3.7 and 3.9. Most of the comments reflect the suggestions made in the last panel session. Many people expressed that they would have benefited from expanded work sessions and more technical assistance. The full results of the evaluations are in Appendix G.

7. NEXT STEPS

The current workshop was proposed as a first step to bring countries together in Asia in the environment of the expanded international response to the AIDS epidemic. Participants suggested plans for a future meeting, centered on an expansion of the work components of the workshop in time and scope, and adding more technical instructions. They also discussed the development of a listserv, comprising information on all previous workshop participants, including country delegates and donor agency representatives, to facilitate a forum for questions and requests that can be shared globally. Currently, MEASURE Evaluation is planning a 2-week training session for early 2005 in Bangkok. The listserv, moderated by MEASURE Evaluation, was established in spring 2004.

APPENDIX A: GUIDANCE FOR COUNTRY PRESENTATIONS

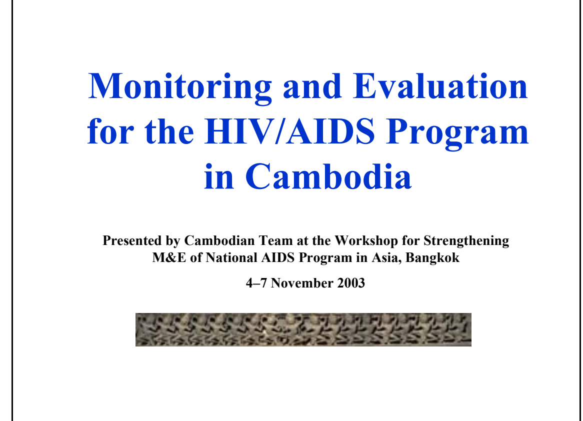
Each country should prepare a 10-minute presentation for the workshop group. The goal of these presentations is to summarize national (and where appropriate, state/provincial) M&E capacity and identify challenges to be met in strengthening present capacity. These presentations will act as a baseline for further workshop activities aiming to further M&E activities within countries. **Presentations should show an overall picture of M&E status and of challenges to moving forward.**

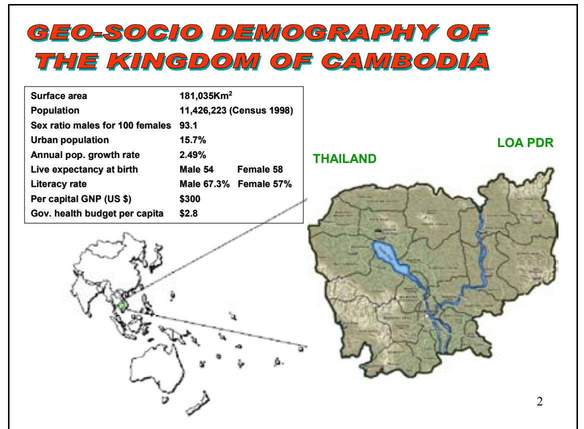
The following points should be used as a guide to develop the presentations:

- **Brief** background of AIDS epidemic in the country
- Summary of existing national plan or efforts toward developing a national plan
  - Surveillance of HIV incidence/prevalence rate
  - Other activities including the use of indicators
- Challenges to developing or implementing a national plan. This may include the difficulty in coordinating state/provincial levels and the lack of financial and technical resources.

APPENDIX B: COUNTRY PRESENTATIONS

Cambodia Presentation

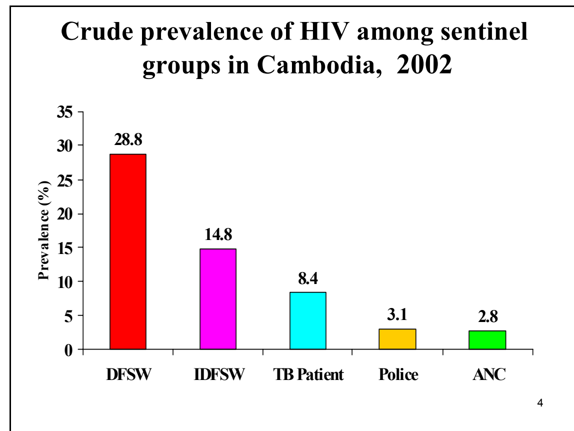


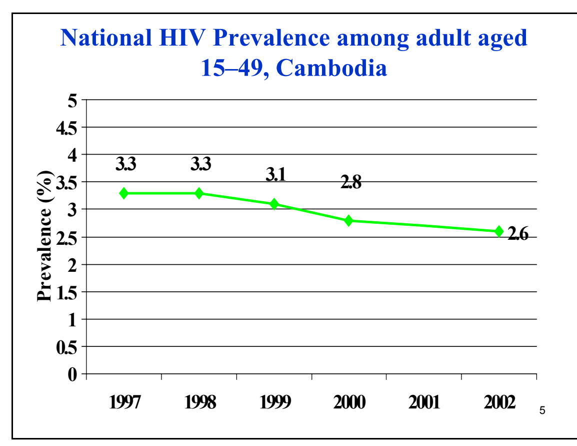


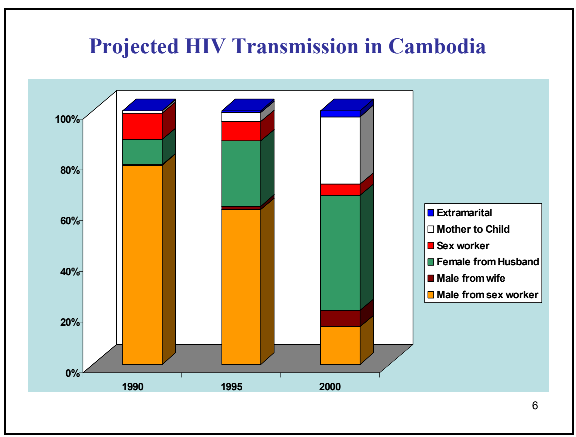
HIV/AIDS Profile of Cambodia, 2002

- Highest HIV prevalence rate in Asia
- Estimated number of HIV-infected 157,000
- Adult prevalence rate 2.6%
- Estimated number of AIDS patients 25,000
- Estimated number of OVC 30,000

3







Cambodia Presentation, continued

Current Status of M&E

- **NCHADS**: M&E unit
  - -HSS, BSS, SSS
  - - Routine monitoring system for core and non-core indicators (HIS, Home-based care, VCCT, ARV, and OIs)
  - - Planning M&E framework proposed by midterm review of the national HIV strategic plan.

7

Current Status of M&E

- **DPHI/MoH**: National Health Information System (HIS)
- **GFATM**: M&E plan submitted and approved
- **NAA**: Multisectoral country response information system (Database)
- **NGOs**: Performance Management Plan (PMP) for the USAID-NGOs and MoU with NCHADS

8

Evaluation Design

Coordination USAID, NCHADS, & URC

Method	Health Facility Assessment	HSS & BSS	KAPC & Project Records	CDHS CDHS+
Implementing agency	NCHADS and URC	NCHADS	Partners	ORCMacro
Assistance	URC and FHI	CDC and FHI	Coordination Partners	2000 and 2005
Frequency	2003 and 2005	2003, 2004, 2005	2004	
Level	Focus Area provinces and ODs	National and Focus area provinces	Focus Ods	National and Focus provinces

9

Other Sources of Data

- Demographic and Health Survey
- Human Development Report
- Socio-Economic Survey
- Health Facility Survey
- Commune Database

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Next Steps

- Increase coordination
- Strengthen M&E capacity/motivation
- Develop comprehensive national M&E framework
- Establish National M&E coordination committee and leadership
- Develop research agenda

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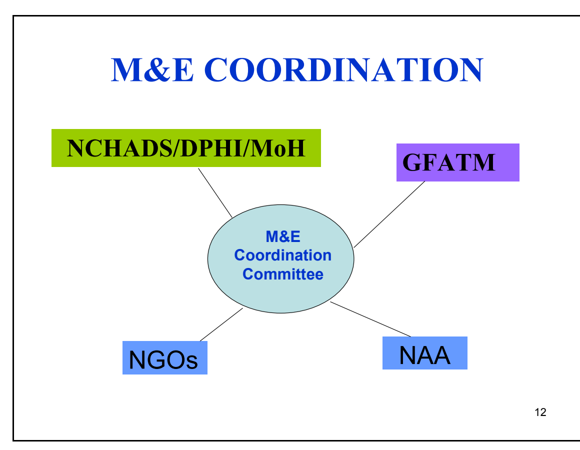


THANK YOU
13

China Presentation

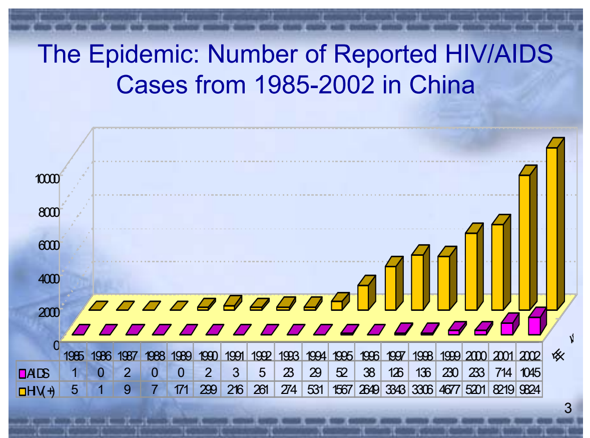
National AIDS Program: Monitoring and Evaluation in China

Dr. Dongbao Yu
National Center for AIDS/STD Control and Prevention, China CDC
Nov. 5, 2003, Bangkok

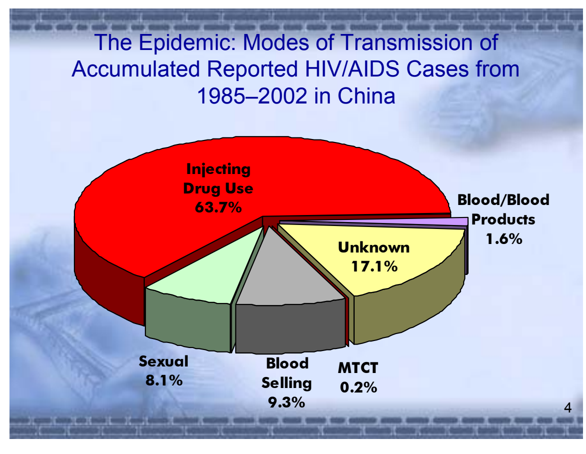
Talking Points

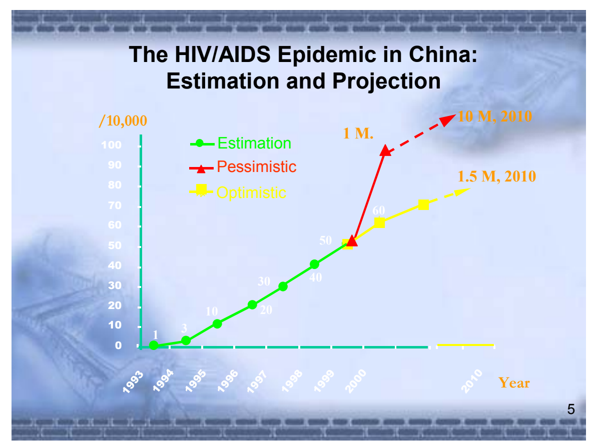
- Overview of the HIV/AIDS epidemic
- Introduction to the Midterm Evaluation Plan
- Introduction to the followup to UNGASS *Declaration of Commitment*: *China Report (Jan.–Dec. 2002)*
- The Integration of the UNGASS M&E to the national M&E plan
- Issues and challenges

2



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
AIDS	1	0	2	0	0	2	3	5	23	29	52	38	126	136	230	233	714	1045
HIV(+)	5	1	9	7	171	299	216	261	274	531	1567	2649	3343	3306	4677	5201	8219	9824





Why midterm evaluation? Requirements of two national plans

- China Medium- and Long-Term Plan for AIDS Prevention and Control (1998-2010)
- China Action Plan to Contain, Prevent and Control HIV/AIDS (2001-2005)

6

China Presentation, continued

Objectives

1. Following up the progress of implementation of "Medium- and Long-Term Plan" and "Action Plan," focusing on realization of working objectives by 2002
2. Supervising and urging further implementation of the two plans in sectors and provinces
3. Contributing to adjustment and implementation of 2005 and 2010 indicators in the two plans

7

Principles

1. Be practical, realistic and simple
2. Self evaluation by province, review and check by central with sampling
3. Focus on priority indicators
4. Classification of epidemic areas
5. Multisector involvement

8

Scope

1. Each province, and down to each prefecture (city)
2. Counties that reported HIV+ cases
3. 2-3 counties without HIV+ in each province
4. OSCCC member self-report progresses

9

Methodology

1. Document/File review
2. Survey–Questionnaire and interview
3. Government report

10

Indicators

Two Types of Indicators

Core indicators: 10

Every province must report.

Additional indicators: 14

Classified and report based on HIV transmission mode and number of cases.

11

Core Indicators

No.	Indicator	Scope
1	Making and implementation of policy, planning, law and regulation, etc.	P1, P2
2	Leading and organizing for AIDS control	P1, P2, C
3	Government funding in 3 years	P1, P2, C
4	Media campaign frequency for AIDS/STD prevention and voluntary blood donation	P1, P2
5	People's awareness of AIDS prevention knowledge	P3

P1–Province; P2–Prefecture; P3–Organized by province; C–County

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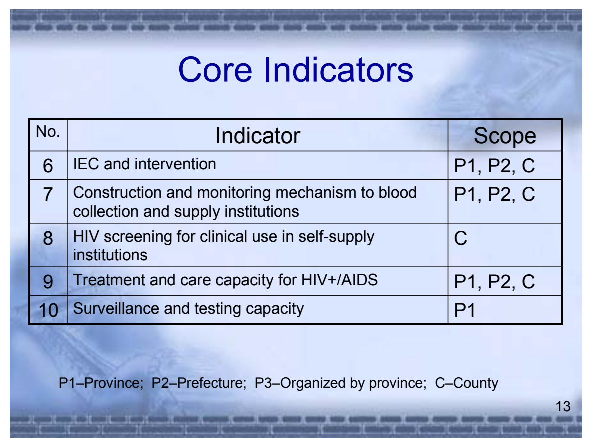
China Presentation, continued



Core Indicators

No.	Indicator	Scope
6	IEC and intervention	P1, P2, C
7	Construction and monitoring mechanism to blood collection and supply institutions	P1, P2, C
8	HIV screening for clinical use in self-supply institutions	C
9	Treatment and care capacity for HIV+/AIDS	P1, P2, C
10	Surveillance and testing capacity	P1

P1–Province; P2–Prefecture; P3–Organized by province; C–County

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Additional Indicators

No.	Indicator	Scope
1	Voluntary blood donation rate	P1, P2
2	Condom use among CSWs in entertainment establishment	P3
3	Needle sharing and condom use among IDUs	P3
4	Eligible sample collection in provincial Sentinel surveillance sites	P1
5	Report forms submitted timely from provincial sentinel surveillance sites	P1

P1–Province; P2–Prefecture; P3–Organized by province; C–County

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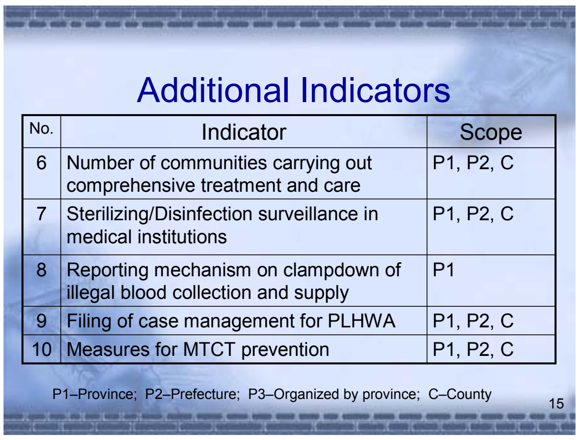
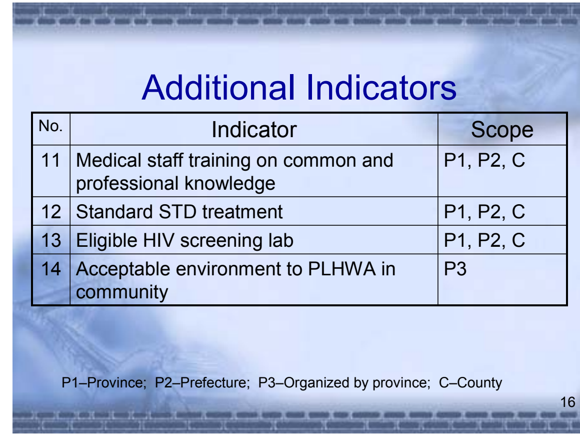


Additional Indicators

No.	Indicator	Scope
6	Number of communities carrying out comprehensive treatment and care	P1, P2, C
7	Sterilizing/Disinfection surveillance in medical institutions	P1, P2, C
8	Reporting mechanism on clampdown of illegal blood collection and supply	P1
9	Filing of case management for PLHWA	P1, P2, C
10	Measures for MTCT prevention	P1, P2, C

P1–Province; P2–Prefecture; P3–Organized by province; C–County

15



Additional Indicators

No.	Indicator	Scope
11	Medical staff training on common and professional knowledge	P1, P2, C
12	Standard STD treatment	P1, P2, C
13	Eligible HIV screening lab	P1, P2, C
14	Acceptable environment to PLHWA in community	P3

P1–Province; P2–Prefecture; P3–Organized by province; C–County

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The UNGASS Report: Glance at HIV/AIDS Epidemic in China

- HIV prevalence
  - Sex workers: 0.3%; IDUs: 7.2%; STI clinic attendees: 1.3%; Pregnant women: N/A

Data Source: Surveillance Report, CCDC

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National Response to the HIV/AIDS Epidemic

- **National commitment at a glance**
  - National Composite Policy Index: ***0.9***
  - Government funds spent on HIV/AIDS:
    - ***Direct: USD 12 million***
    - ***Indirect: USD 150 million***

Source: Government documents and archival files

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China Presentation, continued

National Response to the HIV/AIDS Epidemic

- The percentage of schools with teachers who have been trained in life-skills-based education and who taught it during the last academic year: *N/A*

19

National Response to the HIV/AIDS Epidemic

- The percentage of large enterprises/ companies that have HIV/AIDS workplace policies and programmes: *N/A*
- The percentage of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT: *< 20 cases nationwide*

20

National Response to the HIV/AIDS Epidemic

- ***Care/Treatment***
  - The percentage of patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated, and counselled: *N/A*
  - The percentage of people with advanced HIV infection receiving ARV combination therapy: *< 400 cases nationwide in the past years*

21

National Response to the HIV/AIDS Epidemic

- The percentage of respondents 15–24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission or prevention: *separate surveys by different authors*

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National Response to the HIV/AIDS Epidemic

- The percentage of people aged 15–24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner: *N/A*
- The percentage of injecting drug users that have been covered with HIV/AIDS prevention services: *1–5%*

23

National Response to the HIV/AIDS Epidemic

- **Impact alleviation**
  - Ratio of orphaned to non-orphaned children 10–14 years of age who are currently attending school: *N/A*

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China Presentation, continued

Challenges to M&E in China

- Output/outcome vs. impact indicators.
- One-shot evaluation vs. long-term, continuous M&E.
- For DoC: some indicators might be difficult to report due to the cultural and other factors.
- Some indicators might need different definition due to the differences in perception.

