



Report on Needs Assessment for District M&E Taskforces in Zimbabwe

Report produced by:

Biomedical Research and Training Institute - Manicaland HIV/STD Prevention Project
On behalf of the Zimbabwe National AIDS Council

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Executive Summary

As part of the National HIV and AIDS Strategic Plan, NAC has established a comprehensive M&E system for programmes covered by the plan and implemented through its governmental and non-governmental partners (The Monitoring and Evaluation Framework 2006-2010). In line with this system, data on a set of standard M&E indicators are collected on a monthly basis at district level and are captured into a national database. The captured data are analysed and reports are produced using CRIS software and Excel Core Output Indicator spread-sheets that are available at district, provincial and national levels. In addition, NAC has established a network of M&E taskforces to work with its own officials at the provincial and district levels to help coordinate the local implementation of the national M&E strategy.

In July 2011, NAC, UNAIDS and UNFPA commissioned the Biomedical Research and Training Institute (BRTI) to assess the need for and to develop an strengthened model for implementation of M&E activities at the district level focussing particularly on improving data completeness and quality and local utilisation of data. This document presents findings from the needs assessment that was conducted as the initial stage of this work. The needs assessment comprised three major elements: (i) a situational analysis of policies and guidelines on M&E; (ii) consultations with key stakeholders, and (iii) a national survey of DACs and district M&E taskforces members on the functionality of district M&E taskforces.

Findings from the assessment showed that taskforces had been established and are functioning in most NAC districts. However, with appropriate support, these taskforces have the potential to contribute more to optimising the accuracy, interpretation and utilisation of national M&E data. A number of suggestions are made for how this might be done, particularly by allowing for more meaningful local participation and ownership (section 5.3).

The following are some of the more substantial changes that could be considered:

1. Provide more formal training in M&E skills for taskforce members, particularly in the areas of report generation, data analysis and interpretation

2. Revise and detail the timetable for submission of M&E reports by DACs and provinces to allow for meaningful involvement of district taskforces in the review, correction and interpretation of the data to be submitted
3. Address gaps in national data on key global indicators by initiating data collection on these indicators at district level
4. Add establishment, administration and facilitation of district M&E taskforces in the job description for District AIDS Coordinators
5. Develop and distribute standard terms of reference for district M&E taskforces that are specific to the role of these taskforces at district level and include key deliverables
6. Develop a small number of *outcome* indicators for use at district level together with simple tools for calculating and presenting these indicators. These tools could include spread-sheets with built-in graphics that can be updated and printed for use in interpretation and dissemination and estimates for the denominators required to calculate the indicators

Following discussion of these suggestions with NAC, the NRMEAG and other partners, BRTI will work on these further (utilizing the resources identified in the review of existing policies and guidelines) to produce a comprehensive model and tool-kit for use by DACs and district M&E taskforces.

Acknowledgements

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DRAFT

List of Acronyms

ASOs	AIDS service organizations
BRTI	Biomedical Research & Training Institute
CDC	Centers for Disease Control
CEO	Chief Executive Officer
COI	Core Output Indicators
DAAC	District AIDS Action Committee
DAC	District AIDS Coordinator
DNO	District Nursing Officer
DOMCCP	Diocese of Mutare Community Care Programme
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
ESP	Expanded Support Programme
FACT	Family AIDS Caring Trust
FOST	Farm Orphan Support Trust
HBC	Home-based care
HIV	Human Immunodeficiency Virus
HTC	HIV testing and counselling
ICT	Information Communication Technology
M&E	Monitoring and Evaluation
MEO	Monitoring and Evaluation Officer
MOHCW	Ministry of Health and Child Welfare
NAC	National AIDS Council
NARF	National Activity Report Form
NATF	National AIDS Trust Fund (AIDS Levy)
NHIS	National Health Information System
NRMEAG	National M&E Advisory Group
OI	Opportunistic Infection
ODF	Organisational Details Form
OVC	Orphans and Vulnerable Children
PAAC	Provincial AIDS Action Committee
PAC	Provincial AIDS Coordinator

PATAM	Pan African Treatment Access Movement
PLWHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RDC	Rural District Council
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
WAAC	Ward AIDS Action Committee
WAD	World AIDS Day
YFC	Youth Friendly Corner/Centre
ZNFPC	Zimbabwe National Family Planning Council
ZNNP+	Zimbabwe National Network of People Living with HIV

Definition of Terms

- Activity:** actions taken or work performed through which inputs such as funds, technical assistance, and other types of resources are mobilized to produce specific outputs.
- Coverage:** the extent to which a program/intervention is being implemented in the right places (geographic coverage) and is reaching its intended target population (individual coverage).
- Data analysis** is a process of inspecting, cleaning, transforming, and modelling data with the goal of highlighting useful information, suggesting conclusions, and supporting decision making. Data analysis has multiple facets and approaches, encompassing diverse techniques under a variety of names, in different business, science, and social science domains.
- Data quality:** refers to the extent to which data adheres to the six dimensions of quality i.e. accuracy, reliability, completeness, precision, timeliness and integrity
- Evaluation:** the rigorous, scientifically-based collection of information about program/intervention activities, characteristics, and outcomes that determine the merit or worth of the program/intervention. Evaluation studies provide credible information for use in improving programs/interventions, identifying lessons learned, and informing decisions about future resource allocation.
- Goal:** a broad statement of a desired, usually longer-term, outcome of a program/intervention. Goals express general program/intervention intentions and help guide the development of a Program/intervention. Each goal has a set of related, specific objectives that, if met, will collectively permit the achievement of the stated goal.
- Health information system (HIS):** a data system, usually computerized, that routinely collects and reports information about the delivery and cost of health services, and patient demographics and health status.
- HIV/AIDS M&E plan:** a multi-year implementation strategy for the collection, analysis and use of data needed for program / project management and accountability purposes. The plan describes the data needs linked to a specific program /

project; the HIV/AIDS M&E activities that need to be undertaken to satisfy the data needs and the specific data collection procedures and tools; the standardised indicators that need to be collected for routine monitoring and regular reporting; the components of the HIV/AIDS M&E system that need to be implemented and the roles and responsibilities of different organisations / individuals in their implementation; how data will be used for program / project management and accountability purposes. The plan indicates resource requirement estimates and outlines a strategy for resource mobilization. *Note:* A national HIV/AIDS M&E plan is a multi-sectoral, 3-5 year implementation strategy which is developed and regularly updated with the participation of a wide variety of stakeholders from national, sub-national, and service delivery levels.

HIV/AIDS M&E work plan: An annual costed HIV/AIDS M&E plan that describes the priority HIV/AIDS M&E activities for the year and the roles and responsibilities of organizations / individuals for their implementation; the cost of each activity and the funding identified; a timeline for delivery of all products / outputs.

Indicator: a quantitative or qualitative variable that provides a valid and reliable way to measure achievement, assess performance, or reflect changes connected to an intervention.

Monitoring: a routine tracking and reporting of priority information about a program or project, its inputs and intended outputs, outcomes and impacts.

Outputs: the results of program/intervention activities; the direct products or deliverables of program/intervention activities, such as the number of HIV/AIDS counselling sessions completed, the number of people served, the number of condoms distributed.

Programme: an overarching national or sub-national response to a disease. A program generally includes a set of interventions marshalled to attain specific global, regional, country, or sub national objectives; involves multiple activities that may cut across sectors, themes and/or geographic areas.

Qualitative data: data collected using qualitative methods, such as interviews, focus groups, observation, and key informant interviews. Qualitative data can provide an understanding of social situations and interaction, as well as people's values,

perceptions, motivations, and reactions. Qualitative data are generally expressed in narrative form, pictures or objects (i.e., not numerically). Note: The aim of a qualitative study is to provide a complete, detailed description.

Quantitative data: data collected using quantitative methods, such as surveys. Quantitative data are measured on a numerical scale, can be analysed using statistical methods, and can be displayed using tables, charts, histograms and graphs. Note: The aim of a quantitative study is to classify features, count them, and construct statistical models in an attempt to explain what is observed.

Stakeholder: a person, group, or entity who has a direct or indirect role and interest in the goals or objectives and implementation of a program intervention and/or its evaluation.

Taskforce is a unit established to work on a single defined task or activity. It can also be defined as a temporary grouping of persons mandated by a permanent structure to fulfil a specific, often short term, objective.

Triangulation: the analysis of data from three or more sources obtained by different methods. Findings can be corroborated, and the weakness or bias of any of the methods or data sources can be compensated for by the strengths of another, thereby increasing the validity and reliability of the results.

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1.0 Background and Introduction

In line with the first Zimbabwe National HIV and AIDS Strategic Plan (ZNASP I), NAC established a comprehensive M&E system for HIV/AIDS programmes implemented through its governmental and non-governmental partners (The Monitoring and Evaluation Framework 2006-2010). In this system, data on a set of standard M&E indicators are collected monthly at district level and are captured into a national database. CRIS software and Excel COI spread-sheets have been made available at district, provincial and national levels for data analysis and reporting purposes (See Annex). In addition, NAC has established a network of M&E taskforces to work with its own officials at provincial and district levels in coordinating the local implementation of the national M&E strategy. The Ministry of Health and Child Welfare (MOHCW) is also in the process of replacing its biomedical HIV/AIDS control programmes M&E system with a new electronic system which is to be linked to the NAC system.

Whilst comprehensive M&E systems have been established for HIV/AIDS programmes in Zimbabwe, a number of challenges remain regarding their practical implementation. In particular, the systems rely heavily on local structures at the district and sub-district levels which may lack the skills, capacity and resources needed to implement M&E activities. As a consequence, the coverage of the M&E system may be limited in some programmatic and geographic areas and the data collected and input into the national M&E database could be of variable quality. Furthermore, whilst it is important that data analysis and interpretation, dissemination and utilisation of results are done at the district level to inform the development of HIV/AIDS programmes, local taskforces may lack the skills needed to fulfil this function effectively. An additional difficulty has been in linking and standardising the information contained in the NAC M&E database with information from the Ministry of Health and Child Welfare's own M&E records, particularly with regard to the national ART programme.

Given these difficulties, a district-level M&E implementation model and toolkit could be of value in strengthening the system and improving local utilisation of M&E data to enhance

programming activities. In particular, it could be helpful if the model is framed such that it provides guidance and practical tools for analysing and interpreting routine M&E data: e.g (i) to identify gaps in coverage and weaknesses in data quality and assessing the implications of these for observed trends in key programme indicators; and (ii) to assess programme performance. Therefore, an initial needs assessment was conducted to investigate the need for and to inform the design of a district model. This report describes the findings of this needs assessment.