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Challenges to M&E in China

- The representativeness of some data might be questionable given the size and population of China.
- Technical difficulties for some of the indicators.
- Integration with the national indicators.

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Support Requested from Development Partners

- Training and communication with partners
- Methods development for survey and estimation
- Establishment, management, and utilization of data/information base
- Financial and technical support

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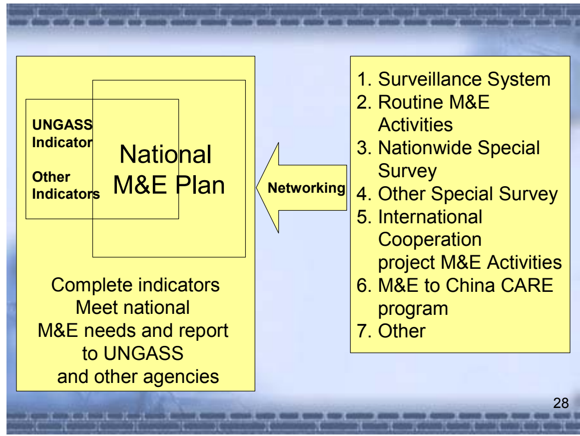


India Presentation

National Monitoring and Evaluation Framework for NACP—India

Dr. I. B. Sareen

NACO India

Workshop for Strengthening Monitoring and Evaluation of National AIDS Programs in Asia,
November 4–7, 2003, Bangkok, Thailand

Background

- First HIV infection reported in 1986 in Chennai
- Estimated HIV prevalence in 2002, 3.86–4.58 million (0.8 % prevalence)
- Diverse epidemic
- Modes of transmission
  - All India, 84% Heterosexual
  - Manipur State, 50% in IDU of all cases

National Response

- NACPI (Phase I) 1992–1999
  - Awareness raising
  - Capacity building
- NACP II (Phase II) 1999–2004
  - Decentralization
  - TIs
  - Behavioural interventions

Partnerships

- Involvement of all stakeholders
- Framework, instruments, and indicators drawn up in a consultative manner
- Involvement of SACS, UN agencies, international bilateral agencies right from inception

M&E Plan

- Budget allocated
- M&E advisory group established
- List of indicators identified by experts committee
- Handbook of Indicators and Computerized Management Information System (CMIS) developed
  - Core indicators
  - Additional indicators
  - Optional indicators

Handbook of Indicators

OVERVIEW OF INDICATORS BY PROGRAM AREAS, MEASUREMENT OF INDICATORS AND SOURCE OF INFORMATION TO BE USED FOR MONITORING NACP-II IMPLEMENTATION

	Program Area Indicator	Objective Measurement of Indicator	Source	Type	Expected Outcome
I	Condom Programming				
2	Condoms sold through retail outlets in the country	Increase in sale of condoms through retail outlets in the country	Retail Audit;	Process	Annual increase of 5% in condom[illegible] sold through the retail outlets.
II	IEC Activities and Media				
4	Correct knowledge on methods of [illegible] prevention in general populati[illegible]	Increase in proportion of general population having [illegible]rrect knowledge on [illegible] [illegible]ention.	BSS	Outcome	2001 – at least 50% identify 2 correct methods 2004 – at least 75% identify 2 correct methods 2007 – at least 90% identify 2 correct methods
III	Inter Sectoral Collaboration				
7	Implementation of School HIV Control Programme	Increase in proportion of high schools implementing School HIV Control [illegible]grammes	School survey	Process	2001 – at least 40% implementing program 2004 – at least 75% implementing program 2007 – at least 95% implementing program
IV	Voluntary Counselling and Testing				
9	Voluntary walk-in individuals tested and counseled at VCTC	Increase in proportion of Voluntary walk-in individuals using VCTC services and are counseled and tested as per required standards of care	CMIS	Process	2001 – at least 20% of persons are voluntary walk in persons 2004 – at least 30% of persons are voluntary walk in persons 2007 – at least 50% of persons are voluntary walk in persons

UNGASS Indicator

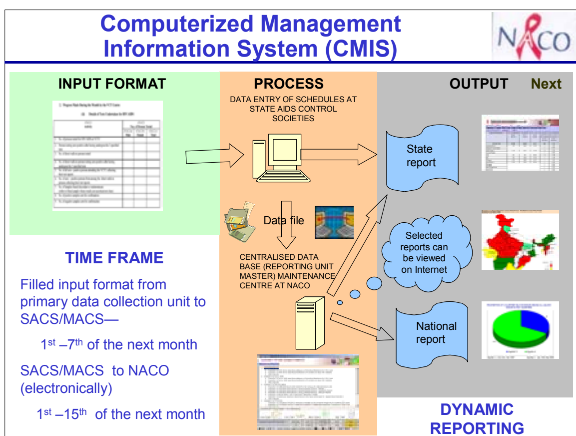
UNGASS Indicator

India Presentation, continued

Data Source for M&E

- HIV Sentinel Surveillance–455 sites
- Behavioural Sentinel Surveillance (GP and HRG)—National and state baseline
- CMIS all states—Blood banks, STD, VCTC, TI, IEC, etc. from 5,112 PDGUs
- Family Health Awareness Campaign reports
- STD facility surveys
- PPTCT reports

Computerized Management Information System (CMIS)



Output Report – Blood Bank

Table Reports

Indicator Driven Output Reports

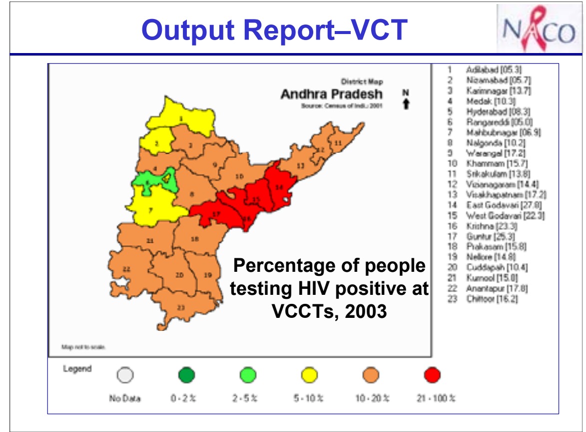
National Level Reports

- Indicators for BLOOD BANK
  - Proportion of collected blood units tested for HIV among all collected blood units
  - Proportion of voluntary blood donors among all blood Donors - Monthly
    - Government Blood Banks
    - Voluntary/Charitable Blood Banks
    - Private Blood Banks
    - All Blood Banks
  - Proportion of voluntary blood donors among all blood Donors - Quarterly (Trend)
  - Proportion of voluntary blood donors among all blood Donors - Annual (Trend)
  - Proportion of Blood banks with Component Seperation Facility
  - Other Reports
    - Proportion of posts of Blood bank Technicians vacant at the Blood Bank
    - Trend in Proportion of Blood banks not equipped with critical equipment - by type of Blood Bank
    - Proportion of Blood Banks not equipped with adquate quantity of critical consumables - by type of Blood
    - Trends in Proportion of Blood testing positive for HIV, Hepatitis- B & C, Malaria & VDRL
    - Trends in proportion of Blood Banks providing counseling facilities
    - Trends in proportion of Blood banks organizing Voluntary Blood Donation Camps
    - Trends in proportion of blood units collected through camps

Graphical Presentation of Indicators...

Line Graph | Pie Chart | Map Output | Bar Chart

Output Report–VCT



Achievements

- List of Indicators developed
- CMIS developed and implemented
  - 40% of states reporting
- Training in use of CMIS initiated

Constraints

- Incomplete data and poor-quality information
- Participation of private sector lacking
- Developing data sets/systems not inclusive/participative
- Lack of skills in processing, analysis, and use of data for planning
- Lack of ownership by states

India Presentation, continued

Future Directions

- Building capacity at state, district, and subdistrict level for data collection analysis and use (feedback and action)
  - Training, supervision, equipment
- Involve states in M&E plans to promote ownership
- Review and identify relevant indicators

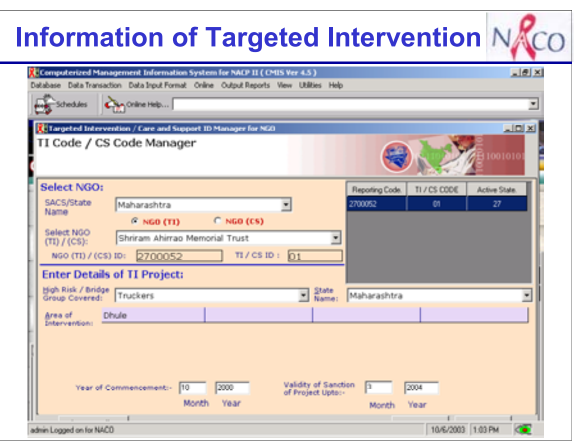
Thank You

Coverage

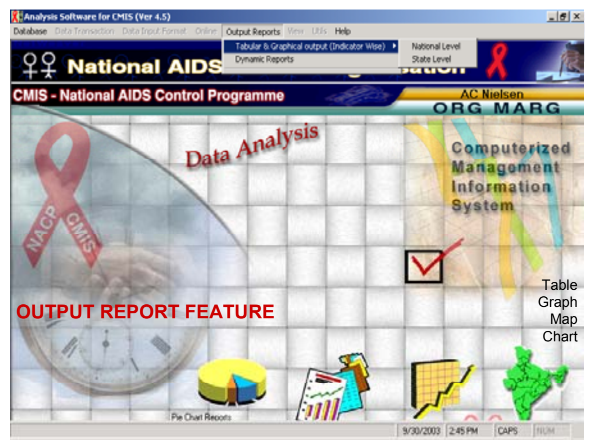
- For GP: Survey conducted in all 35 States and UTs
- Country divided into 22 State sampling units
- 11 units covered during April–June 2001
- Remaining units covered during July–Sept 2001
- For FSW and Clients of FSW: 32 States/UT covered (21 sampling units)—Dec 01–Feb 02
- For MSM: 5 locations—Delhi/ Mumbai/Kolkata/ Bangalore/Chennai—Feb–Mar 02
- For IDU: 5 locations—Delhi/Mumbai/Kolkata/ Chennai/Manipur—Feb–Mar 02

Objectives of CMIS

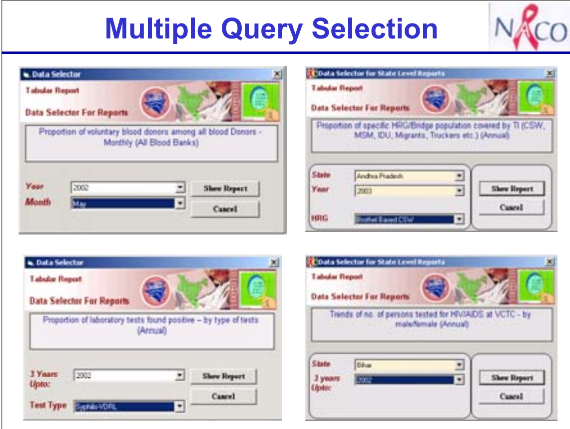
- Assess status of project implementation.
- Initiate remedial action based on regular, standardized collection.
- Ensure timely flow of data for immediate corrective measures.
- Ensure correctness and completeness of data collection.

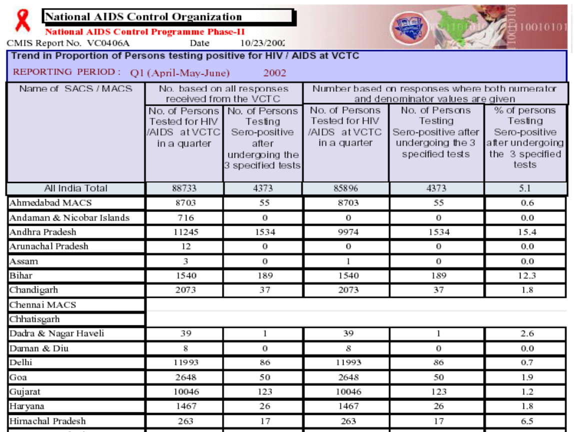


India Presentation, continued



Multiple Query Selection





National AIDS Control Organization

National AIDS Control Programme Phase-II

CMIS Report No. VC0406A Date 10/23/200?

Trend in Proportion of Persons testing positive for HIV / AIDS at VCTC

REPORTING PERIOD : Q1 (April-May-June) 2002

Name of SACS / MACS	No. based on all responses received from the VCTC		Number based on responses where both numerator and denominator values are given		
	No. of Persons Tested for HIV /AIDS at VCTC in a quarter	No. of Persons Testing Sero-positive after undergoing the 3 specified tests	No. of Persons Tested for HIV /AIDS at VCTC in a quarter	No. of Persons Testing Sero-positive after undergoing the 3 specified tests	% of persons Testing Sero-positive after undergoing the 3 specified tests
All India Total	88733	4373	85896	4373	5.1
Ahmedabad MACS	8703	55	8703	55	0.6
Andaman & Nicobar Islands	716	0	0	0	0.0
Andhra Pradesh	11245	1534	9974	1534	15.4
Arunachal Pradesh	12	0	0	0	0.0
Assam	3	0	1	0	0.0
Bihar	1540	189	1540	189	12.3
Chandigarh	2073	37	2073	37	1.8
Chennai MACS					
Chhatisgarh					
Dadra & Nagar Haveli	39	1	39	1	2.6
Daman & Diu	8	0	8	0	0.0
Delhi	11993	86	11993	86	0.7
Goa	2648	50	2648	50	1.9
Gujarat	10046	123	10046	123	1.2
Haryana	1467	26	1467	26	1.8
Himachal Pradesh	263	17	263	17	6.5

Other Data Sources

- Monitoring and Evaluation framework (Handbook of indicators)
- HIV Sentinel Surveillance—455 sites
- HSS—Data on consistent sites (180)
- BSS GP—National and state baseline
- BSS HRG—National and state baseline
- HRG Mapping
- HRG size estimation

Other Data Sources…

- CMIS all states—Info on Blood banks, STD, VCTC, TI, IEC, etc. from 5,112 PDGUs
- CNA
- FHAC reports
- STD facility survey
- TI evaluation reports
- PPTCT reports
- PFMS

Use of Data in Programming

- Awareness of its existence
- Access to data
- Skills to make sense of it
- Disseminate it effectively
- Environment to use it
- Quality support from the M&E unit
- Instead passive collection and transfer

India Presentation, continued

National Monitoring and Evaluation Framework for NACP—India

Dr. I. B. Sareen
NACO, India

National Monitoring and Evaluation Framework for NACP -India

Background

- Emphasis on M&E right from the beginning of NACP II—Built-in and budget provided
- Importance on evidence-based programming
- Importance of developing state-level capacities for collection, analysis, interpretation of data, and relevant remedial action

National Monitoring and Evaluation Framework for NACP -India

Partnerships

- Involvement of all stakeholders—primary concern
- Framework, instruments, and indicators drawn up in a consultative manner
- Involvement of SACS, UN agencies, international bilateral agencies right from inception

National Monitoring and Evaluation Framework for NACP -India

OVERVIEW OF INDICATORS BY PROGRAM AREAS, MEASUREMENT OF INDICATORS AND SOURCE OF INFORMATION TO BE USED FOR MONITORING NACP-II IMPLEMENTATION