The needs assessment comprised three elements:

- (i) Review of existing national M&E policies and procedures with particular attention to current terms of reference, guidance and training given to district taskforces;
- (ii) Consultations with NAC, MOHCW and UNAIDS M&E officers, the National M&E Advisory Group, NGOs, and other national stakeholders to assess whether there is need for a district model, what it should comprise of, and arrangements that will be needed to support effective implementation; and a
- (iii) National survey of the 85 NAC districts to assess the functionality and needs of M&E taskforces. A brief questionnaire was distributed to District AIDS Coordinators, MOHCW M&E Officers and other district M&E taskforce members to determine *inter alia* aspects such as the frequency of taskforce meetings, current activities and their impact on local programmes, compliance with existing national guidelines, challenges and perceived needs, and views on the utility of a standard district model and what it should comprise.

2.0 Review of Policies and Guidelines on M&E

2.1 Introduction

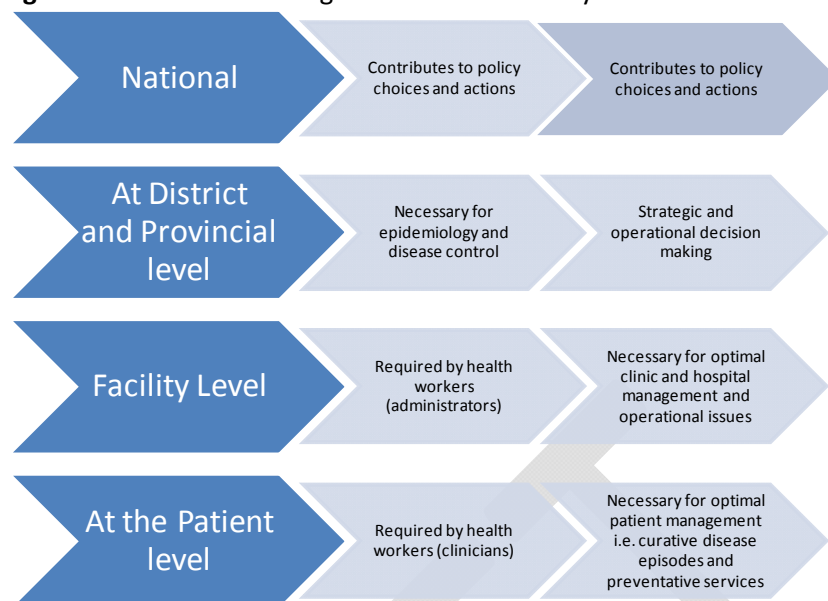
The needs assessment started with a review of the national strategies and guidelines in place to direct M&E at lower levels. Most of the documents were developed by NAC, MOHCW and UNAIDS, their technical partner on M&E in Zimbabwe. These documents were reviewed to provide an overview of the standards guiding district M&E in the country.

2.2 Zimbabwe National Health Strategy (2009-2013) - MOHCW

The main thrusts of the 2009-2013 National Health Strategy are to provide a framework for immediate resuscitation of the health sector (Health System Strengthening) and to put Zimbabwe back on track towards achieving the Millennium Development Goals (MDGs). The strategy is based on information from several studies carried out from 2006-2009, existing national plans and programmes and existing programme-specific policy and strategic documents. The strategy also takes into consideration regional and international policies, strategies and commitments made by the country, for example, the Millennium Development Goals. In addition, the strategy emphasises the importance of monitoring and evaluation of health data for informed decision-making at all levels.

The figure below gives an outline of the Health and Management Information System from lower levels to the national level. This clearly shows how systems at national level are fed by district and provincial systems. It is crucial, therefore, that a District M&E Model contributes meaningfully to the national picture.

Figure 1: Health and Management Information Systems and Research



Source: Adapted from Zimbabwe National Health Strategy, 2009-2013. pp99-100.

2.3 Zimbabwe National AIDS Strategic Plans – NAC

2.3.1 Zimbabwe National AIDS Strategic Plan 1 (2006-2010)

The Zimbabwe National AIDS Strategic Plan 1 (ZNASP 1) provides policy and strategic guidance in HIV and AIDS planning, implementation, monitoring and evaluation. The ZNASP 1 also gives a brief background on the relationship between NAC and national strategy on the response to the HIV and AIDS epidemic, the strategic planning process, statements of vision, mission and values, operational environment, strategic focus, outcomes, outputs, activities, risk analysis and implementation and management of the strategic plan - i.e. The 3 Ones. The document provided a guide for all HIV/AIDS programming for implementers and highlighted M&E as a major component in implementing programmes.

2.3.2 Zimbabwe National AIDS Strategic Plan 2 (2011-2015)

The second Zimbabwe National HIV and AIDS Strategic Plan (ZNASP 2) succeeds the first ZNASP and is a five-year (2011 to 2015), multi-sectoral framework developed to inform and guide the national response towards achieving zero new infections, zero discrimination and zero AIDS deaths by 2015. The strategic plan mainstreams gender dimensions in the response strategies and sets out indicators that will be used to measure performance and anticipated results. The plan provides meaningful opportunities for many and diverse stakeholders to participate in the implementation of the national response.

The ZNASP 2 envisages that the National M&E system will be strengthened and decentralised to provide the evidence necessary to support “evidence and results-based” management of the response. In particular, it is anticipated that the M&E system will provide all the indicator values and baselines for the second ZNASP.

To encourage community-led planning, monitoring and evaluation, CBOs, FBOs and NGOs will be trained in participatory approaches, on community planning, leadership and governance. Accountability and ownership will be enhanced. Skills in data collection, analysis and reporting will be developed. Communities will be encouraged to use strategic information collected to improve their interventions. According to the ZNASP 2, part of the training will focus on but not be limited to:

- Evidence and results-based planning and programming
- Financial planning and management
- Human resource capacity development, and
- Advocacy and networking

2.3.3 NAC Strategic Plan: July 2011 – December 2015

NAC's role is to lead and facilitate the attainment of the "3 Ones" principle enunciated in the ZNASP. After the Zimbabwe National HIV and AIDS Strategic Plan 2 (ZNASP, 2011-2015) was formulated, the NAC Organizational Strategic Plan for the period July 2008 to June 2011 was due for renewal. Therefore, NAC formulated a new strategic plan that would be aligned to ZNASP 2. The strategic planning process comprised a review of relevant documents, stakeholder consultations and a strategic planning workshop.

The strategic plan has a Results Framework (RF) with clear outcomes, outputs, indicators, baseline values, targets, sources of information, frequency of monitoring and responsibilities. The performance parameters are aligned to the ZNASP 2. This is designed to facilitate monitoring and evaluation of the strategic plan as well as adoption of the Balanced Scorecard System for personnel performance measurement.

The RF will be supported by detailed action plans covering the whole life of the strategic plan. These action plans will be used as a basis for formulating annual and quarterly work plans and budgets.

Table 1: Strategic Thrusts and Outcomes of the NAC Strategic Plan, July 2011 to December 2015

ZNASP 2 Impact/Outcome Area	NAC strategic thrusts	Outcomes
Coordination	Coordination of national response	National response to HIV effectively coordinated and managed
Monitoring and Evaluation	Information management, M&E and research input	Effective information management and functional M&E system
Coordination and M&E	Communication	Effective internal communication and availability of strategic information
Enabling environment	Enabling policy, legal, regulatory and social environment	Conducive environment for effective HIV response created
Financial gap for ZNASP reduced	Resource mobilisation and management	Financial gap for ZNASP reduced to less than 20%, and effective disbursement and tracking of resources for the national HIV and AIDS response
Capacity to effectively manage the national response	Institutional capacity strengthening	NAC and partners have adequate institutional capacity to plan and implement the national response

Source: NAC Strategic Plan (July 2011 – December 2015) piv

2.4 Monitoring and Evaluation Plans for ZNASP 1&2 – NAC

2.4.1 Monitoring and Evaluation Plan for ZNASP 1 (2006–2012)

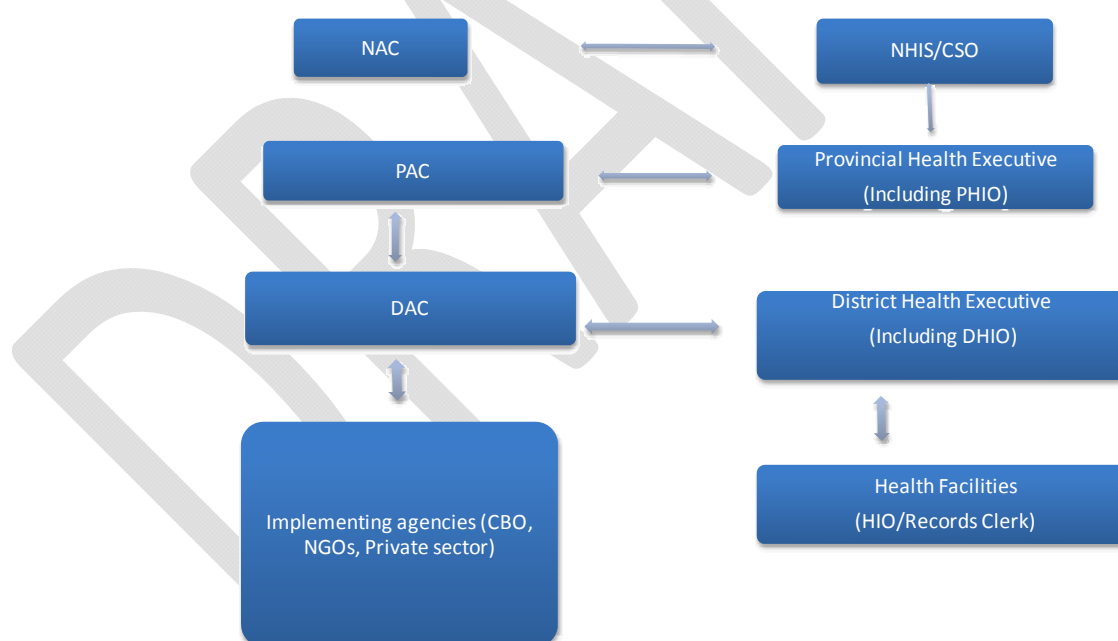
The initial National M&E Plan was aligned with the strategic priority areas of the ZNASP 1. The overall goal was to provide a systematic approach to tracking activities related to the ZNASP 1 strategic areas. It articulated, by programme area, details of the information needed including: indicators (NARF), data sources, data collection methods, data flow, data analysis, data use and reporting, and feedback as well as the responsibilities of implementing partners and stakeholders. Strategies for developing M&E capacity in terms of human, material and financial resources and detailed costed annual action plans were also included in the first national M&E Plan.

The main objectives of the plan were to assist stakeholders to:

- Guide policy and planning of the national response
- Strengthen coordination of all partners and stakeholders working on HIV/AIDS
- Monitor effectiveness of programmes
- Facilitate data dissemination among implementing partners and stakeholders, and
- Guide resource mobilization

The national M&E system to be implemented by NAC was also outlined in the plan. Of particular relevance here is that the districts were to be the main pillar of the functionality of the system as they were the primary data collectors for the M&E System. It is important to note that the validity of the data at this level is crucial as it informs the nation as a whole. Figure 2 shows the structure of the M&E Reporting System which M&E taskforces at all levels were expected to implement.

Figure 2: Linkages between NAC and MOHCW in the National M&E Reporting System



Adapted from: the M&E Plan for Zimbabwe HIV and AIDS National Strategic Plan (2006–2012) p15.

The M&E plan also set out some standard priorities for M&E to be adopted at all levels (Table 2).

Table 2 District-Level Involvement in Priority and Standard M&E Reports

REPORT	RESPONSIBLE	KEY PERSONS
DAC District Quarterly Statistical Report*	M&E Officer, DAC	WAAC, VAAC, DA, DMO , NAC, PAC & district level implementers
District Health Information Quarterly Report	Health Information Officer/DMO	DAC, PMD, district implementers
NAC National Quarterly Report	NAC M&E Unit	All stakeholders, umbrella organizations, private sector, DAC , and PAC, MOH and CSO
Quarterly AIDS/TB Unit Report	AIDS/TB unit (Director)	MOHCW Dir of Preventive Services, Members of the planning pool, NHIS, NAC and PMOs
NAC M&E Bulletin	NAC	All stakeholders
NAC Annual M&E Report	NAC M&E Unit (Director)	All stakeholders, umbrella organizations, development partners, private sector, DAC , PAC, Cabinet Committee, Parliamentary Health Committee
Annual AIDS/TB Unit Report	AIDS/TB Unit (Director)	All stakeholders, umbrella organizations, development partners, private sector, DAC , PAC, Cabinet Committee, Parliamentary Health Committee
Thematic reports**	NAC and stakeholders	All stakeholders, umbrella organizations, development partners, private sector, DAC , PAC, relevant government departments

*The DAC District Quarterly Statistical Report is produced using the National Activity Report Form (NARF)

**The current themes are: Prevention, Treatment, Care and Support, Coordination, Management and Systems Strengthening, and Enabling Policy and Legal Environment

District-level inputs are highlighted in bold

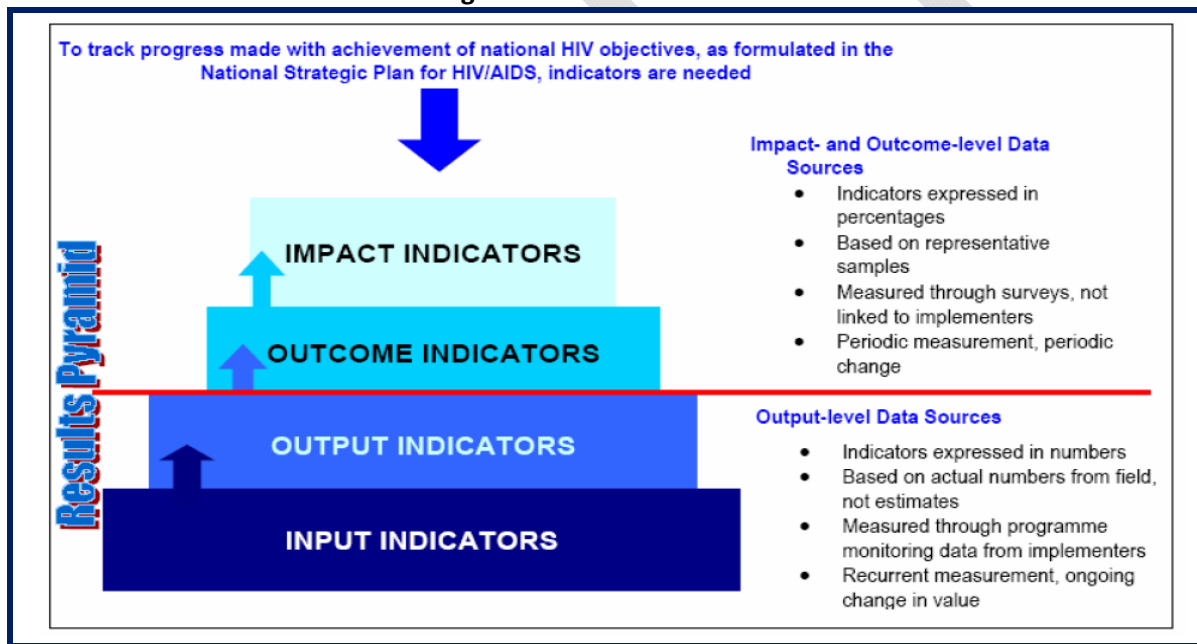
Source: M&E Plan for Zimbabwe HIV and AIDS National Strategic Plan (2006–2012) p19.

Initially, the assumption was that there would be an M&E officer for each district but, due to issues of feasibility and sustainability, the M&E officers were based at provincial level where they had to cover several districts. Therefore the DAC district quarterly reports are now developed with support from the provincial based M&E officers.

2.4.2 Monitoring and Evaluation Plan for ZNASP 2 (2011-2015)

The M&E Framework and Plan for 2011-2015 was developed by NAC with support from the multi-sectoral National Research and Monitoring and Evaluation Advisory Group (NRMEAG). The plan builds on the M&E Plan for 2006-2010. It aims to guide all stakeholders in effective monitoring and evaluation of the national strategy throughout the 5-year period of the ZNASP 2 (2011-2015). This is in accordance with the “3 Ones” principle, particularly the 3rd “One” which prescribes “One agreed country-level M&E system”. The main purpose in developing the second M&E framework and plan was to closely monitor and evaluate the implementation and progress towards achieving the goals of the ZNASP 2.

Figure 3: M&E Results Chain



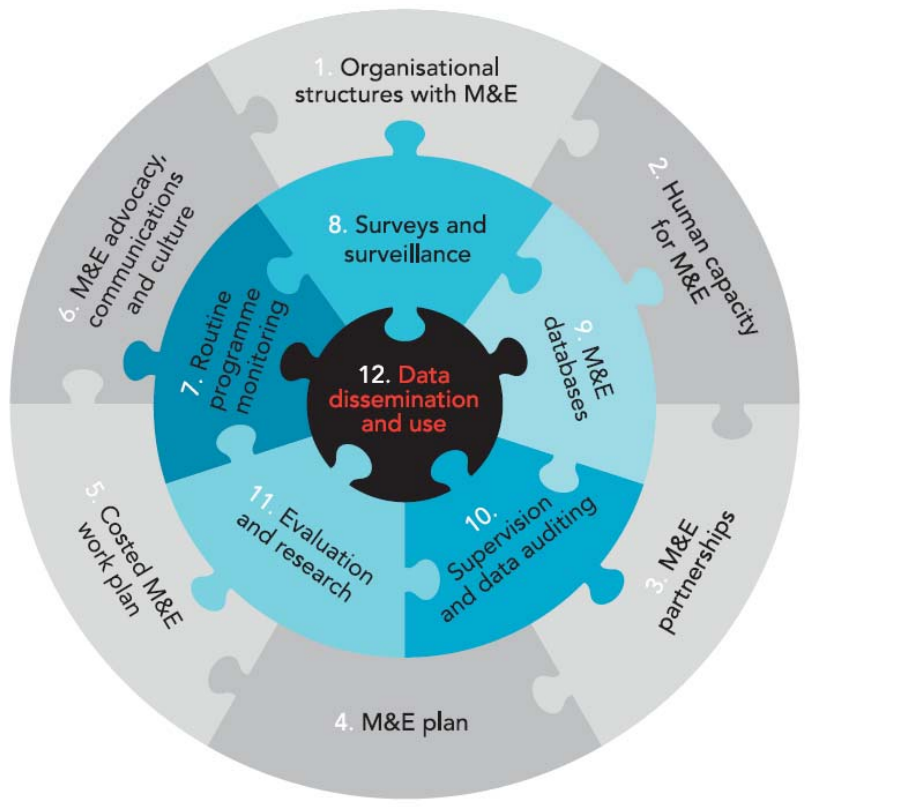
Source: Monitoring and Evaluation Plan for ZNASP 2 (2011-2015) p12

The National M&E Plan is aligned with the strategic priority areas of the results based ZNASP 2011-2015. The overall goal of the current national M&E plan is to provide a systematic approach to tracking activities related to the ZNASP strategic areas. The plan spells out, by programme area, details of what information is needed including: indicators data sources, collection methods, flow, analysis, use and reporting, and feedback as well as the responsibilities of implementing partners and stakeholders.

Figure 3 shows the results chain that is being used to track progress made with national HIV objectives as formulated in the ZNASP 2.

The M&E Plan also outline the 12 components of a good M&E system (Figure 4) that includes individuals, organizations, functions/actions, and the organizational culture that are fundamental to improving and sustaining M&E system performance. The middle ring focuses on the mechanisms through which data are collected, verified and analyzed. Data dissemination and use (for decision making) has been placed at the centre of the framework to represent the primary purpose of the M&E system.

Figure 4: Organizing Framework for a functional National HIV M & E system.



Source: Monitoring and Evaluation Plan for ZNASP 2 (2011-2015) p13

2.4.3 National HIV & AIDS Activity Report Form Indicator Guide – NAC

This document is the indicator guide for the National Core Output Indicators in the national M&E system managed by the National AIDS Council. It provides detailed descriptions of the following:

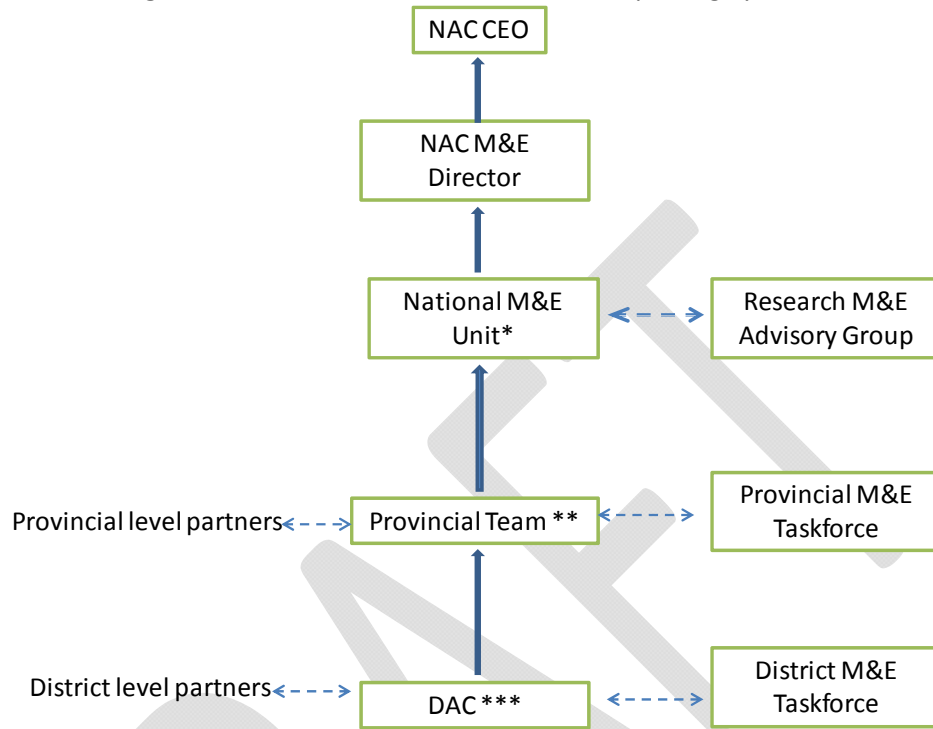
- Indicator definitions and narratives
- The indicator code
- The rationale for the indicator
- Proposed methods for measuring the indicator
- Frequency of collection
- Data source i.e. implementer providing the data
- Source tools
- Forms of disaggregation, and
- Guidance on interpretation of indicators.