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II	IEC Activities and Media				
4	Correct knowledge on methods of HIV prevention in general population (UNGASS Indicator)	Increase in proportion of general population having correct knowledge on methods of HIV prevention.	BSS	Outcome	2001 – at least 50% identify 2 correct methods 2004 – at least 75% identify 2 correct methods 2007 – at least 90% identify 2 correct methods
III	Inter Sectoral Collaboration				
7	Implementation of School HIV Control Programme (UNGASS Indicator)	Increase in proportion of high schools implementing School HIV Control Programmes	School survey	Process	2001 – at least 40% implementing program 2004 – at least 75% implementing program 2007 – at least 95% implementing program
IV	Voluntary Counselling and Testing				
9	Voluntary walk-in individuals tested and counseled at VCTC	Increase in proportion of Voluntary walk-in individuals using VCTC services and are counseled and tested as per required standards of care	CMIS	Process	2001 – at least 20% of persons are voluntary walk in persons 2004 – at least 30% of persons are voluntary walk in persons 2007 – at least 50% of persons are voluntary walk in persons

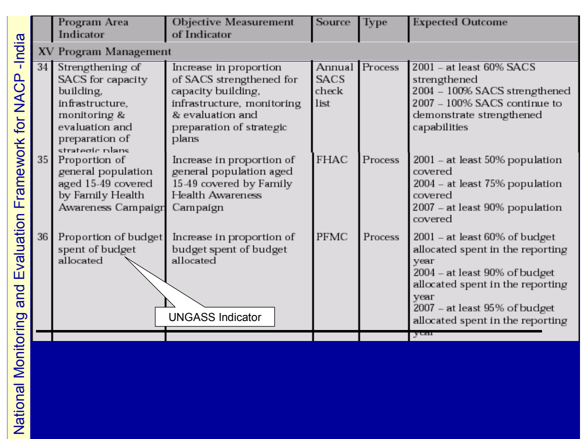
National Monitoring and Evaluation Framework for NACP -India

	Program Area	Objective Measurement	Source	Type	Expected Outcome
V	Sexual Behavior of Young People				
11	Young persons (15-24) reporting use of condom in their last sex with a non regular partner	Increase in proportion of young persons reporting use of condom in their last sex with a non regular partner	BSS	Outcome	2001 – at least 50% report condom use 2004 – at least 75% report condom use 2007 – at least 95% report condom use
VI	Targeted Interventions for High Risk Groups and Bridge Populations				
13	Specific HRG/bridge population covered by TI (CSW, MSM, IDU, Migrants, Truckers etc)	Increased proportion of specific HRG/ bridge population covered by TI (CSW, MSM, IDU, Migrants, Truckers etc)	CMIS	Process	2001 – at least 30% HRG covered 2004 – at least 75% HRG covered 2007 – at least 90% HRG covered
VII	STI Care and Prevention				
18	STI Clinics providing good quality services including adequate supply of essential drugs (UNGASS Indicator)	Increased proportion of STI Clinics providing good quality services including adequate supply of essential drugs among all STI clinics in public and private sector	Facility Survey	Process	2001 – at least 30% STI clinics meet quality 2004 – at least 90% STI clinics meet quality 2007 – 100% STI clinics meet quality
VIII	Blood Safety				
21	Proportion of voluntary blood donors	Increase in proportion of voluntary blood donors among all blood donors	CMIS	Outcome	2001 – at least 60% voluntary donors 2004 – at least 80% voluntary donors 2007 – at least 95% voluntary donors
IX	Care and Support				
22	Adequate availability of drugs for treating Opportunistic Infections	Increased proportion of health facilities reporting adequate availability of drugs for treating Opportunistic infections	CMIS	Process	2001 – at least 60% facilities report adequacy 2004 – at least 90% facilities report adequacy 2007 – 100% facilities report adequacy

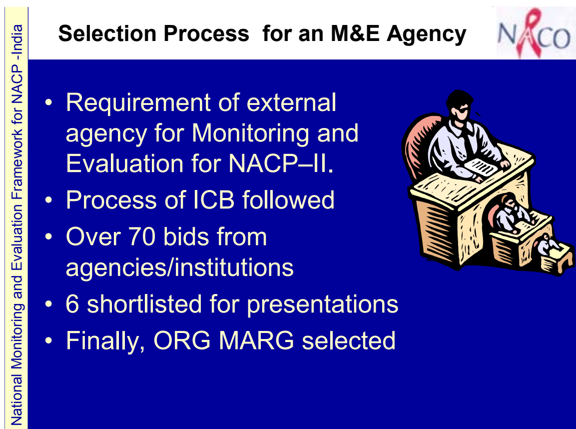
National Monitoring and Evaluation Framework for NACP -India

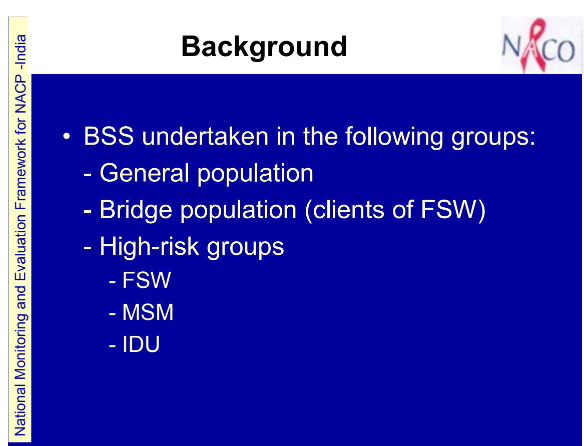
	Program Area Indicator	Objective Measurement of Indicator	Source	Type	Expected Outcome
X	Stigma and Discrimination				
24	Health care providers' attitudes towards PLWHA	Increase in proportion of health care providers' positive attitudes towards HIV positive persons	Health provider Survey	Process	2001 – at least 50% providers are positive 2004 – at least 75% providers are positive 2007 – 100% providers are positive
XI	Mapping AIDS trends				
25	Median age of newly diagnosed AIDS cases	Increase in median age of newly diagnosed AIDS cases	CMIS	Outcome	Increase in median age of newly diagnosed HIV/AIDS cases.
XIII	Sentinel Surveillance				
28	HIV prevalence among pregnant women (UNGASS Indicator)	Decrease in HIV prevalence among pregnant women	Sentinel Survei-llance	Outcome	2001 – < 5% (H); < 3%(M); < 1% (L) 2004 – < 5% (H); < 3%(M); < 1% (L) 2007 – < 5% (H); < 3% (M); < 1% (L)
XIV	Women's Empowerment				
31	Accessibility of women to correct information on HIV transmission and prevention and negotiation for safe sex	Proportion of women having access to correct information on HIV transmission and prevention and discuss issues related to safe sex with their spouses	Special survey	Outcome	Negotiation for safe sex 2001 – at least 50% women having access to correct information able to negotiate safe sex 2004 – at least 75% women having access to correct information able to negotiate safe sex 2007 – at least 90% women having access to correct information able to negotiate safe sex

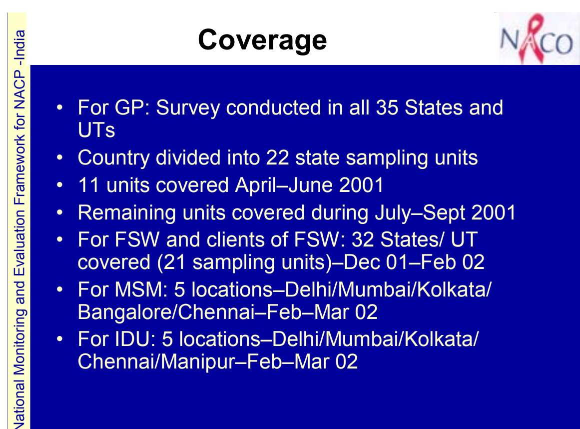
India Presentation, continued

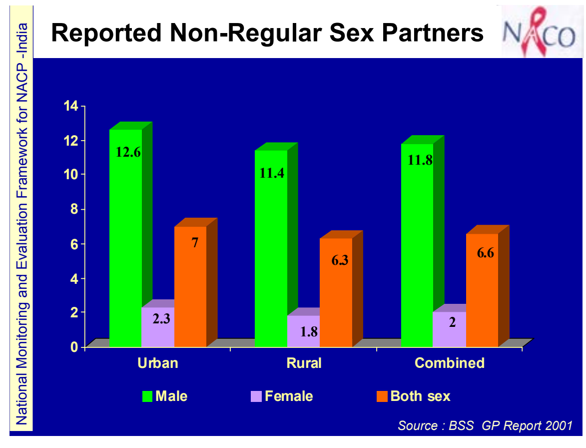


	Program Area Indicator	Objective Measurement of Indicator	Source	Type	Expected Outcome
XV	Program Management				
34	Strengthening of SACS for capacity building, infrastructure, monitoring & evaluation and preparation of strategic plans	Increase in proportion of SACS strengthened for capacity building, infrastructure, monitoring & evaluation and preparation of strategic plans	Annual SACS check list	Process	2001 – at least 60% SACS strengthened 2004 – 100% SACS strengthened 2007 – 100% SACS continue to demonstrate strengthened capabilities
35	Proportion of general population aged 15-49 covered by Family Health Awareness Campaign	Increase in proportion of general population aged 15-49 covered by Family Health Awareness Campaign	FHAC	Process	2001 – at least 50% population covered 2004 – at least 75% population covered 2007 – at least 90% population covered
36	Proportion of budget spent of budget allocated	Increase in proportion of budget spent of budget allocated	PFMC	Process	2001 – at least 60% of budget allocated spent in the reporting year 2004 – at least 90% of budget allocated spent in the reporting year 2007 – at least 95% of budget allocated spent in the reporting year

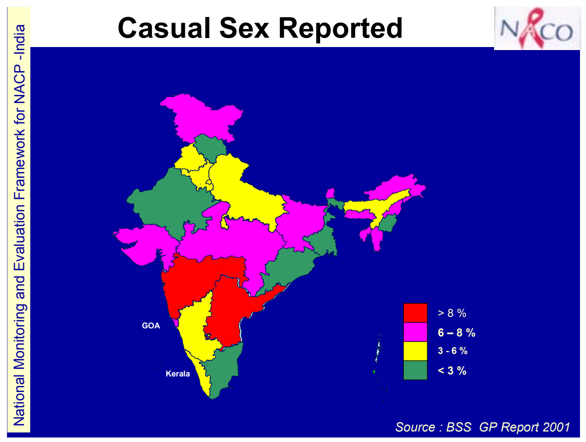


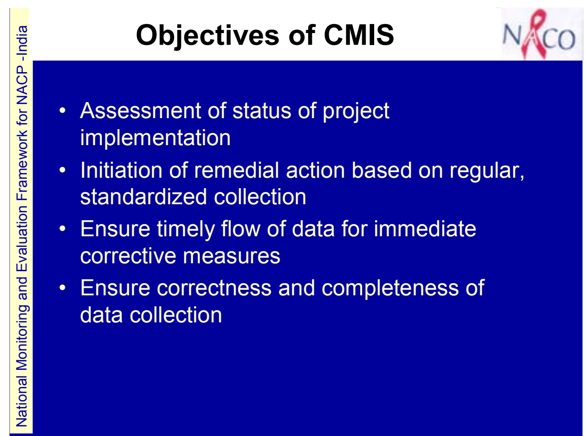


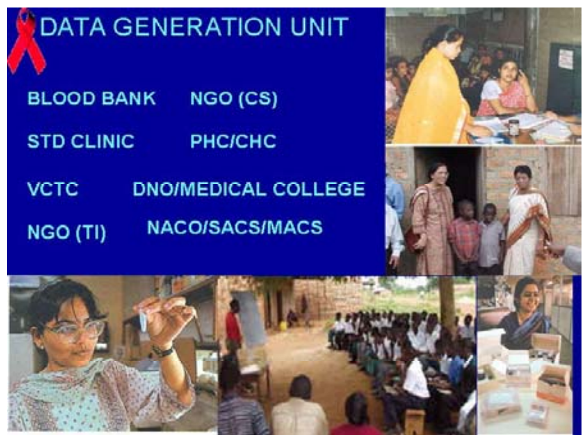


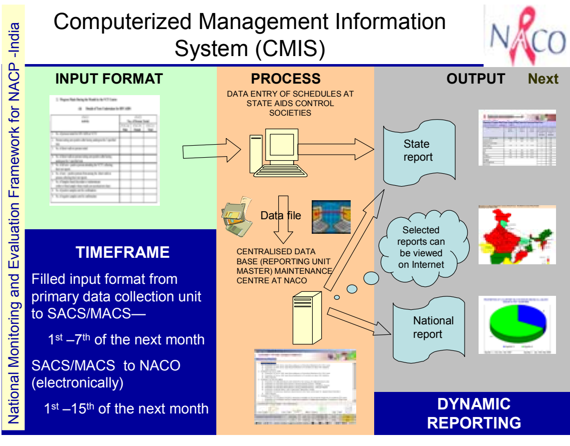


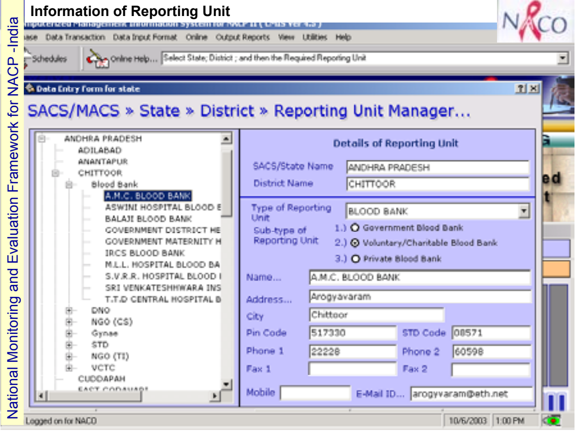
India Presentation, continued

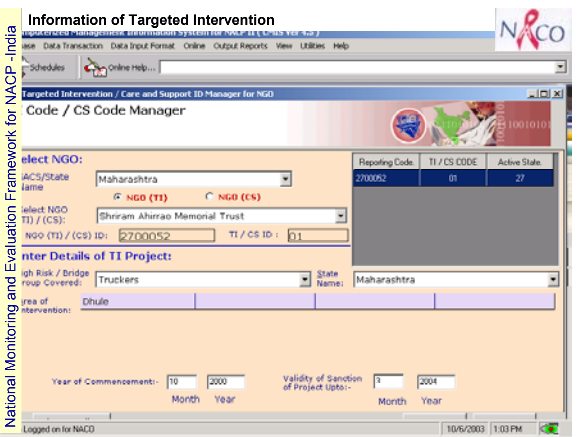












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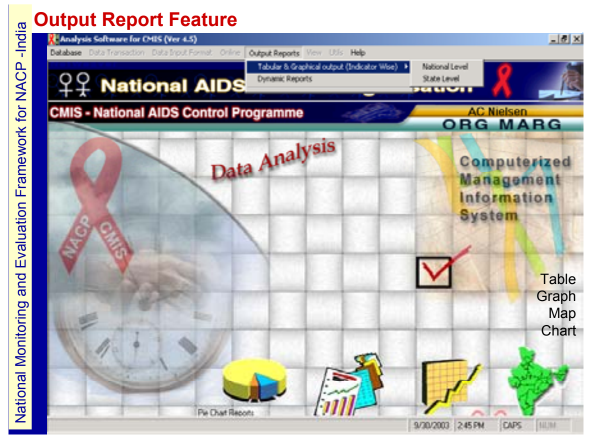
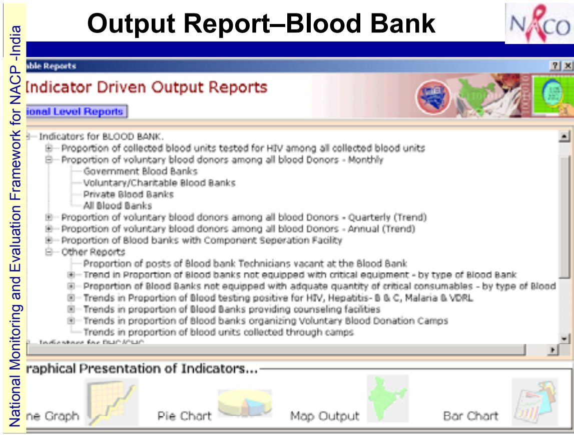
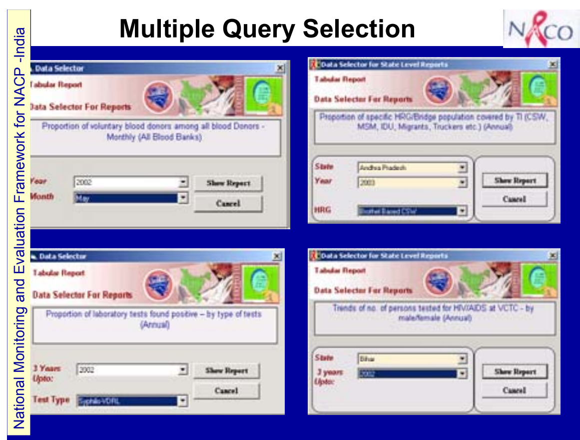
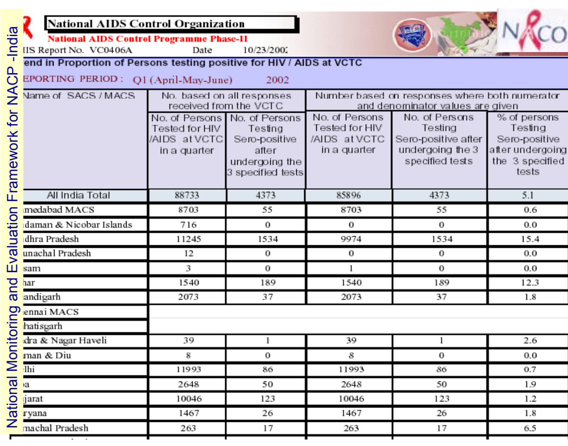