The indicator guide helps to create a good understanding of what an indicator is intended to measure, how to collect it, and how to interpret and use the data. The indicator guide is one of several documents that form the components of the national M&E system, which also include the M&E framework, the M&E plan, the indicator framework, and the national database system. This guide enhances data utilisation in that it provides information on the usefulness of the indicators and how they can be used to guide district programming.

2.4.4 Structure of the National M&E Reporting System

The structure of the national M&E reporting system is summarized in Figure 5.

Figure 5: Structure of the National M&E Reporting System



*Led by the M&E Director, M&E coordinator, IT Coordinator, Database Officer, Research and Documentation Officer, 1 GF M&E officer ** 2 M&E officers *** DAC with M&E duties

Figure 5 shows the multi-sectorial implementation of the M&E Reporting system that is being led by NAC under the ‘3 Ones’ principle. Reports from district level are submitted through the different levels for national reporting.

The M&E taskforces are multi-sectorial with NAC acting as the secretariat at all levels. NAC District M&E systems on HIV/AIDS are implemented by NAC under The 3 Ones Principle. The system requires that all programme implementers do the following:

- Complete the Implementers Details Form and submit this form to the local DAC Office where a data entry code is issued
- Complete the NAC Activity Report Form (NARF) in duplicate every month (only reporting indicators for relevant programme areas); keep one copy and submit the second copy to the local DAC by the 5th of every month.

2.4.5 National M&E Database and Tools - NAC

The National M&E Reporting System has adopted the CRIS database system developed by UNAIDS. The objective of CRIS is to provide support to monitoring and evaluation activities in National AIDS Committees/Councils. It is intended to facilitate the organization, entry, analysis, exchange, and reporting of information on a country's response to HIV/AIDS. Currently the CRIS database is being used together with an Excel COI spreadsheet that has a list of the national Core Output Indicators (See Annex).

All NAC M&E Personnel, including the DACs, receive training on the CRIS and Excel COI systems.

2.4.6 Terms of Reference (TORs) for M&E Taskforces – NAC

NAC has developed standard TORs for use by M&E taskforces at all levels. The district taskforce is expected to work with the NAC secretariat to ensure implementation of the national M&E system. The taskforce is expected to be an engine to fuel data collection and utilisation at district level. However, these terms of reference are not tailor-made for districts but are intended to apply at all levels. The standard NAC TORs for M&E taskforces are as follows:

- Ensure timely submission of relevant HIV/AIDS data on a monthly basis
- Verification and validation of HIV/AIDS data - e.g. COI and baseline data
- Analyse and interpret data and disseminate information to stakeholders and policy makers on a regular basis
- Capacity building of ASOs in the implementation of the M&E system
- Identify best practices, document and share with partners for replication
- Identify and spearhead the carrying out of HIV and AIDS research studies
- Initiate exchange visits to facilitate a “look and learn” approach to programming

2.5 International Guidelines

2.5.1 Basic Terminology and Frameworks for M&E – UNAIDS

This document is part of the international guidelines provided by UNAIDS to national AIDS councils to assist in implementation of national M&E systems. It defines the basic language of M&E and introduces concepts and frameworks that form the foundation of M&E for example:

- Programme logic model
- Utilisation of programme data for programme improvement, accountability and feedback to partners
- Types of data - i.e. inputs, activities, outputs, outcomes, impact
- Levels of M&E - input, output and process monitoring mainly for districts, and
- The main components of an M&E system to be implemented at each level.

2.5.2 Guidance on Capacity Building for M&E – UNAIDS

The guidance provides practical advice for national AIDS programmes to develop a unified and effective national monitoring and evaluation system. The guidance also helps countries to define an agreed set of national performance objectives of the M&E system. The guidance includes basic concepts related to M&E capacity building, focuses on planning for capacity building, explores strategies and interventions for addressing capacity gaps and gives recommendations for M&E capacity building. Capacity-building strategies and interventions to strengthen the national M&E system are also highlighted at all levels and guidance is given on how the data can be used for decision-making.

2.5.3 An Introduction to Indicators – UNAIDS

This guideline gives the fundamentals of indicators i.e. definition, importance, essential components, types and how to select indicators. Its focus is on indicators as they are an essential component of an effective M&E system.

2.5.4 Making M&E Systems Work – A Capacity Development Toolkit – World Bank

([ived.dpt.gov.tr/DocObjects/.../Making_M_and_E_Systems_Work.pdf](http://ved.dpt.gov.tr/DocObjects/.../Making_M_and_E_Systems_Work.pdf))

The handbook provides a roadmap of the components to sustainable M&E system. It basically defines all the pieces of an M&E jigsaw puzzle to help ensure the sustainability of investments in M&E systems. The book describes strategies that increase the extent to which information from M&E system is used to inform decisions that will improve results even at the lowest level.

The handbook gives several reasons why information is not always used to making decisions to improve organisation's results as:

- Timing
- Conflicting government
- Political ideology and public opinion
- Dispute over data, measures of impact, data collection methods or data analysis tools, and
- Unclear measurement or analysis tools, challenges with data storage and analysis

3.0 Consultations with stakeholders

3.1 Introduction

Consultations were done with NAC, MOHCW and UNAIDS M&E officers, the National Research and M&E Advisory Group (NRMEAG), international and local NGOs and other national stakeholders on the need for a district model, what it should comprise, and arrangements needed to support effective implementation. Stakeholders commented on the achievements of the NRMEAG in development of the M&E systems and suggested ideas for a district model.

3.2 Achievements, Lessons and Challenges of the NAC M&E System

- NAC's presence at district level provides a strategic opportunity for advising the MOHCW and other partners on M&E
- Most of those consulted understood that there were functional multi-sectoral taskforces in all districts that met quarterly
- TORs for M&E taskforces were developed in consultation with NRMEAG and disseminated for adoption by taskforces at all levels
- M&E personnel from partners attended the NRMEAG; these members are nominated by stakeholders or co-opted by the secretariat as per need
- The NRMEAG has provided guidance to various evaluations that have been done - e.g. on the ESP, ZNASP I and for the UNAIDS Know-Your-Epidemic – Know-Your-Response Modes of Transmission mathematical modeling exercise.

3.3 Suggestions for an Improved District M&E Model

- Data needed for national reports on key global M&E indicators should be collected at district level to avoid the need to base reports on estimates
- Districts should focus on a few indicators that inform decisions
- The usefulness of meetings determines attendance and contribution; therefore, NAC should ensure that M&E taskforce meetings are useful

- Taskforces at all levels are good platforms for coordination but there should be unity and commitment - the success of the M&E system does not depend solely on resources but also on commitment by leadership to work together harmoniously on the implementation of the systems - i.e. from NAC and MOHCW. Some stakeholders felt these organisations were not committed sufficiently to ensure the success of the M&E system at district level
- There is need for NAC/MOHCW to harmonize the following:
 - The reporting period: the MOHCW reporting period is from 26th of every month to the 25th of the following month; NAC's reporting period is the calendar month
 - Reporting deadlines: the deadline for hospitals and clinics to report to the district MOHCW office is 5th of every month, the same day that DAC requires consolidated reports from the district MOHCW offices
- The taskforces depend on NAC, MOHCW and UNAIDS to push for their effectiveness rather than to rely on the chairperson or the other stakeholders to push for things to happen
- Policies and guidelines have been issued on M&E globally but nationally it has not been so; there is need for UNAIDS (as the M&E advisor) to strengthen capacity to advise NAC and MOHCW on M&E
- Indicators are developed to suite donor needs rather than district stakeholder needs; there is need to ensure the indicators proposed are collectable and integrated into existing M&E systems
- There is need for greater data quality assurance in NAC and MOHCW - i.e. DACs and/or Health information Officers should be qualified in M&E (i.e. by qualification and technical capacity) as well as having an appreciation of the health field
- NAC should work more with local NGOs in implementing the M&E system as this will incorporate ideas from stakeholders
- M&E Taskforce TORs should be tailor-made for each level rather than using the same TORs at national, provincial and district levels

- District-level M&E tools should be simplified to ensure that interpretation is uniform across all levels

3.4 Sustainability of the District M&E Model

- Feedback remains crucial to allow evidence-based communication at district level; this also helps motivate involvement of stakeholders in the reporting system
- Ownership of projects (e.g. ESP and the National Behaviour Change Programme) is needed to stimulate interest in the district - district partners should own projects through involvement in the development process and through regular updates
- Districts should be given enough time for verification and validation of data before submitting reports to higher levels (and/or there should be a mechanism for correcting previous reports following verification)
- There should be deliverables specific to the M&E taskforces at each level – e.g. work plan, reports etc. Taskforces have been a forum for updates about programmes rather than facilitating effective implementation of M&E systems of HIV/AIDS programmes
- An inventory of resources required for M&E should be clearly outlined and these resources made available

3.5 Partner Contribution

- High staff turnover amongst partners contributes to a lack of continuity within M&E taskforces. In addition to monetary rewards, job satisfaction can be improved by ensuring that outputs are achieved from staff efforts – this might be done, in part, if partners feedback M&E results within their organisations
- Advisory group members could be utilized rather than hiring consultants who lack experience with the M&E system
- Partners at all levels should prioritize M&E in their programmatic plans

4.0 National Survey of the 85 NAC Districts

All 85 NAC district M&E taskforces were surveyed on their functionality and needs between July 2011 and December 2011. A brief questionnaire was developed and administered to district taskforce members to determine *inter alia* aspects such as the frequency of taskforce meetings, current activities, and their impact on local programmes, compliance with existing national guidelines, challenges and perceived needs, and views on the utility of a standard district model and what it should comprise.