National AIDS Control Organization

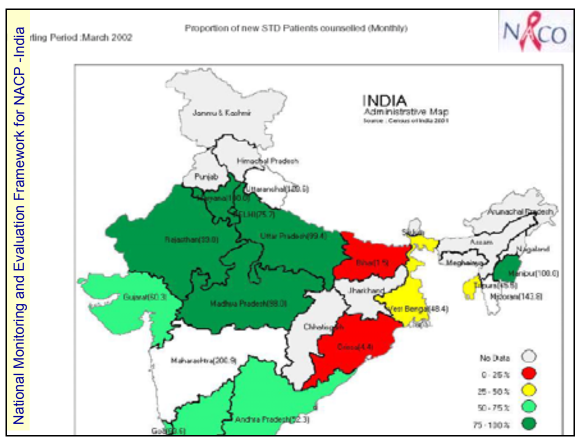
National AIDS Control Programme Phase-II

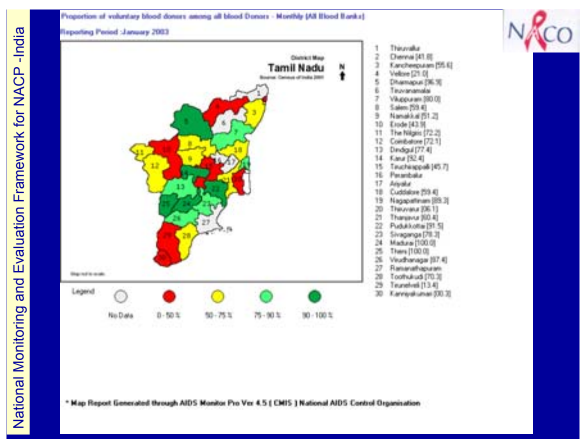
IIS Report No. VC0406A Date 10/23/200[illegible]

end in Proportion of Persons testing positive for HIV / AIDS at VCTC

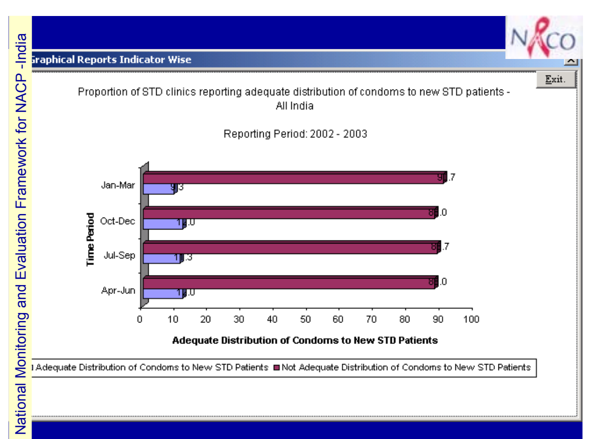
EPORTING PERIOD : Q1 (April-May-June) 2002

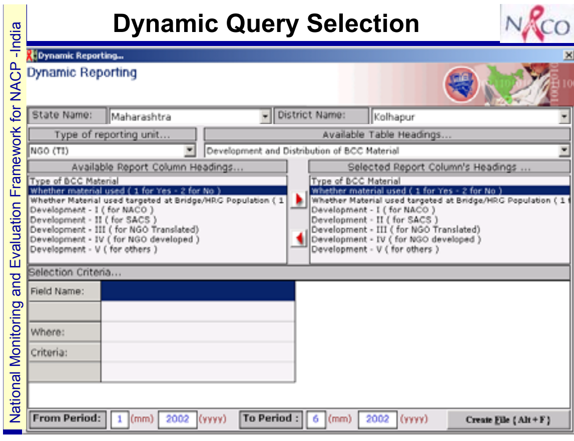
Name of SACS / MACS	No. based on all responses received from the VCTC		Number based on responses where both numerator and denominator values are given		
	No. of Persons Tested for HIV /AIDS at VCTC in a quarter	No. of Persons Testing Sero-positive after undergoing the 3 specified tests	No. of Persons Tested for HIV /AIDS at VCTC in a quarter	No. of Persons Testing Sero-positive after undergoing the 3 specified tests	% of persons Testing Sero-positive after undergoing the 3 specified tests
All India Total	88733	4373	85896	4373	5.1
medabad MACS	8703	55	8703	55	0.6
daman & Nicobar Islands	716	0	0	0	0.0
dhra Pradesh	11245	1534	9974	1534	15.4
unachal Pradesh	12	0	0	0	0.0
sam	3	0	1	0	0.0
har	1540	189	1540	189	12.3
andigarh	2073	37	2073	37	1.8
ennai MACS					
hatisgarh					
dra & Nagar Haveli	39	1	39	1	2.6
man & Diu	8	0	8	0	0.0
lhi	11993	86	11993	86	0.7
a	2648	50	2648	50	1.9
jarat	10046	123	10046	123	1.2
ryana	1467	26	1467	26	1.8
machal Pradesh	263	17	263	17	6.5





India Presentation, continued



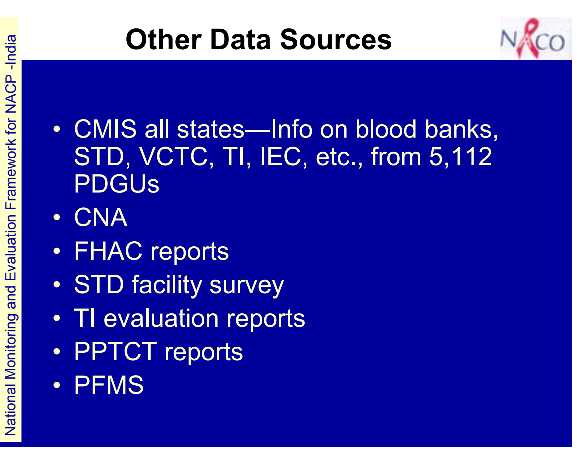


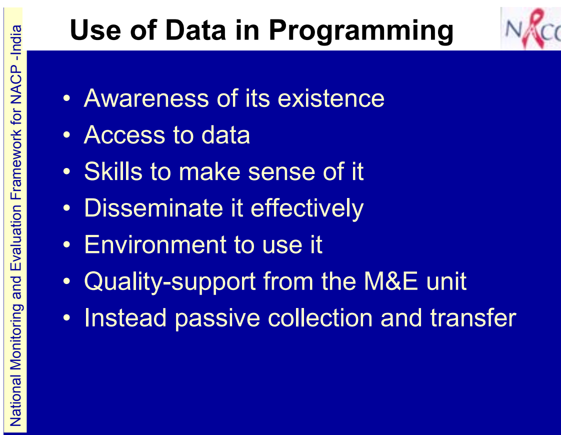
Other Data Sources

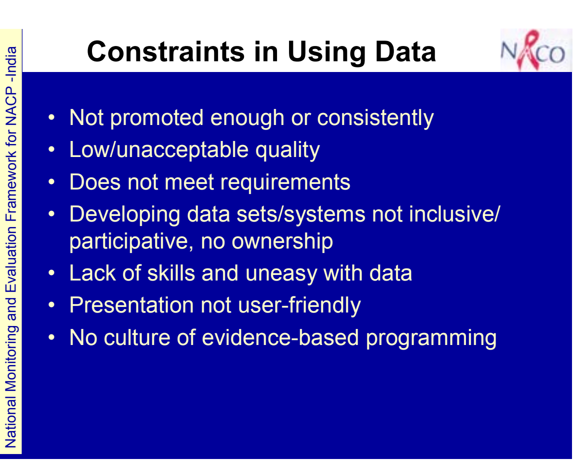
National Monitoring and Evaluation Framework for NACP -India

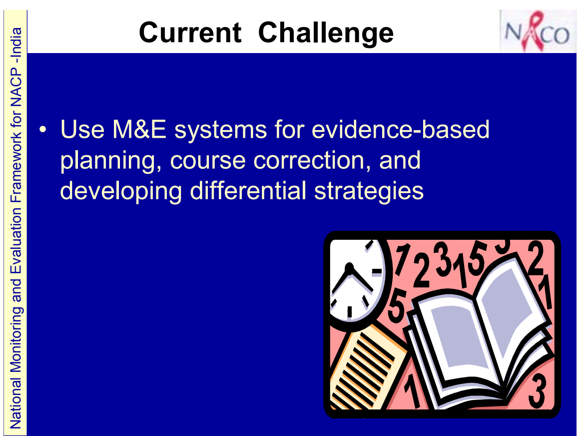
NACO

- Monitoring and Evaluation framework (Handbook of indicators)
- HIV sentinel surveillance—455 sites
- HSS—Data on consistent sites (180)
- BSS GP—National and state baseline
- BSS HRG—National and state baseline
- HRG mapping
- HRG size estimation








Current Challenge
NACO
National Monitoring and Evaluation Framework for NACP -India
• Use M&E systems for evidence-based planning, course correction, and developing differential strategies

Thailand Presentation

Strengthening Monitoring and Evaluation of National Aids Programs In Thailand

Somyot Kittimunkong
AIDS Cluster, Bureau of AIDS, TB, and STIs
Department of Disease Control
Ministry of Public Health, Thailand

Outline

- Current monitoring and evaluation (M&E) in Thailand
- Proposed data, tools, and information system
- Challenges in M&E program in Thailand

2

Current M&E in Thailand

- Monitoring and Evaluation is a part of program at all levels
  - Global (UNGASS/Global Fund)
  - National AIDS Plan
  - Organisation (Balanced scorecard, KPI)
  - Project

3

HIV/AIDS-Related Information

- Report
- Survey
  - Qualitative
  - Quantitative
- Other, e.g., research

4

HIV/AIDS-Related Information

- General information (socio-economic)
- Health status
  - Morbidity
  - Mortality
  - Target population
- Surveillance
- Resources
- Activities/Services

5

HIV/AIDS Epidemic in Thailand

HIV prevalence rate among adults	1.8 %
New infections in 2002	23,676
New infections during 1991 (peak)	142,819
Number of PWHA at present	695,000
Cumulative HIV/AIDS cases	984,000
Cumulative HIV/AIDS deaths	289,000
Number of deaths in 2001	55,000
PWHA access to ARV in 2003	Approximately 23,000
Target of access to ARV in 2004	50,000

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Thailand Presentation, continued

HIV/AIDS Surveillance System

- HIV/AIDS case-reporting system (1984)
- HIV serosurveillance system (1989)
- Behavioral surveillance system (1995)
- STD Surveillance system
- HIV/AIDS projection

7

HIV Prevalence Among Commercial Sex Workers (CSWs), Thailand 1989–2002

%

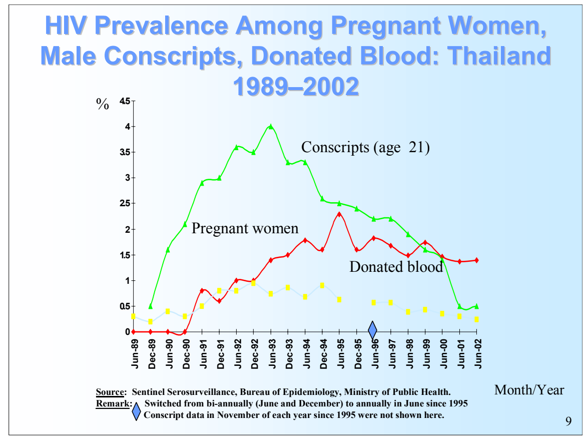
Brothel-based

Non-brothel-based

Time

Source: Serosurveillance, Bureau of Epidemiology, Ministry of Public Health.
Remark: Switched from bi-annually (June and December) to annually in June since 1995

8



Prevent Mother-to-Child Transmission

- Antiretroviral during pregnancy and labour
- Milk for children born with HIV positive women
- Decrease infection rate
  - From 30% to 8%

10

Focused Interventions for 2004

- Condom and social marketing
- Youth health program
- Casual sex and safe sex
- Public education
- Counseling (VCT)
- Targeted group education
- Special approach program for mobile population, vulnerable communities, and border area
- Access to care and services
- Strengthening services and advocacy
- Antiretroviral access
- PMTCT
- Treatment of opportunistic infection
- HIV/TB integrated strategy
- Community involvement
- CCC (family medicine)

11

Proposed Data, Tools, and Information System for M&E

- UNGASS and Global Fund
- National AIDS Plan
- Balanced Scorecard/KPI
- Country Respond Information System
- Regional/Goal Model
- Geographic Information System

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Thailand Presentation, continued

Challenges in M&E Programs in Thailand

- To identify the focal point and institution response to the target groups
- To compile indicators from all sources gathered into a matrix to identify the core and additional indicators
  - Core indicators
  - Additional indicators

13

Strength and Support

- Capacity building
- Technical support
- Hardware and software

14

Thank you

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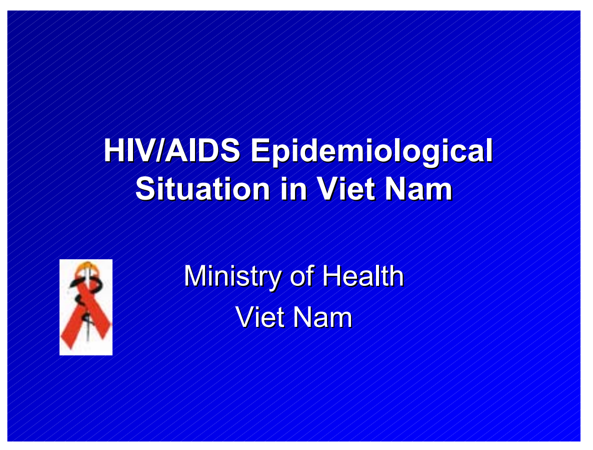
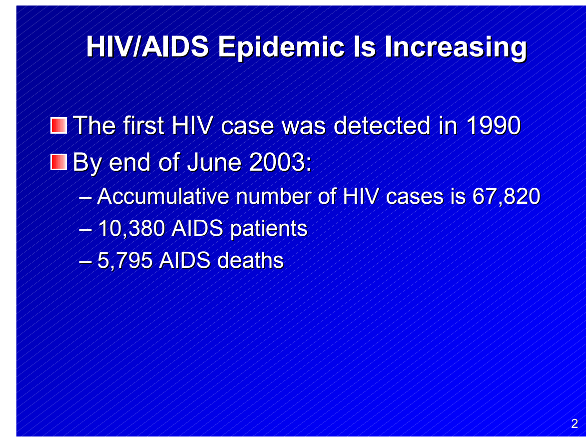
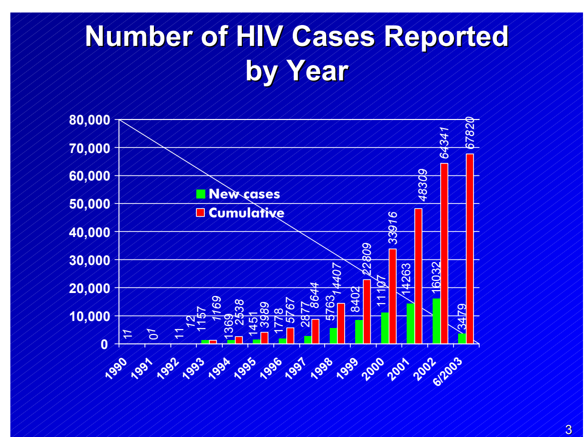
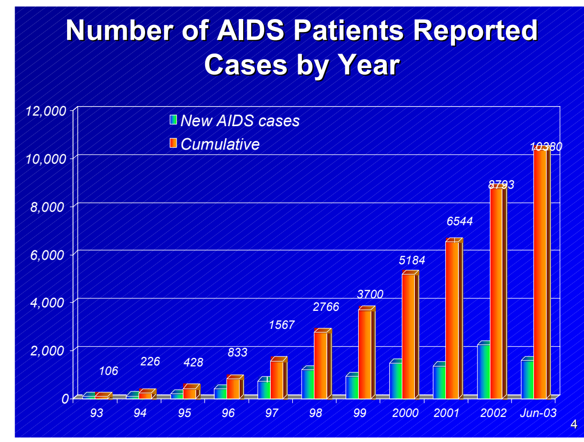
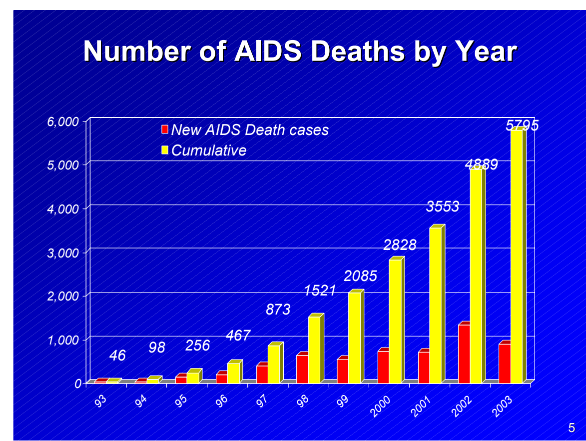
Viet Nam Presentation

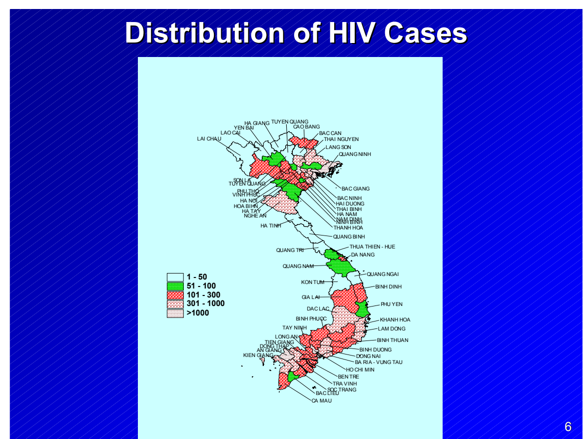












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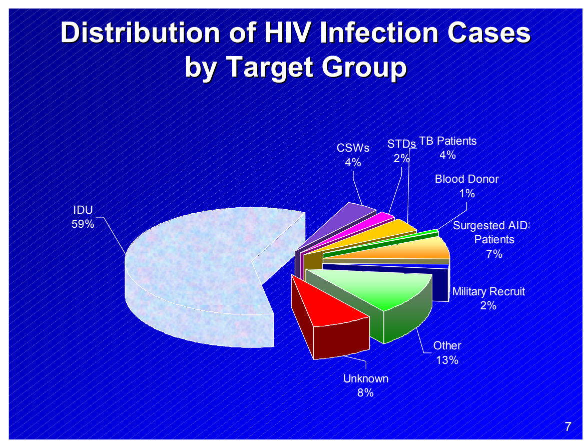
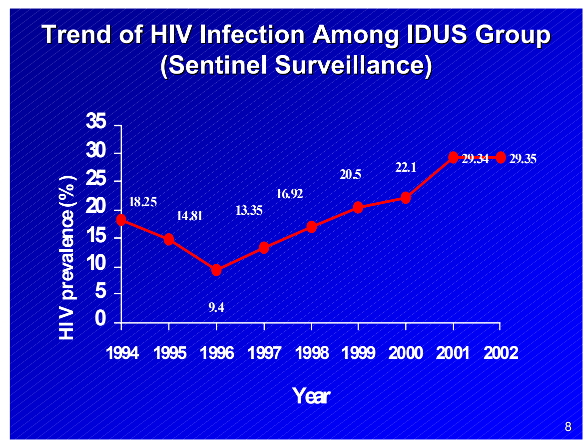
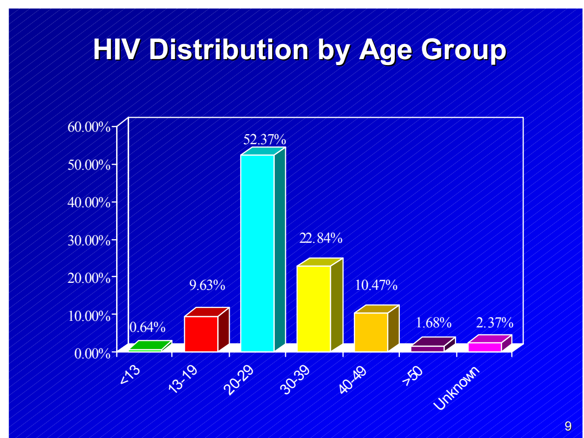
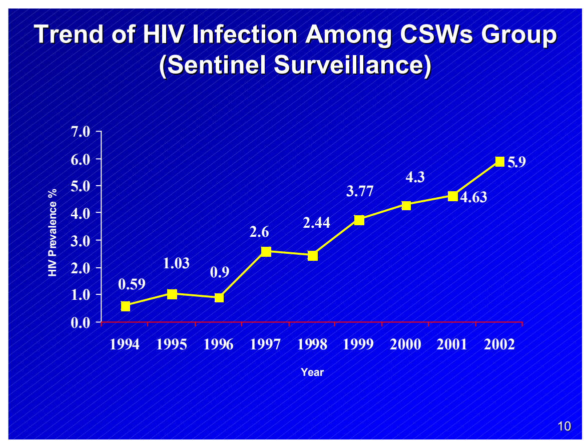
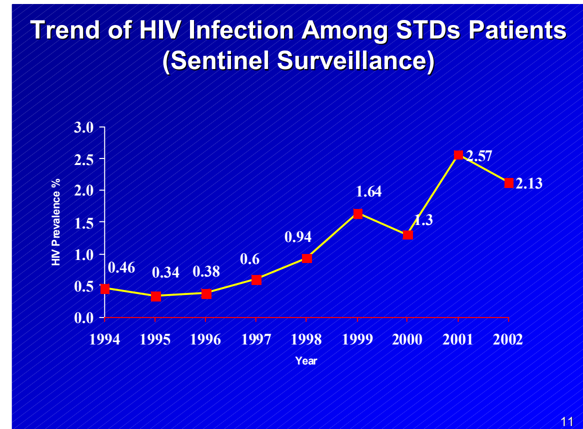
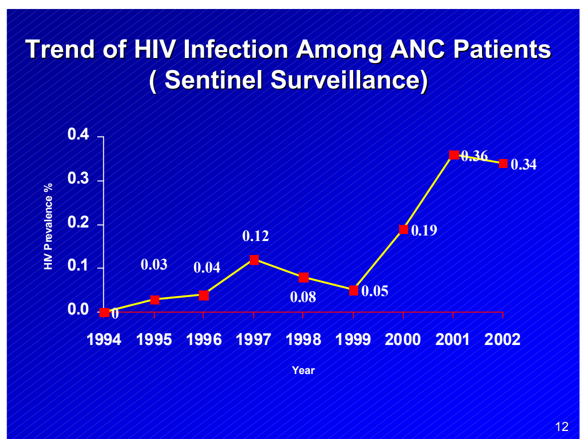




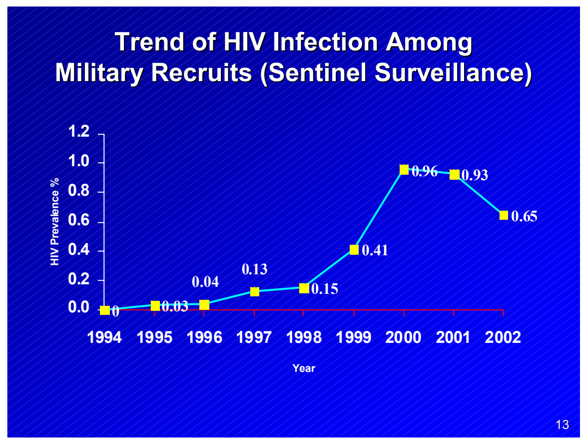


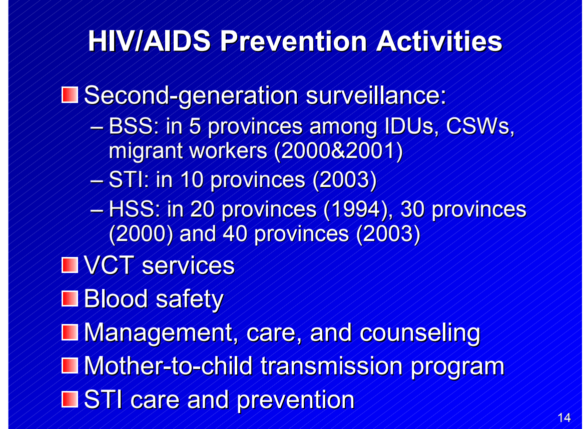


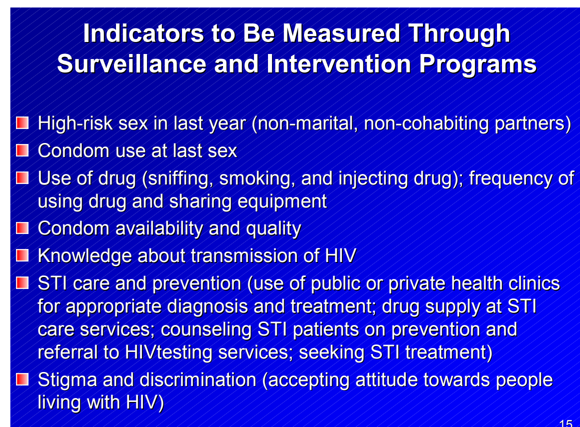


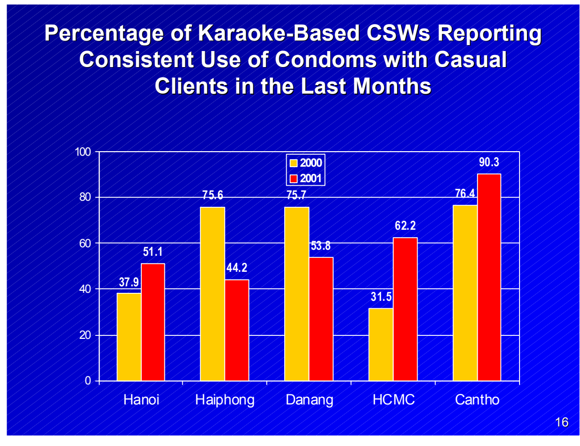


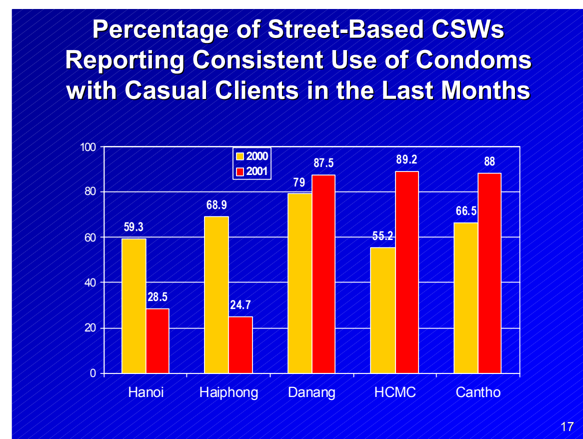
Viet Nam Presentation, continued

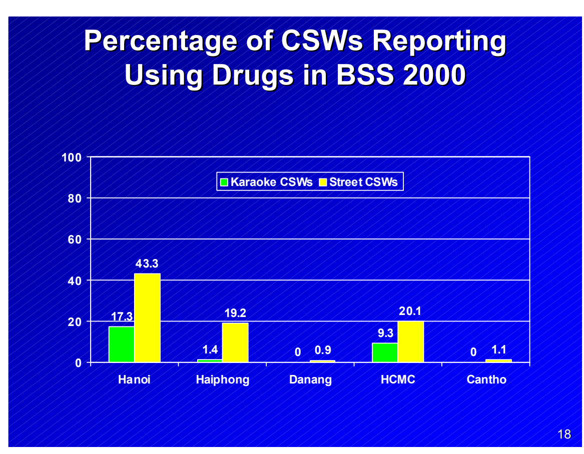




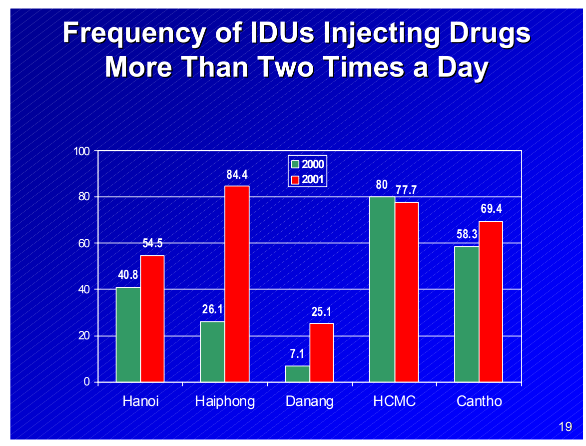


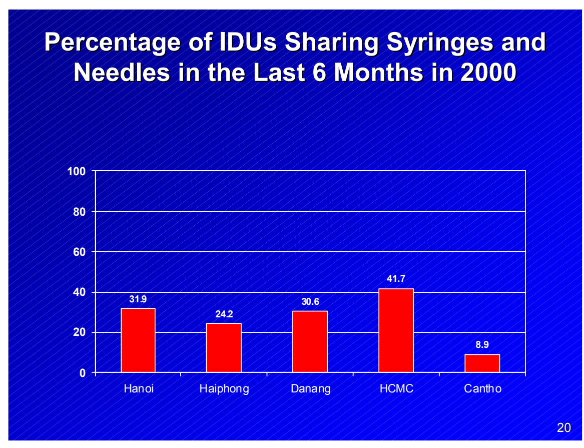


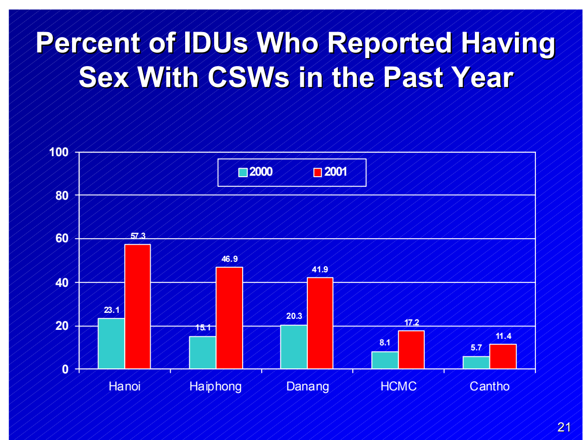


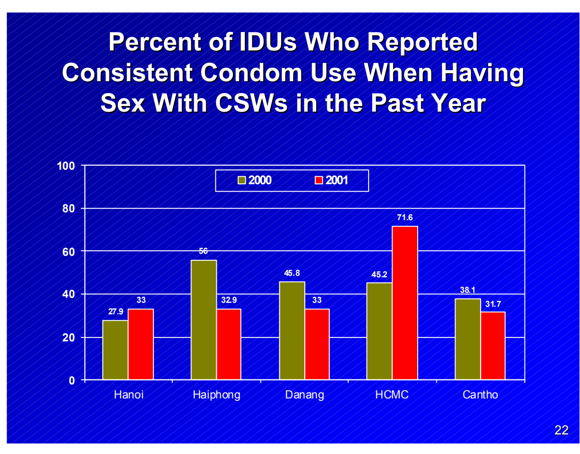


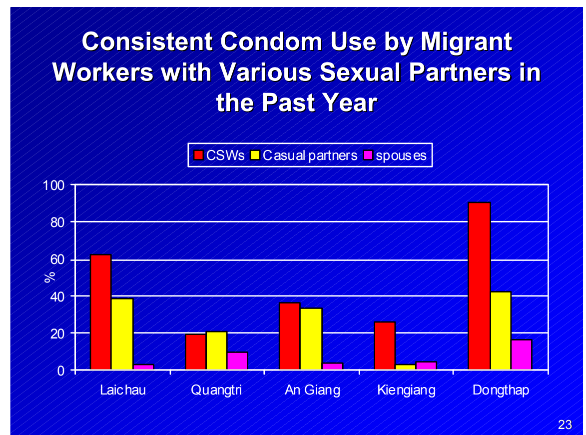
Viet Nam Presentation, continued

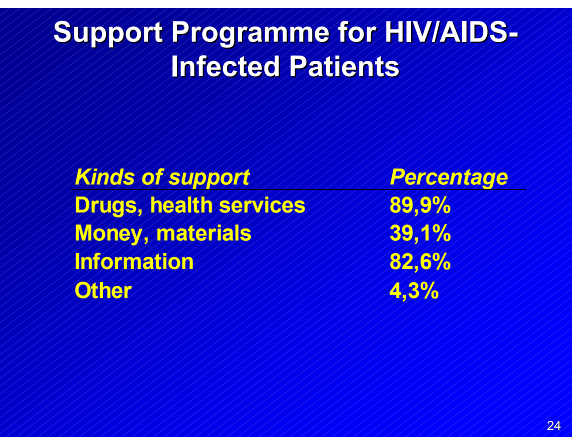












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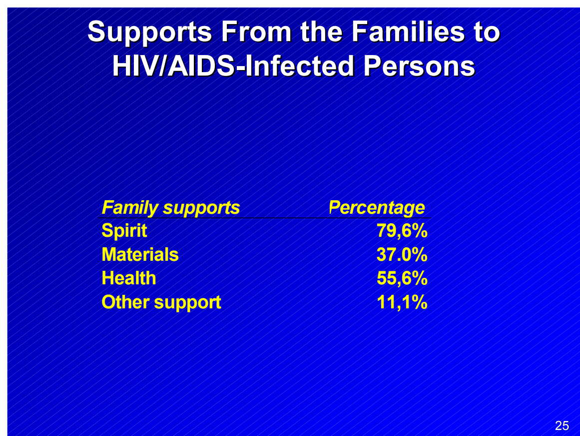

Supports From the Families to HIV/AIDS-Infected Persons

Family supports	*Percentage*
Spirit	79,6%
Materials	37.0%
Health	55,6%
Other support	11,1%

25

Persons Who Take Care of HIV/AIDS-infected People (Result of the Survey on HIV/AIDS Infections)

Who take care HIV/AIDS cases	*Percenatge*
Family	81.0%
Friend	14,6%
Health workers	77,4%
Union	8,0%
Others	15%

26

Discussions

- Condom use was still low in high-risk groups.
- The consistent use of condom in CSWs was low (31%–75% between cities and provinces).
- The number of CSWs using drug seemed higher in street based CSWs (20,1%–43,3%) than in karaoke-based CSWs (9,3%–17,3%) in HCMC and Hanoi, respectively.
- Percentage of IDUs sharing syringes and needles was relatively high 24%–41,7%.
- Number of IDUs who reported having sex with CSWs in last 12 months were 41.9%–57.3% in Danang, Haiphong, and Hanoi.
- Percentage of IDUs who reported consistent use of condoms when having sex with CSWs fluctuated between 27.9% and 71.6% in cities.