4.1 Methodology

Initially the sample size for the survey was 20 districts but it was increased to cover all 85 NAC districts to give the most representative picture possible. Four respondents were selected for each district - the District AIDS Coordinator (DAC), the relevant Provincial M&E Officer, the Health Information Officer, and one other district taskforce member. The DAC was asked to select the other member of the taskforce. The Provincial M&E Officers were included since they provide M&E support to the districts.

A pre-coded questionnaire was developed for the survey in consultation with NAC and MOHCW officials. Topics covered included the functionality of the taskforce, compliance with national guidelines, current activities and their impact on local programmes, challenges and perceived needs, and views on the utility of a standard district model and what it should comprise. Respondents were also asked to attach copies of key documents - e.g. terms of reference, annual work plan, and sample reports.

Questionnaires were distributed to eligible respondents through the NAC structures and completed questionnaires were returned to NAC Head Office before being handed to BRTI for data processing and analysis. The survey method was also used to collect qualitative and quantitative data from taskforce members using self-administered questionnaires.

The main advantages of the survey methods used included:

- The data collected cover the whole country including all provinces and urban and rural districts
- Reporting bias was reduced through the use of self-administered questionnaires
- The inclusion of structured and open-ended questions permitted the collection of quantitative and qualitative data
- Taskforce members were given time to complete the questionnaires at their own convenience; and
- The costs of distributing and administering the questionnaires were minimised

However, there were also some disadvantages associated with the methods of data collection used. These included:

- Delays in the return of questionnaires and availability of data for analysis as some respondents required a number of follow-ups before returning the completed questionnaires
- Non-return of a sizeable minority of questionnaires which may have resulted in selection bias in the data collected
- Difficulties in analysing the data collected in the open questions due to the inability to probe when incomplete or unclear answers were provided. Hence some responses had no explanations
- Respondent concerns about the confidentiality of information provided and views expressed due to the use of NAC's internal structures for the distribution and collection of the questionnaires may have led to reporting bias

The data were entered into a purpose-built Access database and data analysis was conducted using Stata version 11 and Excel software.

For the main analyses, to avoid duplicate responses for the same district, only responses from a 'lead respondent' were included. In most cases, the lead respondent was defined to be the DAC. However, if no response was received from the DAC, then the Health

Information Officer, another taskforce member or the Provincial M&E Officer (in this order of preference) was considered to be the lead respondent. Analyses were also done for selected outcomes to compare responses from different respondents from the same district taskforce to compare perspectives and to assess possible reporting bias.

4.2 Response Rate

Overall, responses were received from at least one taskforce member for 74% (63/85) of districts. However, the response varied between provinces from 33% in Harare to 100% in Manicaland, Mashonaland West and Matabeleland South (Table 3). The response rate was highest in districts with mixed urban and rural areas and lowest in urban districts. Although the overall response rate in the survey was reasonably high, many of the districts that responded failed to provide information on individual questions within the questionnaire. This raises questions concerning data quality and possible participation/selection bias in the data.

Table 3 National Survey Response Rate by Province and Urban/Rural Composition

Province	Districts responding	Total districts	Response rate
Harare	4	12	33.3%
Manicaland	8	8	100.0%
Mash Central	7	8	87.5%
Mash East	5	9	55.6%
Mash West	10	10	100.0%
Masvingo	7	8	87.5%
Mat North	6	7	85.7%
Mat South	7	7	100.0%
Midlands	4	10	40.0%
Bulawayo	5	6	83.3%
	63	85	74.1%
Urban	16	26	61.5%
Mixed	9	10	90.0%
Rural	38	49	77.6%
	63	85	74.1%

4.3 Overview of District Taskforce Activity

The main findings from the survey are summarised in Table 4.

Table 4 Overview of District M&E Taskforce Activity

Indicator	Yes	Copy supplied
Survey response rate (63/85)	74.1%	-
M&E taskforce has been established [†]	98.4%	-
M&E taskforce has met in the last 6 months	88.7%	-
Terms of reference	95.2%	23.8%
Workplan (2011)	66.7%	7.9%
Budget (2011)	-	6.3%
Reports prepared on core indicators	95.9%	11.1%
Reports prepared on data coverage	87.8%	-
Reports prepared on data quality	80.9%	-
Track trends in MOHCW indicators	87.0%	-
ART figures agreed (NAC vs. MOHCW)	87.0%	-

Non-responses excluded: these vary from 2 (M&E taskforce established) to 14-16 (Reports prepared) and 17 (ART figures agreed)

[†]Norton ('No'); Bulawayo North and Luveve (response missing)

M&E taskforces were found to be functioning in almost all districts with 95% having terms of reference. For Norton, no response was received from the DAC but responses were received from the Health Information Officer and another taskforce member. The Health Information Officer reported that the taskforce was not currently operational but the second respondent reported that the taskforce had met one month previously.

Two-thirds of the districts stated that their taskforce had produced a work plan for 2011. However, a sizeable minority did not have work plans and, based on the review of the documents submitted with the returned questionnaires, many districts were not using the standard NAC terms of reference and many of the work plans described programmatic activities rather than M&E taskforce activities.

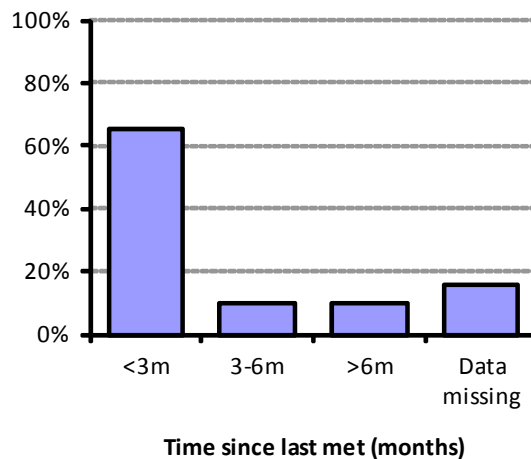
Forty-nine of the 63 districts (78%) that returned the questionnaire responded to the question on preparation of reports on core indicators. Almost all of the taskforces in these districts (96%) stated that they produced reports on core indicators. This was to be expected since this information is included in the standard monthly statistical reports required to be

submitted on a regular basis to the NAC provincial offices. Slightly fewer districts reported preparing reports on data coverage (88%) and data quality (81%). Most taskforces reported tracking trends in MOHCW indicators and also in ensuring that NAC and MOHCW ART statistics were in agreement.

4.4 Frequency of Taskforce Meetings

Two-thirds of taskforces were reported as having met in the last three months (Figure 6) and a further 10% had met in the previous three months. However, another 10% had not met for more than 6 months and 16% (10 districts) failed to provide information on the timing of their most recent meeting.

Figure 6: Time since Last Taskforce Committee Meeting



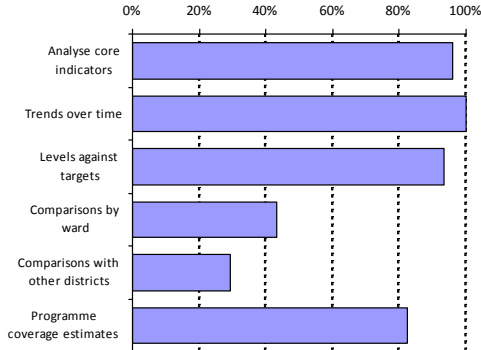
Almost half (48%) of the taskforces reporting had met at least four times in the last year. However, one-in-five taskforces had only met once or twice in the last year.

4.5 Data Analysis Reports Produced

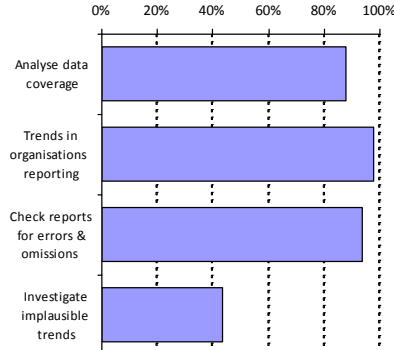
The results on proportions of taskforces producing reports are presented in Figure 7 by type of report.

Figure 7: Reports Produced by District Taskforces

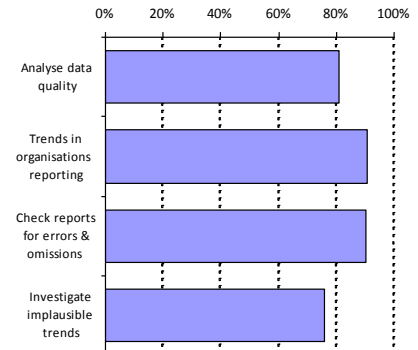
CORE INDICATORS



DATA COVERAGE



DATA QUALITY



63/85 districts, lead respondent

Core Indicators

Almost all taskforces reported producing reports showing trends in core indicators over time and comparing levels against targets. Most also maintained that they produced reports showing programme coverage estimates. However, examination of the copies of reports submitted suggests that few districts actually estimate coverage by relating numbers of clients receiving services to estimates of the numbers in need of these services. Furthermore, fewer taskforces produced reports comparing levels and trends of service provision by ward or with other districts.

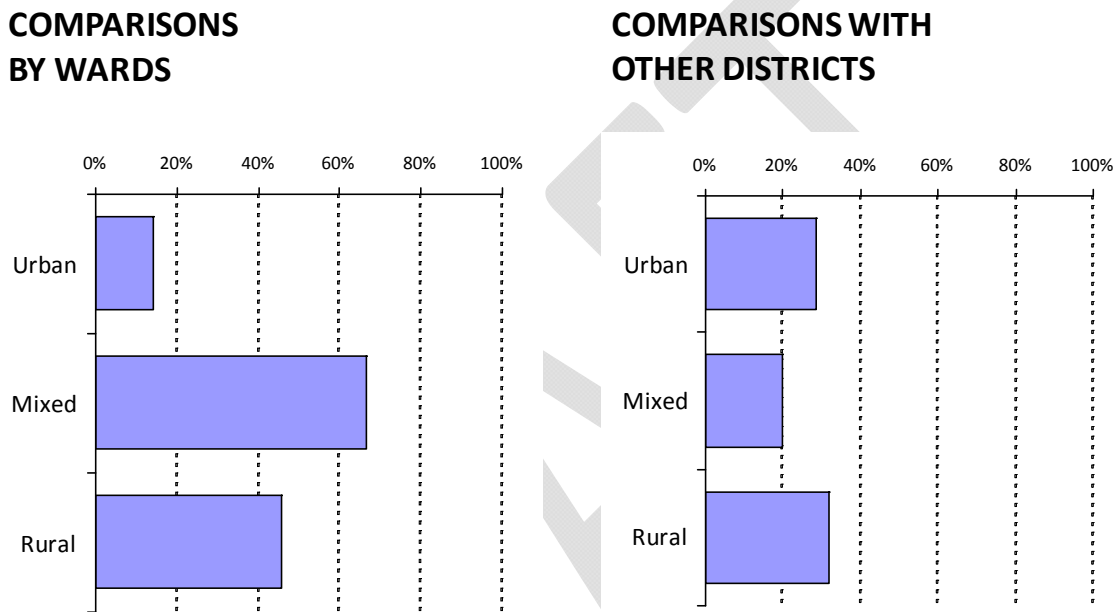
Data Coverage

Most taskforces stated that they produced reports showing trends in numbers of organisations reporting and that they checked reports for errors and omissions. However, few reported investigating implausible trends in programme indicators.

Data Quality

Most taskforces reported assessing data quality by examining trends in the numbers of organisations reporting and checking reports for errors and omissions. Somewhat fewer taskforces (amongst those that reported) stated that they evaluated data quality by investigating implausible trends in key indicators.

Figure 8: District Taskforces Reporting Comparing Core Indicators by Ward and with Other Districts



7 urban, 6 mixed & 24 rural districts reported

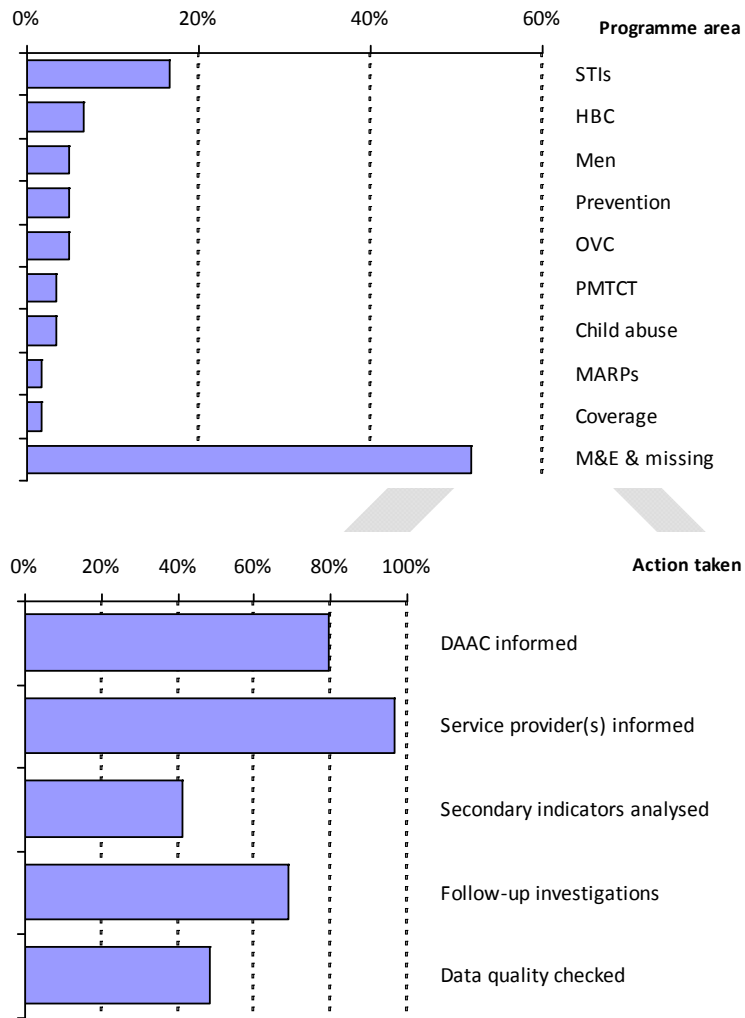
Districts with mixed urban and rural populations were more likely than other districts to report making comparisons by ward (Figure 8). Taskforces in all types of district were relatively unlikely to compare their findings with those of other districts.

4.6 Issues Identified and Action Taken

Programmatic Issues

Figure 9 shows the programmatic issues identified by the taskforces and the remedial actions reported as having been taken.

Figure 9: Programmatic Problems Identified from M&E and Actions Taken

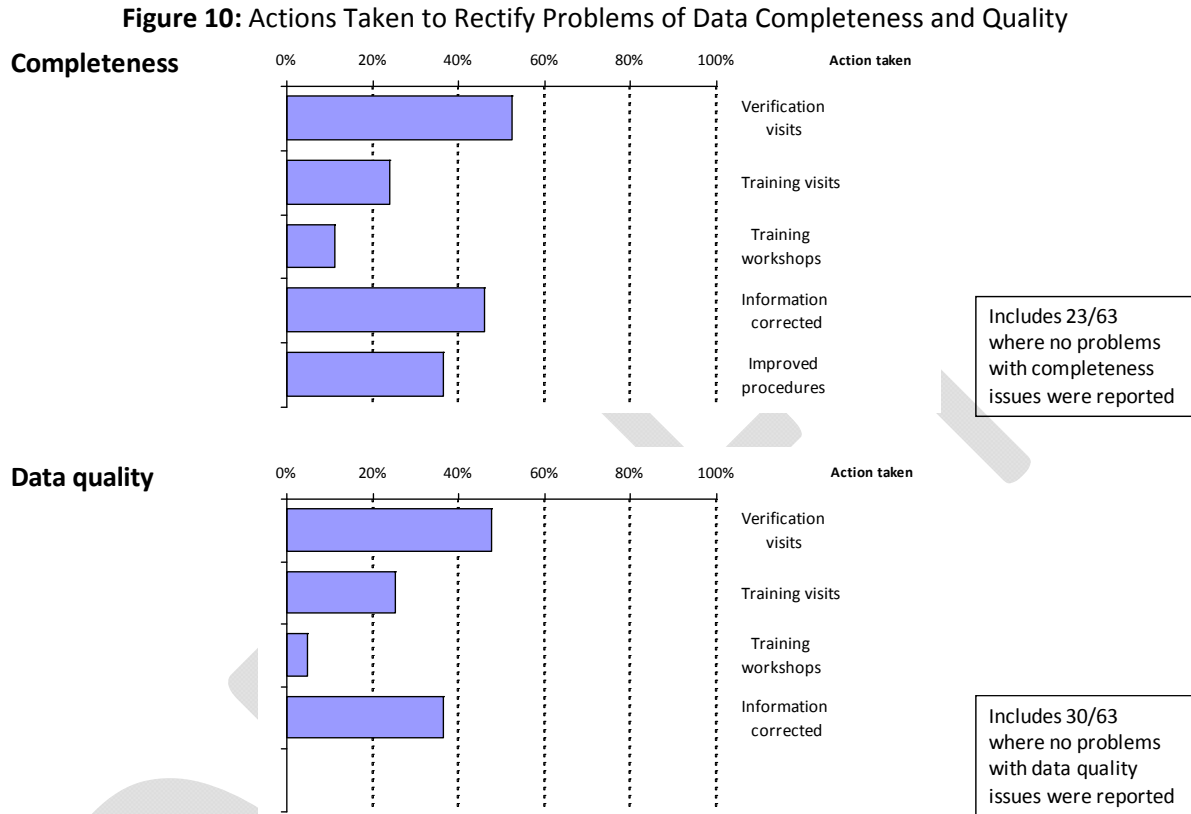


Even though the question specifically requested for programmatic issues, the most common type of problem raised was M&E issues. Of the programmatic issues mentioned, the most common concern was rising numbers of STIs. Perhaps surprisingly, none of the respondents mentioned problems with the scale-up of ART services.

In most cases, service providers and DAACs were informed of the problem. However, little was done in the way of analysis of relevant secondary indicators and few other steps were taken to ensure that the problem was genuine and to understand the problem further.

Data Completeness and Data Quality Issues

Figure 10 shows the results on actions taken by taskforces to investigate and rectify problems of data completeness and data quality.

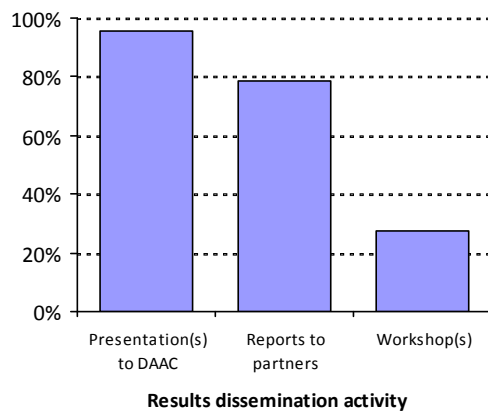


In general, there was a tendency towards fewer actions being taken to rectify data quality problems than for data completeness. In both cases, the most common action taken is to make verification visits. However, in many instances, the opportunity to conduct training during these visits is not taken.

4.7 Dissemination of M&E Results

Almost all of the taskforces that responded to this question (67%) reported presenting their findings to the District AIDS Action Committees and, in most cases, also to partners (Figure 11).

Figure 11: M&E Dissemination Activities in the Last Year



40-44 (/63) districts provided data

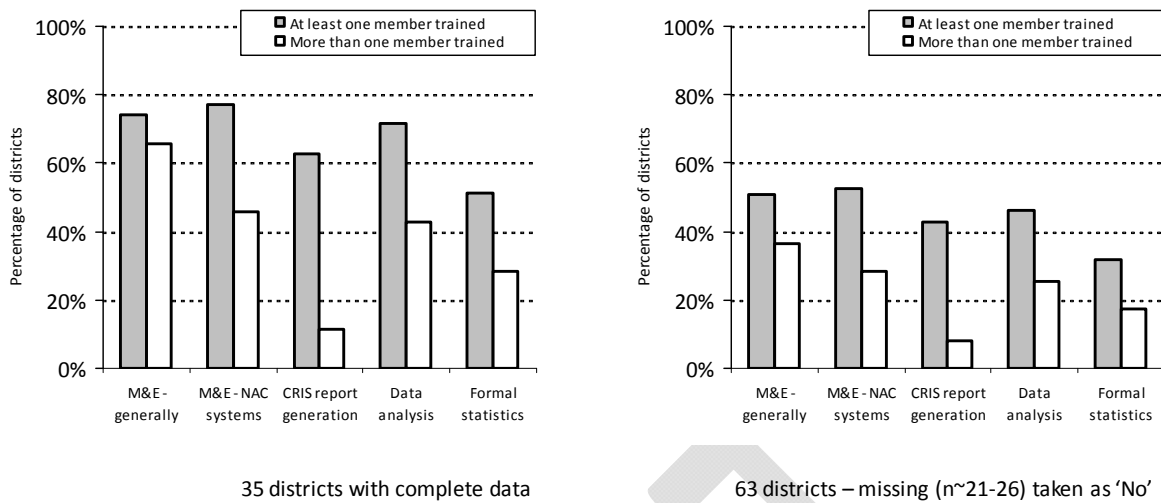
4.8 M&E Taskforce Skills

Training of Taskforce Members in M&E Skills

In most taskforces, at least one member is trained in the key M&E skills (Figure 12). However, it is of concern that more than a third of taskforces do not have a member who has been trained in how to generate reports using the CRIS system. Furthermore, it appears that the only person with training in most M&E skills is the DAC with relatively few other taskforce members having skills in NAC M&E systems, report generation (especially) and data analysis.