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Discussions (continued)

- Percentage of migrant workers who reported having sex with CSWs are 7%–30%.
- Among migrant workers who had sex with CSWs, the number who reported consistent condom use were not high and varied in cities/province (20%–85%)
- HIV/AIDS care and counseling is one of the weaknesses of the HIV/AIDS prevention and control program in Viet Nam because there is no comprehensive network for HIV/AIDS management and care in health facilities and community from the central to grassroot levels.
- Counseling for HIV/AIDS infections (before, during and after HIV testing) has not been nationwide yet in Viet Nam.

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Discussions (continued)

- HIV/AIDS management, care, and counseling were mainly carried at home by family members of HIV-infected patients and community. Home-based care is the key and hot issue in care and counseling.
- VCT services: All 61 provinces only at provincial levels.
- Blood safety: All 61 provinces at provincial levels.
- Management, care, and counseling services are limited in some provinces.
- Mother-to-child transmission programs are carried out in some provinces.

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Recommendations

In Vietnam there still will be many things to improve to have effective and comprehensive HIV/AIDS prevention programs.

- Improvement of the second-generation surveillance with strengthening and integration of BSS, STI, and HSS
- Improvement and expansion of VCT services from provincial levels to community levels
- Improvement of blood safety by ensuring that 100% blood units are screened adequately for HIV, with reduction of blood transfusion from provincial levels to district or regional levels
- Implementation and expansion of mother-to-child transmission programs from provincial levels to community levels by improving the numbers of antenatal clinics offering or referring VCT to pregnant women to reduce MTCT; available provision of ARV therapy for HIV-infected women

30

Viet Nam Presentation, continued

Recommendations

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- Implementation and expansion of mother-to-child transmission programs from provincial levels to community levels by improving the numbers of antenatal clinics offering or referring VCT to pregnant women to reduce MTCT; available provision of ARV therapy for HIV-infected women

30

Challenges

- Lack of resources and technical skills/manpower
- Hidden groups and stigmatization of/discrimination against HIV/AIDS-infected people
- Limitations of HSS, BSS, STI surveillance integration
- Financial shortage to expand and improve quality of VCT, MTCT programs from provincial levels to district levels, especially in rural areas
- How can M&E be implemented through the health care system?
  - Integration with other surveillance
  - Independent M&E to evaluate the effectiveness of interventions and make recommendations for changes of Government policies or commitments
- Available budgets and methods used for M&E to every hot topic

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THANK YOU FOR YOUR ATTENTION !

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APPENDIX C: GUIDANCE FOR CROSS-COUNTRY WORKGROUPS ON M&E PROGRAM AREAS

The goal of this working session is to discuss global indicators for specific programmatic theme areas in the Asian region. To the extent possible, we would like to have each country represented in each group. There is no specific preparation necessary for this working session. As individuals contributing to the establishment of M&E efforts in your countries or of ongoing efforts to establish them, your regional expertise and experience will form the basis for these discussions. The five programmatic theme areas under which the indicators are grouped are:

1. IV drug use indicators
2. National commitment and action
3. Sexual behavior and negotiation
4. HIV surveillance, VCT, and PMTCT
5. HIV/AIDS-related knowledge and stigma.

The following two questions will serve to guide the discussions within each group:

1. What are the challenges to using the indicators as presently constructed in Asian countries?
2. What issues are important to consider regarding their measurement and use in Asia?

The indicators to be discussed within each thematic area appear on the following pages, which will be handed out to group participants. The manual(s) from which the indicators were taken is (are) listed at the top of each sheet, all of which have been included in the registration packet. Facilitators should use the more specific definitions and descriptions of the indicators when the group needs further details.

Rapporteurs should take notes on the discussion, using the indicators as an organizational guide for creating a summary report for the workshop group on Wednesday afternoon.

1. IV Drug Use Indicators (National AIDS Programmes Guide to M&E and UNGASS)

Knowledge of HIV prevention among injecting drug users
Percentage of respondents in a survey of intravenous drug users (IDUs) who, in response to prompting, identify switching to non-injecting drugs and avoiding sharing injecting equipment as a method of preventing HIV transmission (Denominator: All IDUs, in a BSS or other survey of IDUs).

Injecting drug users sharing equipment at last injection
Percentage of injecting active drug users (in the last month) surveyed who report sharing injecting equipment the last time they injected drugs (Denominator: Injecting drug users from a BSS).

Injecting drug users never sharing equipment in the last month
Percentage of injecting active drug users (in the last month) surveyed who report never sharing injecting equipment during the last month (Denominator: Injecting drug users from a BSS).

Drug injectors using condoms at last sex, by partner type
Percentage of injecting active drug users (in the last month) surveyed who report using a condom the last time they had sex (with commercial sex worker, non-marital/non-cohabiting partner, and marital/cohabiting partner) among those who have had sex during the last 12 months (Denominator: Sexually active injecting drug users from a BSS).

Percentage of IDUs who adopted behaviors that reduce transmission of HIV (both by avoiding sharing injecting equipment and by using condoms)—UNGASS
Number of respondents who report never sharing injecting equipment during the last month *and* who report using a condom the last time they had sex (Denominator: Number of respondents who report injecting drugs during the last month *and* having sex in the last month in a cluster-sample survey or targeted snowball sample survey).

2. National Commitment and Action (UNGASS Special Session on HIV/AIDS)

Amount of national funds spent by governments on AIDS
Survey of national expenditure on HIV/AIDS programs (donor funds excluded). Allocated funds should be specified for 1) STD control activities, 2) HIV prevention, 3) HIV/AIDS clinical care and treatment, and 4) HIV/AIDS impact mitigation.

National composite policy index
Country assessment questionnaire covering four broad areas of policy: 1) Strategic plan, 2) Prevention, 3) Human rights, and 4) Care and support.

Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year
Number of schools with staff members trained in and regularly teaching life-skills-based HIV/AIDS education (Denominator: Number of schools surveyed in a school-based survey or educational program review).

Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programs
Number of employers with HIV/AIDS policies and programs that meet defined criteria (Denominator: The 30 employers surveyed, which includes the 30 largest employers—25 private sector and 5 public sector).

Percentage of patients with STIs at health care facilities who are appropriately diagnosed, treated, and counseled
Number of STI patients for whom the correct procedures were followed on history-taking, examination, diagnosis and treatment, effective counseling on partner notification, condom use, and HIV testing (Denominator: Number of STI patients for whom client-provider interactions were observed in a health facility survey).

Percentage of people with advanced HIV infection receiving antiretroviral combination therapy
Number of people with advanced HIV infection who receive antiretroviral combination therapy according to nationally approved treatment protocol (or WHO/UNAIDS standards) (Denominator: Number of people with advanced HIV infection, from program monitoring data).

Ratio of school attendance among orphans to that among non-orphans (aged 10–14)
Orphan school attendance: Number of children who have lost both parents and are still in school/number of children who have lost both parents. Non-orphan school attendance: Number of children with both parents alive, who live with at least one parent, who are still in school/number of children with both parents alive, who live with at least one parent. (From population-based survey such as Demographic and Health Survey [DHS]).

3. Sexual Behavior and Negotiation (National AIDS Programmes Guide to M&E)

Percentage of young people aged 15–24 who report using a condom during sexual intercourse with a non-regular sexual partner—UNGASS
Number of respondents (aged 15–24 years) who report having sex with a non-regular partner in the last 12 months who also report that using a condom the last time they had sex with this partner (Denominator: Number of respondents aged 15–24 who had a non-regular partner in the last 12 months, in a population-based survey such as DHS).

Women's ability to negotiate safer sex with husband
Percentage of respondents who believe that if a husband has an STI, a wife can refuse to have sex with him or propose condom use (Denominator: All respondents who have heard of STIs aged 15–49, in a population-based survey).

Higher-risk sex in the last year
Percentage of respondents who had sex with a non-regular partner in the last 12 months (Denominator: All respondents reporting sexual activity in the last 12 months, from a population-based survey).

Condom use at last higher-risk sex
Percentage of respondents who say they used a condom the last time they had sex with a non-regular partner (Denominator: All respondents who had sex within the last 12 months, from a population-based survey).

Commercial sex in the last year
Percentage of men reporting that they had sex with a sex worker in the last 12 months (Denominator: All men who had sex within the last 12 months).

Condom use at last commercial sex, client report
Percentage of men reporting condom use the last time they had sex with a sex worker in the last 12 months (Denominator: All men who had sex with a sex worker in the last 12 months).

Condom use at last sex, sex worker report
Percentage of sex workers who report using a condom with their most recent client (Denominator: Sex workers surveyed who had sex with any clients in the last 12 months, from a BSS or similar survey).

Higher-risk sex among men in the last year
Percentage of men who had anal sex with more than one male partner in the last 6 months (Denominator: All men who had sex with men in the last 6 months, from a BSS or similar survey).

Condom use at last anal sex between men
Percentage of men or their partners who used a condom at last anal sex with a male partner (Denominator: Among men who had anal sex with a male partner in the last 6 months).

Young people's indicators: median age, percentage of premarital sex, condom at premarital sex, multiple partners, condom use at last sex, condom use at first sex, age mixing (men 10 years older) in sexual relationships.

4. HIV SURVEILLANCE, VCT, AND PMTCT

Surveillance

Sentinel surveillance in defined subpopulations—Second-Generation Surveillance
STI patients, IDUs, sex workers, men who have sex with other men, women at antenatal clinics.

Regular screening of populations—Second-Generation Surveillance
Donated blood recipients or blood donors, occupational cohorts such as factory workers or the military.

Cross-sectional screening in subpopulations at risk—Second-Generation Surveillance
Defined by country; STI patients, IDUs, and sex workers.

Population-based surveys including HIV testing
Subnational population surveys that include HIV testing for the general population.

Voluntary Counseling and Testing

Population requesting an HIV test, receiving a test, and its results
Percentage of people surveyed who ever voluntarily requested an HIV test, received the test, and its results (also in the last 12 months) (Denominator: All respondents in a general population or other survey).

Districts with VCT services
Percentage of districts that have at least one center staffed by trained counselors providing specialized HIV counseling and testing services free or at affordable rates (Denominator: All facilities surveyed).

HIV prevalence among sex workers and their clients, injecting drug users, and men having sex with men—UNGASS
Number of members of the population groups tested whose HIV test results are positive (Denominator: Number of members of the population groups tested for HIV infection, from population group surveillance).

Prevention of Mother-to-Child Transmission

Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT—UNGASS
Number of HIV-infected pregnant women provided with a full course of antiretroviral prophylaxis to reduce MTCT according to the nationally approved treatment protocol (or WHO/UNAIDS standards) in the last 12 months (Denominator: Estimated number of HIV-infected pregnant women from programming and monitoring estimates).

Percentage of HIV-infected infants born to HIV-infected mothers—UNGASS
Estimates based on program coverage, taking the weighted average of probabilities of MTCT for pregnant women receiving and not receiving antiretroviral prophylaxis.

Draft PMTCT Indicators of a Working Group Coordinated by UNAIDS/WHO

Existence of guidelines for the prevention of HIV infection in infants and young children
Guidelines should be available for the four following components: 1) intensified prevention efforts aimed at young women, 2) preventing unintended pregnancies among HIV-infected women, 3) specific interven-

tions to prevent HIV transmission from an infected mother to her unborn child, and 4) referral or care for HIV-infected mothers and their children.

Number and percentage of health care workers newly trained or retrained
The number and percentage of health care workers newly trained or retrained in the minimum package during the preceding 12 months (Denominator: Total number of health care workers in facilities that have implemented the minimum package for preventing HIV infection in women and infants from facility-based data collection).

Prevention and care service points
Percentage of public, missionary, and workplace venues offering minimum package of services to prevent HIV infection in infants/young children in the last 12 months (Denominator: All public, missionary and workplace venues—family planning and primary health care clinics, antenatal care/maternal and child health (ANC/MCH), and maternity hospitals).

Women completing testing and counseling process
This is made up of a series of indicators measuring the proportion of pregnant women who attend at least one ANC visit in a facility offering services to prevent HIV in infants and young children, accept the HIV test, receive posttest counseling and the results of the test (Denominators vary according to the numerators specified).

5. HIV/AIDS-Related Knowledge and Stigma

Knowledge

Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission—UNGASS
Number of respondents (aged 15–24 years) who gave correct answers to all the questions defined (Denominator: Number of respondents aged 15–24 in a population-based survey such as DHS).

Knowledge of HIV prevention methods
Percentage of all respondents who, in response to *prompted* questions, say that a person can reduce their risk of contracting HIV by using condoms or having a sex with only one faithful partner (Denominator: Among all respondents in a population-based or other survey).

No incorrect beliefs about HIV/AIDS
Percentage of respondents who correctly reject the most common local misconceptions about HIV transmission or prevention, and who know that a healthy-looking person can transmit HIV (Denominator: All respondents in a population-based or other survey).

Knowledge of HIV prevention among men having sex with men
Percentage of men who, when prompted, correctly identify avoiding anal sex and using condoms during anal sex as a means of preventing HIV infection (Denominator: All men who have sex with men, from a BSS or special population survey).

Knowledge of prevention of mother-to-child transmission of HIV
Percentage of women and men who correctly respond to prompted questions about preventing mother-to-child transmission of HIV through antiretroviral therapy and by avoiding breastfeeding (Denominator: All respondents in a population-based survey such as DHS).

Stigma and Discrimination

Accepting attitudes toward those living with HIV
Percentage of people expressing accepting attitudes towards people with HIV, based on four questions about the 1) Willingness to care for a family member sick with HIV, 2) Willingness to buy food from a shopkeeper with HIV 3) Belief that a female teacher with HIV should be allowed to keep teaching, and 4) Not wanting it to remain secret if a family member were infected with HIV (Denominator: All respondents in population-based survey).

Employers ensuring no discrimination against people with HIV
Percentage of formal-sector employers sampled with non-discriminatory policies and practices in recruitment, advancements, and benefits for people with HIV (Denominator: All places of employment surveyed).

APPENDIX D: GUIDANCE FOR COUNTRY PARTICIPANTS FOR COUNTRY GROUP WORK TO DEVELOP NATIONAL M&E PLANS

OBJECTIVE

To develop a detailed action plan for the next 12 months that specifies activities to be undertaken to strengthen the M&E of national AIDS programs in the country. This includes developing a list of country-specific contacts for individuals who have the primary responsibility of implementing M&E activities at the national (or state/provincial) level.

PROCESS

Each country will form its own group and focus on developing an action plan to strengthen M&E of AIDS in the next year. The groups will include the country representatives (including expatriates working in the country) and participants who have specific expertise in the country and are able to give technical support.

Each country group will identify a chair and a rapporteur who will take detailed notes and draft the findings. The notes of the rapporteur will be used to publish the workshop report.

WORK PLAN

Summary of M&E Status (30 minutes; 9:00–9:30)

Countries will work with a facilitator to address the following areas to assess the present status of the M&E of national AIDS programs within the country. This information will be based, for the most part, on the preparations that the country representatives made for the Wednesday morning presentations. The discussions should cover the following areas in bold. Example questions are given within each area as possible points to cover, depending on progress of that country in the M&E of national AIDS programs:

M&E Plan and System

- Is M&E adequately represented in the current national strategic plan?
- Is there a framework for M&E?
- Who are the main stakeholders in M&E? What are their prime areas of interest?
- What existing sources of data are available to monitor AIDS programs? How adequate are these sources? Are they used?

M&E Capacity

- Is the national capacity adequate? What are the capacity strengths and weaknesses? How can capacity be strengthened?
- Are there committees or other bodies that include the research community, NGOs, donors, etc. that can help strengthen M&E (e.g., technical resource groups)?
- What role can other agencies, including the private sector, play in strengthening the M&E?

M&E Coordination

- Is there good coordination between the different sectors in M&E?
- Do the National AIDS Commission/Council and the National AIDS Control Program coordinate activities?
- How are districts, regions/provinces involved?
- Are NGOs and international organizations involved and supportive of M&E?

M&E of Priority Programs

- Are there key indicators for the priority programs in the country that can be monitored over time? Are they used frequently?
- Is sufficient attention given to program-monitoring practices?

M&E Results and Dissemination

- What are the key modes of reporting and dissemination?
- Is the format of the national annual report optimal? Can it be improved?
- Are M&E results used to influence policy?