Again, a large fraction of respondents failed to provide information on this topic. It is possible that many of these did not respond because they had not been provided with training. The second section of Figure 12 shows the proportions trained if districts with missing information are assumed to have not received training.

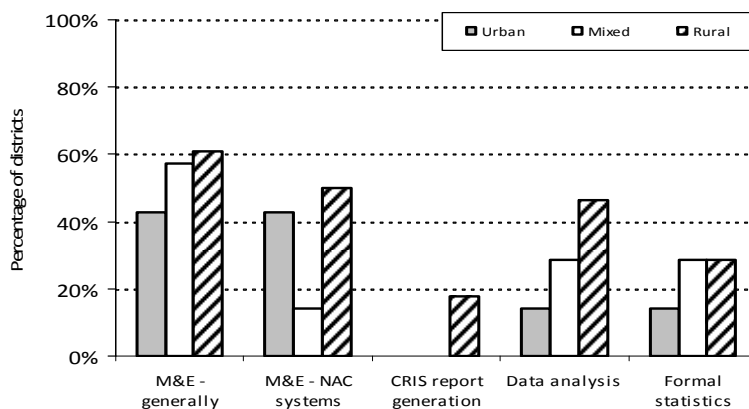
Figure 12: Training of Taskforce Members in M&E Skills



Training of Taskforce Members in M&E: Urban versus Rural Districts

Levels of M&E training tend to be higher in rural districts than in urban districts (Figure 13) although the numbers of urban and mixed (urban and rural) districts reporting were small. None of the urban or mixed districts that reported had a taskforce member who had been trained in report generation using the CRIS system.

Figure 13: Comparison of M&E Taskforce Skills: Urban versus Rural Districts

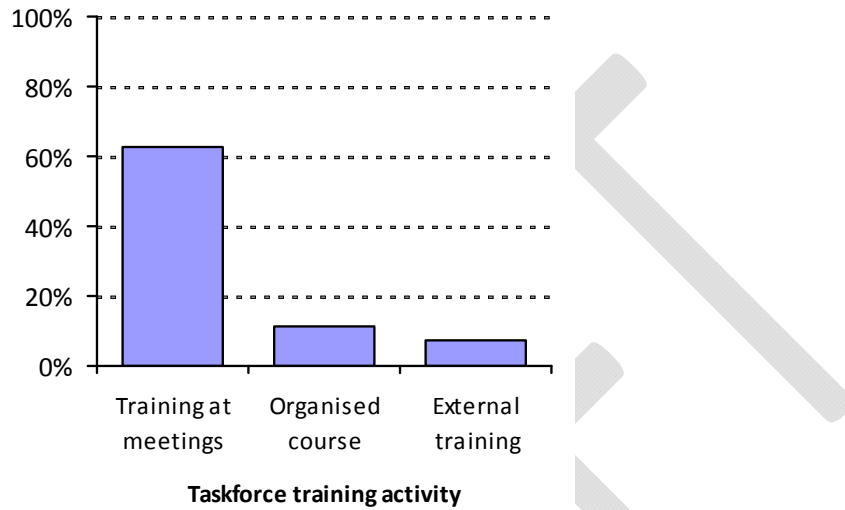


7 urban, 7 mixed & 28 rural districts reported

M&E Training for Taskforce Members in the Last Year

Generally, formal training of taskforce members is low with training at taskforce meetings being the most common form of training provided (Figure 14).

Figure 14: Forms of M&E Training Received in the Last Year

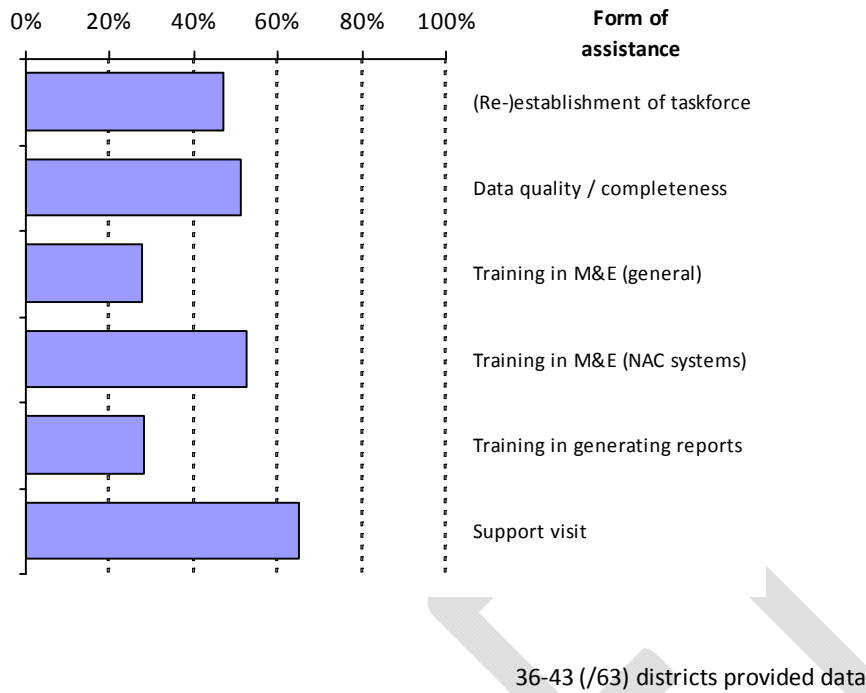


40-43 (/63) districts provided data

4.9 Provincial Support Received in the Last 6 Months

Provincial M&E officers and taskforces are responsible for supporting district M&E taskforce activities. Two-thirds of districts reported having received a support visit in the previous 6 months. Almost half of the districts had received support in connection with re-establishing the local M&E taskforce which suggests that many taskforces are struggling to remain functional. Half of the taskforces received assistance in relation to data completeness and data quality issues and half in training in NAC M&E systems. Only a quarter received assistance in generating reports.

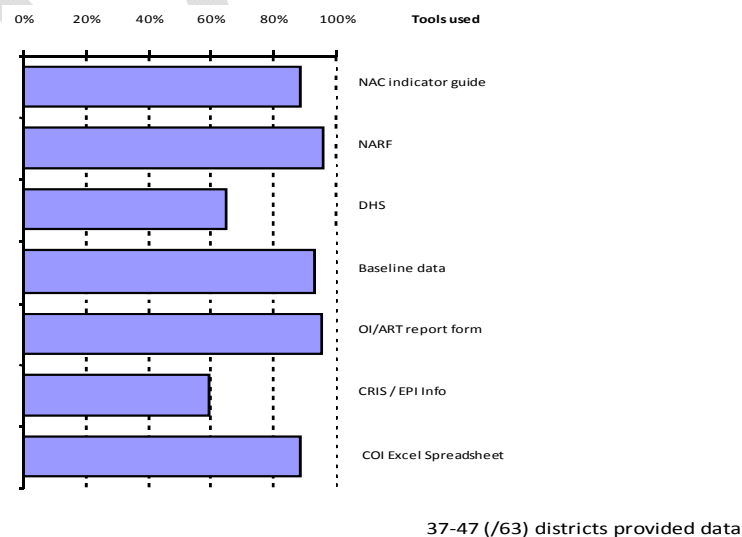
Figure 15: Support Received by District M&E Taskforces from Provincial Offices in the Last 6 Months



4.10 M&E Tools Used by District Taskforces

Almost all taskforces are using the standard NAC tools - i.e. indicator guides, NARF forms, baseline data and the COI Excel spread-sheets. However, use of the CRIS system (60%) and DHS data (67%) were relatively low (Figure 16). This may be because, during 2011, when the survey data were collected, the CRIS system had been put on hold pending the development of an updated system.

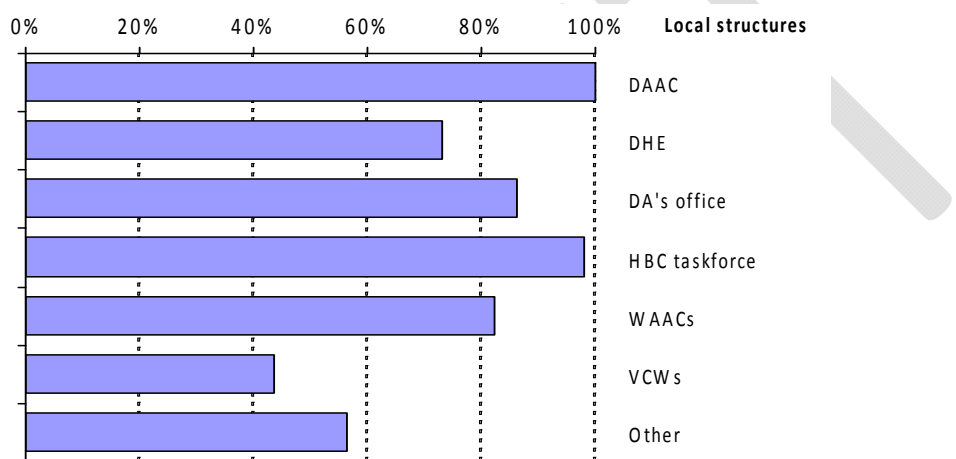
Figure 16: M&E Tools Used by District Taskforces



4.11 Local Structures Engaged in M&E Taskforce Activities

The M&E taskforces reported working closely with mainly the DAACs and the HBC taskforces. Other structures reported to be working with the M&E taskforces included the DA’s office and the WAACs. A possible concern is that more than a quarter of taskforce respondents did not report involvement of District Health Executives.

Figure 17: Local Structures Engaged in M&E Taskforce Activities



32-47 (/63) districts provided data

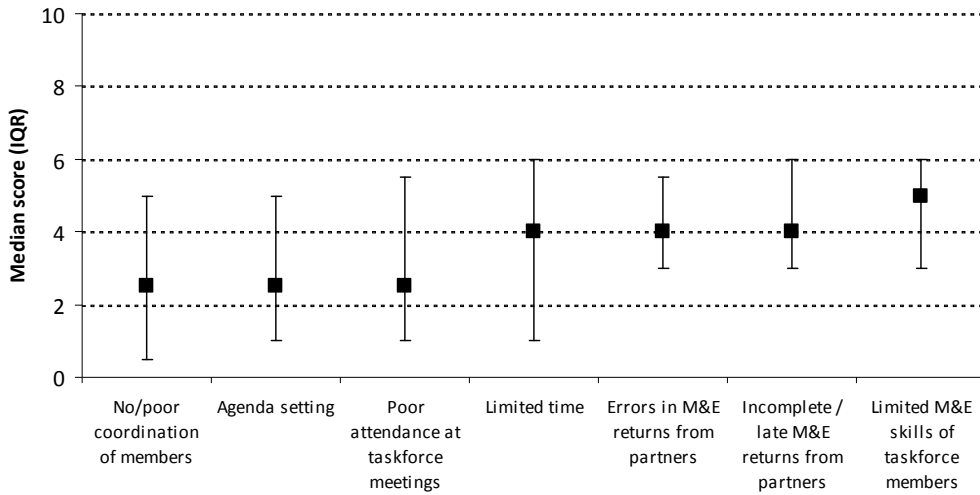
4.12 Problems Faced by District M&E Taskforces

District respondents were asked to rate the seriousness of a list of problems faced on a scale of 0 to 10. Median scores and inter-quartile ranges were calculated for each problem and the problems identified were ranked in order of seriousness (Figure 18).

On this basis, the most serious problem faced was limited M&E skills of taskforce members, followed by incomplete / late M&E returns from partners, errors in M&E returns from partners and limited time available for M&E taskforce activities. In general, poor

coordination of taskforce activities, agenda setting, and poor attendance at taskforce meetings were not seen to be major problems.

Figure 18: Rating of Problems Faced by District M&E Taskforces

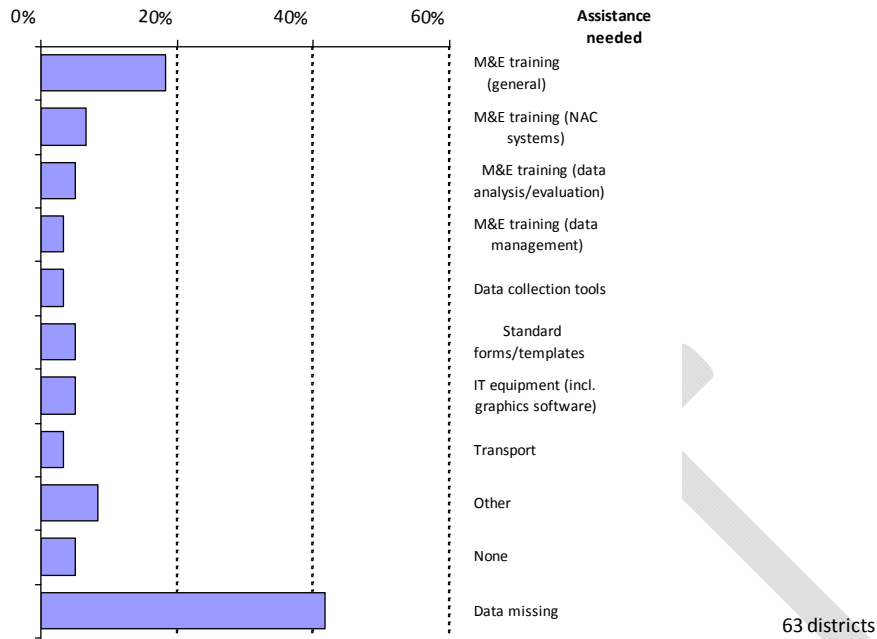


40-47 (/63) districts provided data

Results similar across respondent types

Training in M&E skills was identified as the form of assistance most widely needed by district taskforces (Figure 19). Other needs included more standard forms and templates for use in M&E and more IT equipment.

Figure 19: M&E Tools and Assistance Needed

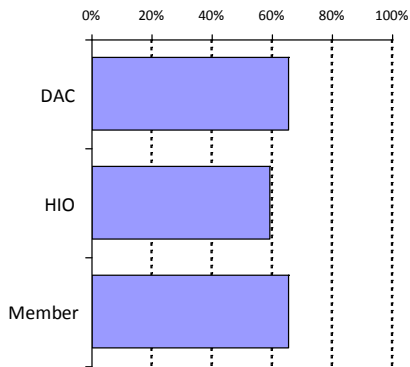


4.13 Comparison of DAC reports with those from Other Taskforce Members

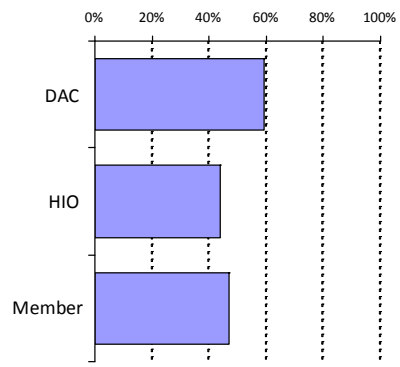
As explained earlier, the main analyses conducted and presented in this report are based on reports from lead respondents who, in most cases, were the DACs. DACs may have exaggerated the performance of their M&E taskforces; therefore, for the 32 districts where reports were received from DACs, Health Information Officers (HIOs) and another taskforce member, for a sample of questions, we compared the responses given by each of the three respondents. Overall, the patterns of responses given by each of these types of respondent were similar. Figure 20 shows the results for two sample indicators.

Figure 20: Comparison of DAC *versus* Other Taskforce Members' reports on Selected Outcomes

TRACKTRENDS IN MOHCW INDICATORS



DHE INVOLVED IN M&E



32 districts with reports from DAC, HIO & another taskforce member

All three respondent types reported that approximately two-thirds of taskforces tracked trends in MOHCW indicators. However, on DHE involvement in M&E taskforce activities, more of the DACs reported DHE involvement than was the case for HIOs and other taskforce members.

DRAFT

5.0 Summary, Conclusions and Recommendations

5.1 Summary

The needs assessment was conducted for the National M&E system being implemented by NAC through its decentralised structures. The focus was on M&E at district level with the aim of informing the design of a possible district model and toolkit for M&E activities. The needs assessment was done in three stages, namely:

- (i) Review of existing M&E policies and procedures with particular attention to current terms of reference, guidance and training given to district taskforces
- (ii) Consultations with NAC, MoHCW and UNAIDS M&E officers, the National research and M&E Advisory Group, international and local NGOs, and other national stakeholders on the need for a district model and toolkit, what it should comprise, and arrangements needed to support effective implementation, and
- (iii) National survey of the 85 NAC districts to assess the functionality and needs of M&E taskforces. A brief questionnaire was administered to District AIDS Coordinators, MOHCW M&E Officers and district M&E taskforce members.

The findings of the needs assessment will be used in the development of a district model and toolkit designed to enhance data quality and utilisation at district level.

5.2 Main Findings

5.2.1 Response Rate

The response rates in the consultation meetings and the DAC survey were reasonable. However, some stakeholders were not available for consultations and there was a high level of non-response on many of the survey questions. There may be an element of reporting bias in the data and some caution is needed in interpretation of the findings; nevertheless, we believe the data provide valuable information for assessing M&E needs at district level.

5.2.2 Functionality of District M&E Taskforces

The findings reveal that almost all districts have functioning (albeit sometimes fragile) taskforces and that most taskforces have met in the last 6 months. In addition, the taskforces prepare reports on a regular basis even though up to 50% require assistance for preparing reports as they lack key skills in M&E. Two-thirds of the districts reported having a work plan.

5.2.3 Data Analysis

Most taskforces reported completing the standard analysis on COI. However, more work could be done to distinguish genuine trends in indicators from those resulting from fluctuations in data completeness and data quality and to relate programme outputs to levels of need for services at district level - i.e. on possible outcome indicators. Few districts identify gaps in service by making comparisons across wards or compare outcomes with other districts as a means of evaluating progress in scaling-up services.

5.2.4 M&E Skills

Taskforce members require more formal skills-building on M&E. Some skills are completely lacking (e.g. CRIS) in other taskforce members. There is potential for a greater role of provincial staff in building capacity of taskforce members.

5.3 Recommendations

The above findings suggest a number of actions that could be taken to strengthen the NAC HIV/AIDS M&E systems including by reinforcing the work done at district level through the development of a district model and toolkit for M&E activities. The toolkit would draw together existing procedures, guidelines and tools and address gaps identified in the needs assessment.

The following specific ideas could be considered:

5.3.1 National M&E System Strengthening

1. Strengthen the partnership between NAC and MOHCW at all levels and harmonise deadlines and reporting periods
2. Utilise the strategic opportunity provided by NAC's presence and M&E capacity at district level for advising the MOHCW and other partners on M&E
3. Address gaps in national data on key global M&E indicators by initiating data collection on these indicators at district level
4. Develop a more detailed and realistic timetable of activities for preparation and submission of reports that allows for meaningful local participation and ownership
5. Promote consistency and accountability by encouraging partners to send the same representatives for taskforce meetings

5.3.2 District M&E Model

1. Revise and detail the timetable for submission of reports by DACs and provinces to allow for meaningful involvement of district taskforces in the review, correction and interpretation of the data to be submitted - i.e. based on the timetable referred to above
2. Develop guidelines and tools for DACs and district taskforces to: (i) impute estimates where there are gaps in the data reported by partners; (ii) make adjustments when partners fail to submit reports and then submit reports for multiple periods retrospectively; and (iii) submit corrected reports for prior periods where follow-up investigations reveal errors in data submitted in earlier reports
3. Provide more tools for use in data analysis including spread-sheets for calculating indicators on coverage
4. Include establishment, administration and facilitation of district M&E taskforces in the job description for District AIDS Coordinators

5. Develop a specific TOR for district M&E taskforces that includes deliverables - e.g. activity plans, reports and targets
6. Develop internal M&E system indicators (based on the TOR deliverables) that can be used by local taskforces and by provincial staff to monitor performance
7. Provide formal training in report generation, data analysis and interpretation, and other M&E skills for (particularly non-DAC) local taskforce members
8. Include training on how to examine indicators in combination (e.g. for PMTCT indicators) as a means of (internal) validation and interpretation
9. Appraise district M&E taskforces on the methods used (nationally) to establish local targets; where possible, increase local participation in the setting of these targets
10. Encourage and provide tools for district taskforces to identify gaps in service provision by comparing levels and trends in key indicators between wards
11. Encourage other M&E taskforce members to support the DAC in the collection, validation, analysis and interpretation of local M&E data
12. Develop a schedule of data analysis and review activities for district M&E taskforces that combines regular review of a small number of key indicators spanning the range of programme areas with a cycle of in-depth analysis of indicators on each major programme area
13. Arrange for routine participation in the quarterly district taskforce meetings by provincial M&E staff – to strengthen support for district efforts and to identify and address local needs as they arise
14. Develop an inventory of resources required for M&E of HIV programmes and make these available to district taskforces - e.g. including data on denominators for calculating selected outcome indicators and mechanisms for comparing local outcomes with those achieved in other districts and nationally (including use of DHS data)

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