Outcome/Impact Assessment

- Is the HIV/STI surveillance system working adequately?
- Does AIDS M&E make sufficient use of national surveys, data collected for other purposes, health information systems, etc.?
- Is there a need for an AIDS impact assessment? Has it been done?

Development of M&E Action Plan and List of Primary Contacts (3.5 hours; 9:30–10:30, 11:00–12:30, 13:30–14:30)

1. The outline of an action plan for the next 12 to 18 months should be developed with the assistance of a facilitator, using a matrix tool to be handed out at the meeting. A key list of 3 to 5 activities to be implemented in the next year or year and a half should be generated. The matrix on the next page should be used as a tool to complete this part of the work plan. Once completed, the matrix will help create a presentation for the entire workshop group during the Wednesday afternoon and Thursday morning sessions.

For each activity the following will be specified:

What: Title of the activity
Why: Objective of the activity
How: Strategy of the activity, steps to implementation
When: Timing of the activity
Who: Responsible persons, organizations, and agencies

2. Each country should generate an overall list (not specific to a given activity) of primary M&E contacts. These contacts may be at the national level only or may include the state/provincial level, depending on the country's health policy structure. This contact list should stand as a coordinated network within the country, through which countries can generate M&E-related requests and through which donors can respond.

What?	Why?	How?	Who?	When?	Comments

Prepare Presentation for Workshop Group (30 minutes; 14:30–15:00)

Each country group will be provided with overhead transparencies. The M&E plans and activities should be summarized for a 10-minute presentation, to be followed by 15 minutes of questions from the group.

The M&E contact list will be copied and distributed to the workshop organizers, who will relay this information to the Partners.

APPENDIX E: ACTION PLANS TO DEVELOP NATIONAL M&E PLANS

Cambodia Action Plan

M&E Plan and System

- Current M&E system exists (mostly from health) but does not adequately represent the National HIV/AIDS Strategic Plan (NHASP)
- Multiple, Overlapping, Competing Frameworks
  - NAA (Including non-health)
  - National Health Sector
  - NCHADS/ MOH
  - Global Fund

M&E Plan and System

- Data Sources
  - HSS, BSS, SSS
  - NHIS, DHS, Health Facility Assessment/Surveys
  - NGO reports and assessments
  - Other (including non-health) are limited
- Adequate or Not?
  - HSS, BSS good for national, but need strengthening to be able to report at provincial level (samples are too small)
- HIS: not adequate for monitoring HIV/AIDS
  - VCCT and STIs: YES
  - ANC/PMTCT (inadequate)
  - TB+HIV (limited pilots)

M&E Capacity

- National capacity—Strengths
  - NHIS currently being reviewed and revised
  - National HIV/AIDS strategy plan exists
  - MOH midterm assessment completed, recommendations moving forward
  - National surveillance system in place
  - Commitment at high government levels
  - Donor funding
- National capacity—Weaknesses
  - Lack of coordination and leadership
  - Lack of data sharing
  - Lack of capacity for data management
  - Some data are not being used for decisionmaking
  - Commitment of funding allocated for M&E

M&E Capacity

- How to improve?
  - Promote the purpose and benefits of M&E
  - Develop a more coordinated approach to address weaknesses
  - Training and followup to reinforce technical skills for M&E

M&E Coordination

- Limited coordination between different sectors and within sectors
- Cambodia group proposes an M&E coordination committee

Cambodia Action Plan, continued

M&E of Priority Programs

Key indicators to monitor priority programs?

- Have:
  - Knowledge, attitudes, behavior, sexual practices
  - Process and coverage (some, particularly care limited)
  - Prevalence of HIV, STI, and HIV/TB
- Don't have:
  - Schools (some) and workplace
  - Gender
  - Human rights
  - Stigma
  - Care and support (institutional and community)
- Need M&E results and dissemination
  - To make data reports relevant and useful for action

M&E Action Plan

- What?

1- Set Up Multisectoral M&E Coordination Committee
- Chaired by National AIDS Authority (multisectoral)
- Subcommittees for Health and Non-Health (Deputy/Subcommittee Chairs)
  - Health is more developed
  - Non-health

2- Proposed Terms of Reference
- Common M&E framework and set of indicators
- Clear timeframe/ frequency for data collection

What?	Why?	Who?	How?	When?
Setting up the National M&E committee	Coordination	NAA NCHADS DPHI/MOH GFATM Partners	Redefine Objectives and ToR	ASAP (Next week)
Develop National M&E Framework	Harmonizing data collection	Committee members (TA needed for training and hand holding	Regular meeting and sharing the existing M/E framework	ASAP
Data Management System	To manage multiple sources of data	Individual health and non-health with subset of core indicators to fit to NAA.	CRIS/NMIS (Need TA for best practices)	Within 6 months

What?	Why?	Who?	How?	When?
Data Analysis and Dissemina-tion Plan	For Decision-making (resource allocation and program planning)	Individual Components Keys stakeholders and others	• Statistical Software • Workshop • Annual profile • Website • Written report • JAHSR	Yearly As periodic
Research Agenda	To investigate gap in the data Gather additional data on areas of interests	Multisectoral involvement	• Qualitative study • Case study • Small survey	Ongoing

China Action Plan

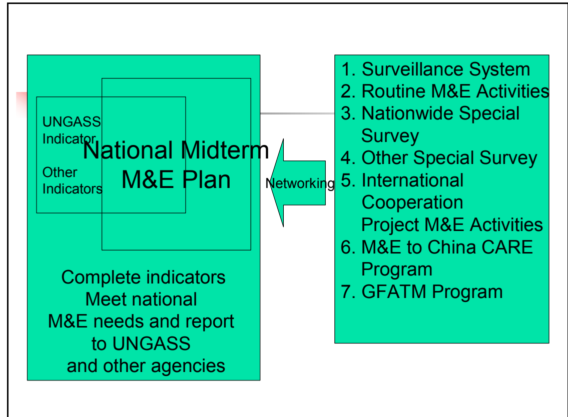
Monitoring & Evaluation in China

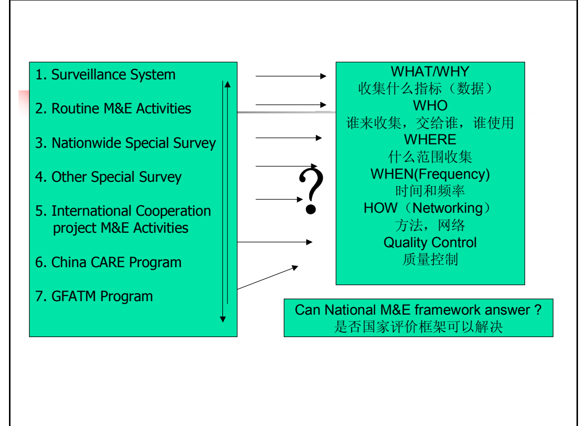
State Council Coordination Committee Office for STD/AIDS Prevention and Control

National Center for STD/AIDS Prevention and Control, China—CDC

Monitoring & Evaluation in China

Summary of M&E Status in China

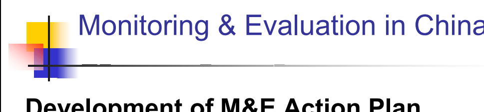




Monitoring & Evaluation in China

Development of M&E Action Plan

What?
Why?
How?
When?
Who?



Monitoring & Evaluation in China

Development of M&E Action Plan

Activity Title:
Strengthening Monitoring and Evaluation System in China
Timeframe:
January to December 2004
Responsible Agencies:
SCCC, NCAIDS/STD
Implementing Agencies:
Multisectors, Provincial multisectors

China Action Plan, continued

Monitoring & Evaluation in China

Development of M&E Action Plan

Activity Objective

- To develop a detailed action plan for the next 12 months to strengthen M&E of national AIDS program in the country

Monitoring & Evaluation in China

Development of M&E Action Plan

Activity Strategies

1. Formulation of M&E teams:
   - At the national level, conducting a mid-term review assessment according to the "Two Plans" by the State Council Coordinating Committee
   - M&E review teams members include multi-sectors, and provincial experts
   - M&E Team will facilitate the expansion of the future M&E Coordinating Mechanism

Monitoring & Evaluation in China

Development of M&E Action Plan

Activity Strategies

1. Formulation of M&E teams:
   - Establishment of an M&E Reference Group consisting of :
     - Different divisions of NCAIDS/STD including Epidemiology, Behavioral Intervention & Health Education, Policy and Information, International Project Management and Coordination, SCCC, &
     - Other partners at national and provincial level, etc.

Monitoring & Evaluation in China

Development of M&E Action Plan

Activity Strategies

2. Development of M&E management information systems
   - Identify the needs and demands of M&E information system
   - Conduct training and workshop to strengthen capacity building at national and provincial levels
   - Development and formulation of M&E guidelines at the national and provincial levels

Monitoring & Evaluation in China

Development of M&E Action Plan

Activity Strategies

3. Strengthen AIDS case reporting and epidemiological surveillance of HIV infection, including new sentinel surveillance sites and special surveys

Monitoring & Evaluation in China

Development of M&E Action Plan

Activity Strategies

4. Behavioral surveillance surveys for key populations (IDU, CSW, STI clinics, pregnant women, long-distance truck drivers, and MSM)

China Action Plan, continued

Monitoring & Evaluation in China

Development of M&E Action Plan

Activity Strategies

5. Training and capacity building for project staff and implementing partners
   - Field visits
   - Translation of National AIDS Program (A Guide to M&E) and distribution
   - Two training workshops at national and provincial level to facilitate the network formulation

Monitoring & Evaluation in China

Development of M&E Action Plan

Activity Strategies

6. Training on participatory methodologies for PLWHA/other workers

Monitoring & Evaluation in China

Two Current Challenging Program

- **GFATM Fund**
  Need assessment and a M&E plan will be made by all the stakeholders

- **CHINA CARES**
  Facilitate the M&E System

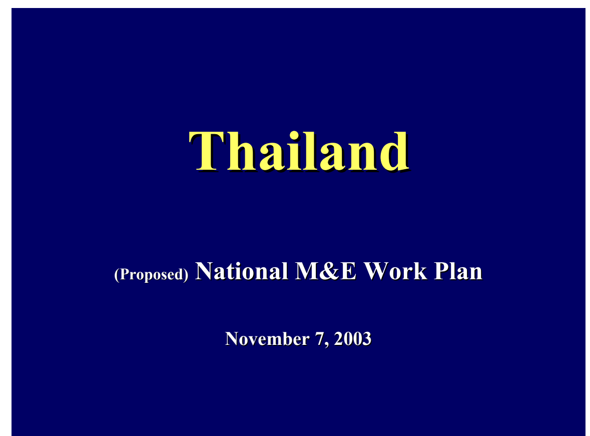
Action Plan to Develop a National M&E Plan: India

What is the problem?	What are the underlying causes?	What actions are needed?	How will it be done?	When?	Responsible for Implementation
1. Incomplete Information/reporting at central and State levels (30%)	Too many indicators	Review current indicators for relevance and reduce as necessary	Establish Technical Resource Committee Committee chaired by NACO and with State Representatives, key stakeholders (donors, ICMR, etc.)	-First meeting within 1 month -Revised list of indicators developed within 3 month	NACO and TRG
	Lack of understanding of use of indicators No feedback, or accountability	Develop training strategy for all levels for - Data collection (local, district, State) - Data analysis feedback reporting (district, State, national level) Prepare State-level plan (SACS), which builds into National plan	Hire national and State consultation team for training needs assessment and assist in strategy development	By March 31, 2004 2 months	Indicate trainings in States action plans due 31 March, 2004 NACO, CDC
	Inadequate staff and equipment	Fill vacancies with qualified staff Consider contracts: Retain trained staff for minimum of 2 years States to reflect equipment and M&E needs in Action Plan (5–10% of budget)	NACO to send directive to State Governments TA to States to facilitate preparation of action plans	3 months	NACO, States
2. Data are not being used optimally	Incomplete data (non reporting) poor quality	Skills-based trainings at all levels Develop a QA plan Supervisory checklist at all levels Periodic evaluation of key data States to reflect QA plan by March 31, 2004	Same as above	By March 31, 2004	NACO, States
	Lack of skills/capacity to use data (national and State)	Assess existing national resources (Review other health programs: Polio, TB) Develop budget/financial needs	Same as above		
	Dissemination about M&E systems inadequate Detailed integrated action plan for M&E program not implemented Local ←> State State <-> local	Develop formats for regular feedback at national and State level	Regional workshops to share existing formats	3 months	NACO, State M&E officers, Software experts

Action Plan to Develop a National M&E Plan: India, continued

What is the problem?	What are the underlying causes?	What actions are needed?	How will it be done?	When?	Responsible for Implementation
3. Multiple donors at national and State level with diverse M&E needs	Diverse list of indicators as per component supported	Collect list of indicator requirements 1st National-level Coordination 2nd State-level Coordination	UN Theme Group Donor Coordination Group (Reconvene)	By December 31, 2003 Ongoing	UNAIDS and NACO States
4. Impact assessment of targeted interventions	It was not planned	Prepare State-specific action plans to include high risk groups in surveillance	Identify key national and international consultants, or to identify	By May 30, 2003	NACO, ICMR
5. M&E low priority	Lack of understanding of importance of M&E Competing priorities Weak health systems	Workshop advocacy	Share information Developing mechanisms for accountability; e.g., link funds to performance	Ongoing	NACO
6. Lack involvement of private sector in M&E	Lack of systems, capacity, accountability	Involve professional organization Accreditation of private labs Corporate sector/Other sectors	Advocacy, workshops, training, CME programs, formats, or for feasibility	Ongoing	NACO

Thailand Action Plan



Country-Specific Context

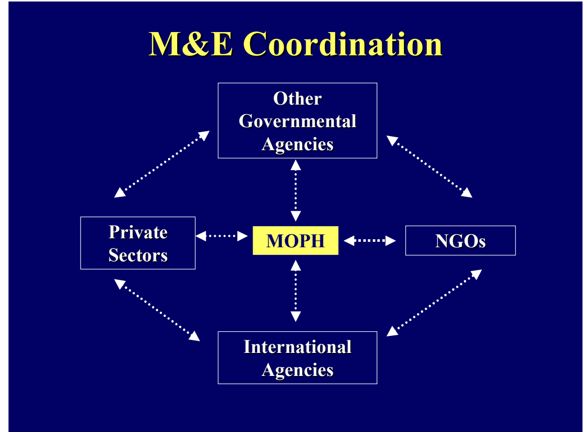
National AIDS Committee (NAC)

Main body

- Bureau of AIDS TB, and STI, MOPH (NAC Secretariat)

Associates

- Governmental organizations:
  - MOPH-related departments and other GOs: other ministries, universities, BMA
- International agencies:
  - UNAIDS, UNFPA,USAID, WHO, GAP (CDC)
- NGOs: Population Council, FHI, HSRI



Objectives

1. To identify the MOPH focal point and institutions for M&E planning and development
2. To compile indicators from all sources gathering matrix to identify the global and local indicators
3. To develop M&E tools and MIS
4. To strengthen national capacity on the implementation of the M&E system

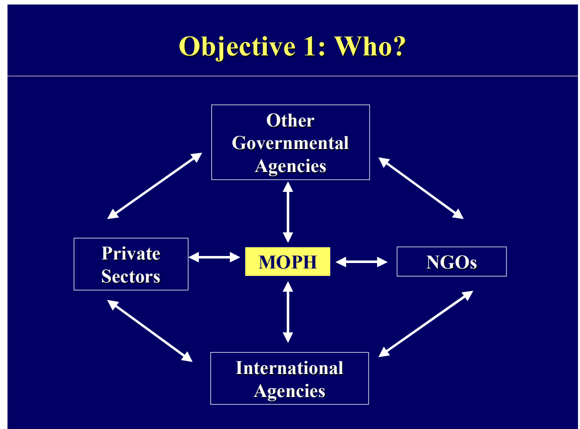
Objective 1

To identify the MOPH focal point and institutions for M&E planning and development

Objective 1

- **Why ?**
  - Set up a breakthrough process to come up with effective and sustainable M&E system.
  - Mandatory unit is required.
- **How ?**
  - Endorse M&E work plan into the national AIDS Committee.
  - Set up focus group and identify roles and responsibilities, define the working group
    - → Monthly meeting for the first 3 months, then every 2 months.

Thailand Action Plan, continued



Objective 1

- **When ?**
  - 1st–3rd month

Objective 2

To compile indicators from all sources gathering matrix to identify the global and local indicators

Objective 2

- **Why ?**
  - For program planning, monitoring, and evaluation
  - For sharing with organizations: National Plan, UNGASS, Millennium Development Goals, Global funds, etc.
- **How ?**
  - Review lists of indicators and available data sources
  - Identify data-accessing process

Objective 2

- **Who ?**
  - M&E Working Group under National Subcommittee on M&E, NAC
- **When ?**
  - 2nd–5th month

Objective 3

To develop M&E tools and management information system (MIS)

Thailand Action Plan, continued

Objective 3

- **Why ?**
  - Scatter M&E database system used by individual implementing agencies
    → Centralized database system
- **How ?**
  - Review existing database system and literatures for management of information system
  - Develop M&E tools and MIS model based on existing system
    → Forms, flow, responsible agencies
  - Development of in-country M&E technical guidelines
  - Pilot the system to assess barriers and resource needs

Objective 3

- **Who ?**
  - Working group and counterparts
- **When ?**
  - 2nd–18th month

Objective 4

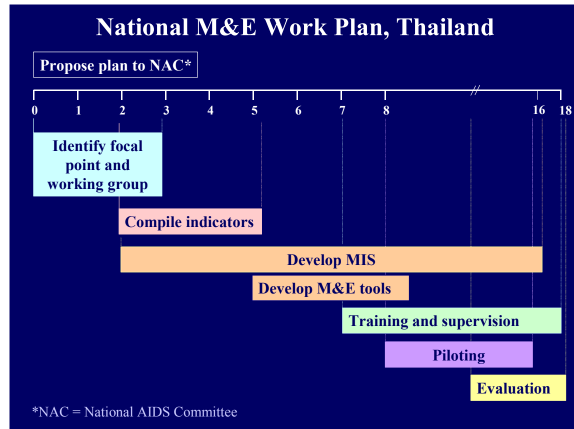
To strengthen national capacity on the implementation of the M&E system

Objective 4

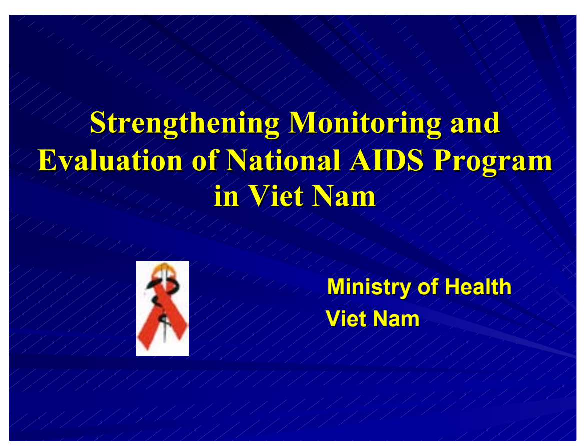
- **Why ?**
  - M&E mechanism and network are important.
  - Chief executive officer (CEO) of health care reform policy to support the system assisting in local policy and program planning.
  - Lack of M&E skills.
- **How ?**
  - Provide M&E training to various policymakers and technical officers (Principle of M&E and guidelines).
  - Provide technical support and supervision.

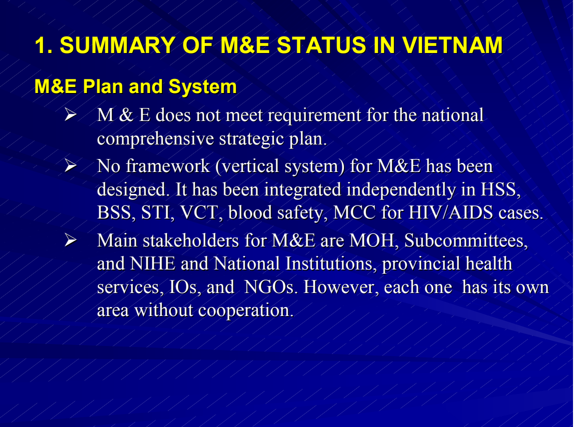
Objective 4

- **Who?**
  - BATS with multiministerial focal points
  - Universities
  - Global AIDS Program, TUC
  - Other counterparts
- **When?**
  - 7th–16th month



Viet Nam Action Plan

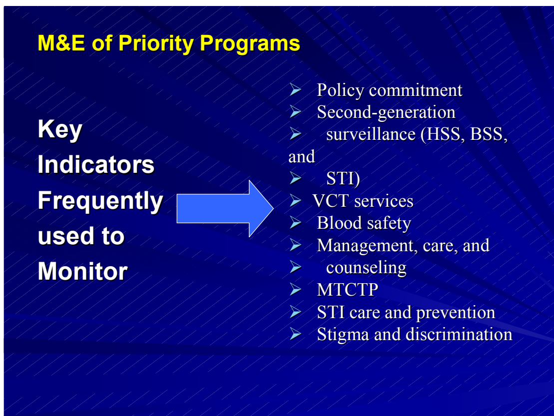




- **The existing sources of data available to monitor AIDS programs:**
  - HSS, STI (inadequate and used)
  - BSS (adequate and used)
  - Other specific local studies (unknown)
  - Health care service reporting system (adequate and used)
  - HIV/AIDS case-finding and surveillance system (adequate and used)
  - NGOs/IOs studies or interventions (unknown)
  - National health statistic surveys (adequate and used)

M&E Capacity and Coordination

- The national M&E capacity is not meet the requirement of the national strategic plan.
- Strengths
  - Good guidelines and support from UNAIDS/WHO/CDC.
- Weaknesses
  - Lack of the decisive leadership role and responsibility
  - Insufficiency of building capacity (personnel and resources).
- Lack of coordination between different sectors.
- Weak cooperation of HIV/AIDS activities among NGOs/IOs, health institutions at national levels and from central to provincial levels.



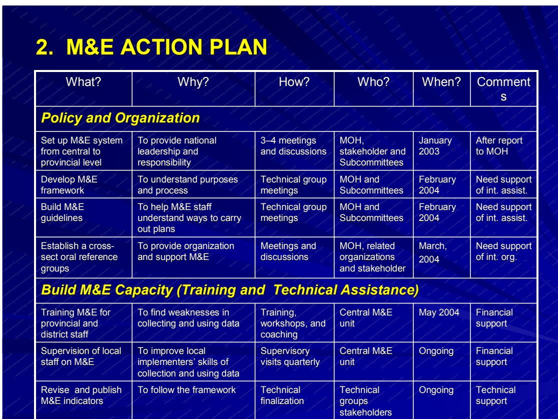
M&E Results and Dissemination

- Reported through meetings of HSS, BSS, or specific researches.
- Disseminated with written reports, bulletins, and journals.
- To some extent, results influenced the policymakers.

Impact Assessment

- STI/HIV surveillance system needs to be improved.

Viet Nam Action Plan, continued



What?	Why?	How?	Who?	When?	Comments
Policy and Organization					
Set up M&E system from central to provincial level	To provide national leadership and responsibility	3–4 meetings and discussions	MOH, stakeholder and Subcommittees	January 2003	After report to MOH
Develop M&E framework	To understand purposes and process	Technical group meetings	MOH and Subcommittees	February 2004	Need support of int. assist.
Build M&E guidelines	To help M&E staff understand ways to carry out plans	Technical group meetings	MOH and Subcommittees	February 2004	Need support of int. assist.
Establish a cross-sect oral reference groups	To provide organization and support M&E	Meetings and discussions	MOH, related organizations and stakeholder	March, 2004	Need support of int. org.
Build M&E Capacity (Training and Technical Assistance)					
Training M&E for provincial and district staff	To find weaknesses in collecting and using data	Training, workshops, and coaching	Central M&E unit	May 2004	Financial support
Supervision of local staff on M&E	To improve local implementers' skills of collection and using data	Supervisory visits quarterly	Central M&E unit	Ongoing	Financial support
Revise and publish M&E indicators	To follow the framework	Technical finalization	Technical groups stakeholders	Ongoing	Technical support

APPENDIX F: WORKSHOP EVALUATION FORM

Workshop for Strengthening Monitoring and Evaluation of National AIDS programs in Asia

November 4–7, 2003
Bangkok, Thailand

Sessions

Please evaluate each workshop session by circling the most appropriate response. Take into considerations that ***CONTENT***, ***CLARITY***, *and* ***USEFULNESS*** *of each session.*

	Needs Improvement		Fair	Good	Excellent
1. Strategic context of expanded response by donor agencies	1	2	3	4	5
*Comments:*____________________					
2. Reviewing M&E practices and challenges—country presentations	1	2	3	4	5
*Comments:*____________________					
3. Working groups on indicators within the Asian context	1	2	3	4	5
*Comments:*____________________					
4. Country group work on forming M&E plans	1	2	3	4	5
*Comments:*____________________					
5. Country plans and activities (include country presentations in Session 6)	1	2	3	4	5
*Comments:*____________________					
6. Plenary and the future	1	2	3	4	5
*Comments:*____________________					

7. What sessions do you feel were the most useful to your work in M&E?

____

____

____

8. Were there topics that you wish had been covered, or topics you wish the workshop had spent more time on?

____

____

____

Workshop Objectives

Overall, how would you rate the success of the workshop in reaching its objectives?

	Needs Improvement		Fair	Good	Excellent
9. Share and discuss M&E practices, plans, and indicators used in each country. *Comments:*__________	1	2	3	4	5
10. Describe country M&E current capacity and identify ways to strengthen it. *Comments:*__________	1	2	3	4	5
11. Develop country-specific short-term action plans of M&E activities. *Comments:*__________	1	2	3	4	5
12. Identify ways to optimize the use of national and international technical and financial resources. *Comments:*__________	1	2	3	4	5
13. Develop lost list of country-specific contacts for persons responsible for M&E activities at the national level. *Comments:*__________	1	2	3	4	5

Logistics

	Needs Improvement		Fair	Good	Excellent
14. Overall, how would you rate the logistics arrangements prior to arrival in Bangkok? *Comments:*__________	1	2	3	4	5
15. Overall, how would you rate the logistics during the workshop in Bangkok? *Comments:*__________	1	2	3	4	5

Other Comments

16. Do you have suggestions for improvements of organization or content?

____

____

____

17. Any further comments or suggestions?

____

____

____

Thank you

APPENDIX G: WORKSHOP EVALUATION RESULTS

WORKSHOP EVALUATION FORM RESULTS

Survey Number	Strategic context of response	Reviewing M&E country presentations	Working groups—Asian	Country group M&E plans	Country plans and activities	Plenary and future	7 & 8	Share M&E practice, plans, and indicators	Country M&E current capacity	Country short-term	Optimize use of resources	Country-specific contacts	Logistics prior to arrival	Logistics during
1	4	5	5	5	5	4		5	5	5	5	5	5	5
2	5	4	4		3	4		4	2		2	4	4	5
3	4	4	4	5	4	4		4	3	3	4	4	4	4
4		5	4	5	5	4		3	4	4	4	1	5	5
5	3	3	5	3	3			3	3	3	4	3	4	4
6	4	4	3	3	3	4		4	4	3	4	3	4	4
7	4	5	4	5	5	4		5	5	5	4	4	5	5
8	4	4		4	3	4		3	4	3	4	5	4	5
9	4	4	4	4	4	4		4	4	5	4	5	5	5
10	5	4	4	4	4	4		4	3	4	3	4	4	5
11	5	5	4	5	4	5		3	4	4	3	4	4	5
12	4	4	4	4	3	4		3	3	4	2	4	4	4
13	5	5	4	3	3	5		4	4	4	3	3	3	5
14	4	5	4	5	5	4		5	4	4	2	5	5	5
15	5	4	4	5	4	4		4	3	4	4	4	5	5
16	5	3	4	3	3	4		4	4	3	3	3	5	5
17	5	4	5	4	4	4		4	4	4	3	4	4	5
18	4	4	3	4	4	4		4	5	4	4	4	5	5
19	4	4	3	4	4	4		4	4	5	5	4	3	4
MEAN	**4.33**	**4.21**	**4.00**	**4.17**	**3.84**	**4.11**		**3.89**	**3.79**	**3.94**	**3.53**	**3.84**	**4.32**	**4.74**
MEDIAN	**4**	**4**	**4**	**4**	**4**	**4**		**4**	**4**	**4**	**4**	**4**	**4**	**5**
MODE	**4**	**4**	**4**	**5**	**4**	**4**		**4**	**4**	**4**	**4**	**4**	**4**	**5**

Workshop for Strengthening M&E of National AIDS Programs

November 4-7, 2003
Bangkok, Thailand

EVALUATION SUMMARY

Question	Survey Number	Response
2. Reviewing M&E practices and challenges—country presentations	12	Each country presentation was candid (?) and interesting.
3. Working groups on indicators within the Asian context	10	Would like to have had a summary of the outcome of the discussion.
	12	Excellent discussion but unclear as to how it will be used.
4. Country group work on forming M&E plans	10	Good guidelines.
	12	Group worked hard; would have benefited from more clear direction.
	13	Not specific by and large.
5. Country plans and activities (include country presentations in Session 6)	12	"Nice reports, but could have been better and more comprehensive with more clear direction."
	13	Most are ideal, not realistic.
7. What sessions do you feel were the most useful toyour work in M&E?	1	"Review M&E practice and challenges, country plan."
	2	Country group work.
	3	Country plans and activities.
	5	"For this workshop, I feel that on cross-country working is quite good, because I can share their information and ideas to pick into M&E plan/indicators."
	6	Strategic context.
	7	"Review M&E practices and challenges, working group on indicators and M&E plan."
	9	Plenary: Working together to promote one voice for M&E of Natational HIV/AIDS programs.
	10	*3 and *4.
	11	Donor agencies panel advocate for country level to committee in M&E.
	12	The country work groups served to set the tone for future action.
	13	Country presentations; summing up presentations, by Ms. Sian Curtis.

Question	Survey Number	Response
	14	Country group work on M&E.
	15	Issues in M&E practices and M&E capacity; break into cross-country working group on five topic.
	16	Working group on indicators.
	17	The reviewing M&E practices and challenges; country plans and activities.
	18	Session 2 & 4 & 5.
	19	Reviewing M&E practices and challenge—country.
8. Were there topics that you wish had been covered, or topics you wish the workshop had spent more time on?	2	Same live examples of good monitoring and documentation of formats that are dynamic and attempt at quality assurance.
	3	Reviewing country M&E practices and challenge.
	4	"More time should have been spent on developing strategies for better coordination, next steps from this workshop."
	5	"As different characteristics country, we need to draft a common indicators and step of M&E plan together. So now use works/cooperative together."
	7	Yes.
	9	Challenges and issues to overcome to enable countries to obtain the indicators.
	10	M&E for ARU delivery.
	11	Present best practices of M&E of some countries.
	12	Many—"I believe the organizers assumed that the group was much further along in their understanding and use of M&E than they actually are." There is need for basic training on why M&E, developing logic models, building the plan "from the logic models, using the information for decisionmaking."
	13	Yes.
	14	Should have one more workshop at end of 2005 in Vietnam to evaluate whether work has been done after this workshop.
	15	The topics I wish this workshop had spent more time on.
	16	Data collection.
	17	Experiences on M&E practice and method to be used with improvement and quality.
	18	Appropriate time.
	19	"Yes, expanding in country plans and activities."
10. Describe Country M&E current capacity and identify ways to strengthen it	2	More commitment at highest level and understanding that it is a process of improving health systems.

Question	Survey Number	Response
11. Develop country-specific short-term action plans of M&E activities	12 14	Need much more time here. International organization should have a partial fund (including) in each country fund for M&E.
12. Identify ways to optimize the use of national and international technical and financial resources	2 9 12 14	Diffused—nobody appeared specific. It should formulate a coordinating system. Not much mentioned here except to spend 5–10% on M&E! Should have a group of international experts to evaluate M&E of each country.
13. Develop lost list of country-specific contacts for persons responsible for M&E activities at national level	8 9 12	Could you contact M&E officers directly? It will facilitate the communications. While this is laudable, its use in the future will probably be minimal.
14. Overall, how would you rate the logistics arrangements prior to arrival in Bangkok?	2 8 12	Did not utilize. But require that the sponsor provide the invitation letter at least 3 weeks before workshop. Flexibility of organizational committee is appreciated.
15. Overall, how would you rate the logistics during the workshop in Bangkok?	14	In hotel room, should have comb.
16. Do you have suggestions for improvements of organization or content?	4 6 7 8 9 10 11 12 13 16 17	Better representation from government people, more discussion on lessons learned and best practices, exposure to cutting-edge practices in M&E globally. More involvement of ministry's representatives. Provide case study, and should organized a followup workshop on the ME. We should have the invitation letter at least 3 weeks before the workshop. Better distribute presentations CD-ROM. Wider publicizing in preparation of the workshop. Introduce best practices from other countries on how to make M&E a success. Start on time. More case studies; success and failure stories. Need more time to discuss details of M&E. Well organized.

Question	Survey Number	Response
	18	No.
	19	May be add more offices at province level to give comment and more recommendation, shall we talk more about indicators for community response program? Because I think it is necessary.
17. Any further comments or suggestions?	2	Results.
	7	If there will be an M&E followup workshop, it may be held in other countries; handouts for presentations should be given in advance so participants can have a look and get more understanding and share comments.
	8	If available, could you provide M&E officers to exchange on the experience between country?
	11	Thanks for the organizers for this excellent workshop, which fuel our team at country level to sit and talk together for further M&E plan (national framework); followup and TA assistance at country level.
	12	This workshop as presented seemed much more focused on form than substance. The logistics were great arrangements, breaks, meals, transportation, evening events, and group picture. However, the substance of the workshop was disappointing—perhaps our expectations were too high, but we wanted much more basic information on how to go about developing action.
	13	Overall, an excellent event; had a good insight into neighborhood problems/attempts/initiatives to serve them.
	14	Regulars leave workshop to evaluate what have been done after one workshop; regulars send expert to do supervisory visit with clear objective base on each country situation to solve problem in M&E.
	17	No.
	19	Is it possible to talk about the help from international organizations (UNAIDS, USAID, WHO, World Bank) in terms of M&E budget, building capacity, etc. for the country? (That answer already in last panel discussion.)

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